# A CASE STUDY OF TRAUMA-INFORMED PRACTICE AND IMPLEMENTATION TO SUPPORT MENTAL HEALTH AND LEARNING IN PUBLIC SCHOOL IN SUFFOLK COUNTY, NEW YORK

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## ABSTRACT

A CASE STUDY OF TRAUMA-INFORMED PRACTICE AND IMPLEMENTATION TO SUPPORT MENTAL HEALTH AND LEARNING IN PUBLIC SCHOOLS IN SUFFOLK COUNTY, NEW YORK

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The purpose of this study is to examine the readiness of school districts in Suffolk County, New York, to implement a trauma-informed system to address the growing needs of mental health interventions in student populations. A review of the literature will show a historical prevalence of mental health providers and individual student interventions within the school building, or in partnership with community agencies. Recent literature shows an increase in school-related issues have origins in student trauma or adverse childhood experiences. The study will examine the issue by conducting a mixed method analysis, using a survey instrument and focus group interviews, of members of the Suffolk Directors of Guidance. Significance of the study will help districts who want to implement a systematic and districtwide approach to mitigating trauma-related student issues by identifying current readiness and examining gaps in preparation to implement the National Dropout Prevention Center's Trauma-Skilled Schools Model.

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# CHAPTER I

# INTRODUCTION

School districts across Suffolk County in New York State are experiencing increased issues with attendance in the form of school refusal, school avoidance, and anxiety. This is a topic of concern for many district leaders, from Superintendents to building Principals, as Pupil Personnel Service providers express difficulty in encouraging students to come to school. Research indicates that the dropout and school non-attendance numbers students today are battling unprecedented levels of stress and increased exposure to trauma (National Dropout Prevention Center, 2018).

Public schools in New York state are charged with providing students Free Appropriate Public Education, or FAPE, (Rehabilitation Act, 1973). There is an understanding of shared responsibility between schools and parent/guardian. Compulsory age of attendance in New York state is 16 years old, where students must be educated. Many students, however, have experienced mental health issues that have impeded their progress in school, leading to complicated issues such as non-attendance, truancy, school avoidance, low academic performance, and greater issues such as self-harm or suicide (CDC, 2019). The result has been schools today have been asked to take on significantly more mental health services for children, from handling basic Mental Health and Wellness, drawing connections between mental health and academic performance, and providing direct services or referrals. The prevalence of mental health issues often has ties to racial composition poverty rate and income level along with the location and size of school. Historically, urban and poorer school communities tend to

have a greater need for mental health services (Slade, 2003), but recent data shows that mental health issues with students in affluent communities are increasing, as they are showing more signs of stress and trauma due to high expectations (Luthar, 2013).

## Statement of the Problem

School administrators, teachers, pupil personnel staff, and parents are all challenged by issues of student attendance. While there are many factors that may contribute to chronic absenteeism, and this has been the focus of much research and intervention, school staff and parents today report an increasingly common issue of anxiety as being a primary cause. The anecdotal support of this from practitioners in the field along with the New York State's Office of Mental Health identifying Suffolk County's need to improve Single Point of Access (SPOA) services to streamline mental health services for youth (OMH Statewide Comprehensive Plan, 2016), underscore the problem of increased mental health issues among youth and the impact it has on learning. According to the National Dropout Prevention Center, the vast majority of mental health issues that affect school performance, school climate, attendance and potential dropout are linked to student trauma (Addis, 2018).

## Purpose of the Study

This study will examine the readiness of school districts in Suffolk County to adopt the National Dropout Prevention Center's Trauma-Skills School Model. A review of the literature shows that most responses to mental health prevention and intervention occurs in the form of identifying and responding to individual students. The most recent

literature shows that, due to the increase in number of students and the difficulty in identifying those students, a model called Trauma-Skills School Model (TSS Model) creates an environment in a school where all students are positively impacted on a Tier 1 Intervention model (National Dropout Prevention Center, 2018). The study will explore the depths in which schools already have trauma-informed awareness and what gap exists to implement a TSS Model. The research on implementing a model of trauma-informed practice is lacking, so it is the objective of this study is to examine readiness of school districts in Suffolk County, New York to do so.

**Research Questions**

1. What elements of trauma-informed practice do the Guidance Directors in Suffolk County already know, and what elements are currently being practiced?
2. What gaps exist between current levels of knowledge and practice need to be met to implement the Trauma-Skills School (TSS) Model?

**Overview of Methodology**

This study will be a mixed method case study exploratory design of qualitative and quantitative analysis. The quantitative method will be used to gather data on the first research question of pre-existing knowledge and practice of trauma-informed practice is already occurring using a cross sectional survey design of Guidance Directors in Suffolk County as the sample. The qualitative method will be used to gather data on the second research question of identifying gaps in the current practice of a sampling of Suffolk

County school districts and the elements of the TSS Model by conducting focus groups of the same sample.

**Significance of the Study**

Trauma-informed care is a term that has applications to the healthcare fields, both in medicine (Massachusetts General Hospital, 2014) and mental health (Harvard Health Blog, 2018), as well as education. As many as one in four children have experienced at least one traumatic event (CDC, 2019), which potentially puts up barriers to physical and mental health, as well as and learning. Trauma-informed care means that providers are sensitive to individuals with trauma stemming from a history of physical, emotional, and/or sexual abuse, or circumstances involving dramatic fear, worry, stress, illness, or loss (Harvard Health Blog, 2018).

Trauma-informed schools are defined by the engagement of the adults in the building to create a system of support for students who are affected by traumatic stress. A system of dealing with students identified as traumatized, along with school-wide culture of respect and support, is the goal for a trauma-informed school (traumawarenessschools.org, retrieved 9/29/2019). The National Child Traumatic Stress Network identifies the following situations that can affect traumatic stress in children and affect their learning and behavior: physical or sexual abuse; abandonment; neglect; the death or loss of a loved one; life-threatening violence in a caregiver; witnessing domestic violence; automobile or other serious accidents; bullying; life-threatening health situations and/or painful medical procedures; witnessing or experiencing community violence (shootings, stabbings, robbery, or fighting) in the home, school and/or

neighborhood; witnessing police activity or having a close relative incarcerated; life-threatening natural disasters; acts or threats of terrorism (viewed in person or on television); living in chronically chaotic environments in which housing and financial resources are not consistently available (NCTSN Child Trauma Toolkit for Educators, retrieved 9/30/2019).

There is much written on the importance of trauma-informed or trauma-sensitive care in the school and health setting. The study focuses on how a practitioner may assist directly with students who have experienced trauma. More recent theories involved systematic and organizational support of trauma-impacted students. According to the National Dropout Prevention Center, many students go unidentified as a student who has experienced trauma, or Adverse Childhood Experiences (ACEs) and they may still be affected by trauma negatively in their school performance. Therefore, there is an increasing push, and supporting literature, of the need for a school-wide model.

The National Dropout Prevention Center (NDPC) has produced a model called the Trauma-Skilled Schools Model, which will serve as the conceptual framework for this study.

**Role of the Researcher**

The role of this researcher will be to provide a comprehensive review of the literature, showing that the historical approach to addressing mental health issues in schools was to identify students and provide interventions, and has now evolved into providing system supports for all students, due to the large numbers of students and the difficulty in fully identifying each one. The researcher will get university approval for

this study, which is aimed at examining the readiness of school districts in Suffolk County, New York, for implementing a school-wide trauma-informed system, using the NDPC TSS Model as the framework. The researcher will conduct the study instruments by conducting surveys and focus groups of the samples in this case study. The qualitative and quantitative data will be analyzed and aggregated, and conclusions and recommendations will be developed.

**Researcher Assumptions**

It is the assumption of this researcher that many districts in Suffolk County do not have a trauma-informed approach as a school- or district-wide system, but many will be individual providers that are familiar with the theories in trauma-informed care. It is likely that these districts have practitioners within their schools, particularly in the PPS department, who practice trauma-informed care with their students.

**Definition of Key Terminology**

The following definitions provide an understanding of terms consistently used throughout this study:

- *Adverse Childhood Experiences (ACEs)*: This term is used to describe all forms of abuse, neglect, and other potentially traumatic incidents a child experiences before the age of 18 (CDC, Adverse Childhood Experiences, retrieved October 9, 2019)
- *Individuals with Disabilities Education Act (IDEA)*: A federal law that makes available a free appropriate public education to eligible children with disabilities

throughout the nation and ensures special education and related services to those children (Department of Education, retrieved October 9, 2019).

- *Mental Health*: Term used to include emotional, psychological, and social well-being, affecting how a person thinks, feels, and acts, with special importance to how we handle stress, relate to others, and make choices (US Department of Health and Human Services, retrieved October 9, 2019).
- *Pupil Personnel Service*: Pupil Personnel Service (PPS) staff include school counselors, psychologists, social workers, attendance teachers and nurses, and are in are trained to evaluate factors that contribute to student difficulties with behavior and academic achievement, and protect the health and safety of students (New York State Education Department, retrieved October 9, 2019).
- *Section 504*: A federal law designed to protect the rights of individuals with disabilities in programs and activities that receive federal financial assistance from the department (Department of Education, retrieved October 9, 2019).
- *Suffolk Directors of Guidance (SDOG)*: The professional organization of lead counselors and administrators in Suffolk County, New York, that will serve as the sample of this study.
- *Tier 1 Intervention*: Tier 1 is commonly identified as the core instructional program provided to all students by the general education teacher in the general education classroom. Research-based instruction and positive behavior intervention and supports are part of the core program (New York State Education Department, retrieved October 9, 2019).

- *Trauma-Informed Practice*: Trauma-Informed Practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for everyone, and that creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper et al., 2010).
- *Trauma-informed School System*: A school system that recognizes that trauma affects staff, students, families, communities, and systems and implements organizational support, partnerships, and capacity-building (The National Child Traumatic Stress Network, retrieved September 29, 2019).
- *Trauma-sensitive:* Term interchangeable with "trauma-informed."
- *Trauma-Skills School Model*: The trauma-informed full school system model, created by the National Dropout Prevention Center, that ensures the school is "trauma-skilled" by training all staff in trauma-informed and all systems are trauma-sensitive (National Dropout Prevention Center, 2018).

**Organization of the Dissertation**

In the remaining chapters of the dissertation, Chapter 2 will examine the literature surrounding mental health in schools and trauma-informed practice. A theoretical and conceptual framework will be included. Chapter 3 will be a description of the methodology, which will be a mixed method design of the case study. Chapter 4 will include the findings and data analysis of the study. Chapter 5 will analyze the findings and provide conclusions and recommendations for future study.

# CHAPTER II

# REVIEW OF RELATED LITERATURE

## Introduction

A review of the literature will examine the prevalence of mental health issues in children and adolescents, a history of mental health interventions and programs in schools in the United States, traditional approaches to identification and intervention, and more recent trauma-informed practice and systems.

## Theoretical Framework

The given culture in a particular learning community is the determinant of behavior within the community. Behavior influences the expectations of the community, as it is based in past learned experiences. The collective behavior of the community creates the learning systems, reflecting the values of the community. Both the systems and expectations then further strengthen and influence the culture.

The theoretical framework of this study is based off the Organizational Theory of Lee Bolman and Terrence Deal. Bolman and Deal (2003) describe organizations within four frames; the structural frame, the human resource frame, the political frame, and the symbolic frame. These frames help leaders and participants in organizations understand the structure, where the strengths and weaknesses are, and thereby understanding improvement and change.

When we look at the problem of mental health issues in students' lives today, and how those issues impact student learning, this study looks at the problem through the

theoretical framework of how to improve organizational structure to address the problem. As this literature review will examine, the issues of mental health have historically been seen as a solution to an individual problem (or student) to the widespread impact of trauma on most students, causing us to look at the problem through an organizational lens. Bolman and Deal help us look at the structural, human, political, and symbolic frames that would need to be considered as one looks at how ready a district would be to implement a full-school trauma-informed model such as National Dropout Prevention Center's Trauma-skilled Schools Model.

**Mental Health Diagnoses in Children and Adolescents Today**

To properly consider the prevalence and significance of mental health diagnoses in children and adolescents today, it must first be known what the term encompasses and what is meant when one is considered to be mentally healthy. In doing so, deviations from progressive and optimal mental health can be identified and contrasted appropriately. Among the leaders in global public health is the World Health Organization who defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2014). In the aforementioned definition, which is included in their constitution, the World Health Organization is intentional to emphasize that the picture of complete health, including mental health, is more than the mere absence of disease, disorder, or disability. Mental health is a broad term that is commonly understood to include social, emotional, and psychological well-being (U.S. Dept. of Health & Human

Services, 2019). The Centers for Disease Control and Prevention (CDC) furthers these definitions with specific regard to adolescents stating that "mental disorders among children are described as serious changes in the ways children typically learn, behave, or handle their emotions" (CDC, 2019). With mental health significantly affecting the way that a child learns, behaves, and rationalizes and the consideration that the average American student attends school for 6.64 hours per day for 180 school days per year, it is evident why schools are being looked to as pillars of community mental health service and support across the nation (U.S. Dept. of Ed, 2008).

According to the CDC, anxiety, depression, behavioral problems, and ADHD are the most prevalent mental disorders diagnosed in children in the United States. Most recent statistics reveal 9.4% of children ages 2-17 years old are diagnosed with ADHD. In children ages 3-17 years old, 7.4% have a diagnosed behavior problem, 7.1% have been diagnosed with anxiety, and 3.2% have been diagnosed with depression. This number totals about 17 million children nationwide. Additionally, several of these conditions frequently occur together. Approximately 3 in 4 children with depression also have a diagnosis of anxiety, for children diagnosed with anxiety, 1 in 3 also have behavior problems and 1 in 3 have been diagnosed with depression as well. Furthermore, the rates of depression and anxiety diagnoses among children have increased over time. In children aged 6 to 17 years, the rates of children diagnosed with anxiety and depression increased from 5.4% in 2003 to 8% in 2007 and to 8.4% in 2012. In children ages 2-8 years old, boys were more likely than girls to have a developmental, behavioral, or mental disorder. Also, more than 1 in 5 children (22%) living below 100% of the federal poverty level were diagnosed with a mental, developmental, or behavioral

disorder (CDC, 2019). Research conducted by the Institute of Medicine and the National Research Council revealed that an estimated 13-20% of all children living in the United States, up to 1 in 5, experience a mental disorder in any given year with, upwards of $250 billion dollars spent each year toward the treatment of said mental disorders. Other mental health disorders that are prevalent in children and adolescents include Autism spectrum disorders, Tourette syndrome, alcohol use disorder, illicit drug use disorder, and cigarette dependence (CDC, 2019). In 2010, suicide was the second leading cause of death in children ages 12-17 years (CDC, 2013).

A study conducted between 2002-2003 provided the first national survey of mental health services in public schools in which a representative sample of 83,000 public elementary, middle, and high schools as well as their associated districts were used. There were several key findings that contribute to the understanding of how prevalent mental health issues are in American youth and how schools play a vital role in the treatment and health of these children. Approximately 20% of the students in this study received a least one type of school-supported mental health service in the school year prior to the study. Most commonly, school-based mental health providers include primarily school counselors as well as nurses, school psychologists, and social workers. Approximately 30% of time spent with students by school nurses was providing mental health services. Finally, 60% of districts reported that referrals to community-based providers had increased compared to the previous year (Foster, Rollefson, Doksum, et. al., 2005).

The mental health and wellbeing of children is an important public health issue in the United States due to their early onset, prevalence, and lasting impact on the

individual, family, and community. These disorders frequently disrupt a child's ability to learn in the classroom, participate in social interactions, and develop healthy relationships with peers (ACMH, 2019). For educators, early identification is a vital part in getting adequate services and treatment (CDC, 2019). Since teachers often spend as much, if not more, time with their students than parents may with their child throughout the course of a school day, they can be the first to recognize signs and symptoms of a mental health issue, thus playing a key role in early identification and referral for treatment and services. Teachers, counselors, and other educators may notice mood changes, social withdrawal, functional decline, increased difficulty in problem solving and logic, nervousness, apathy, increased sensitivity, and exaggerated thinking in students facing potential mental health disorders. Schools have long-since been considered a safe space, a place of gathering in communities across the nation, who have provided food to hungry children and books to kids who have none at home. In the same sense, schools are being looked to as key responders and voices in the mental health crisis facing American children and adolescents today. The need for schools to create systems and put in place processes to help students in the diagnosis and treatment of their mental health issues is prominent, in order for these children to be able to be productive, fruitful, contributive, and healthy students as well as members of their respective communities.

**A Historical Review of Mental Health Services in Schools**

School mental health services have a long history in the United States, starting in the late 19th century. Although it is commonly assumed that mental health services in schools is a relatively new phenomena, educators in the late 1800s were aware of the

physical and emotional issues that affect student learning. Pupils would be seen by "visiting teachers" to talk to students about problems at home, the precursor to what we now know as school social workers (Sedlak, 1997). The 19th century also saw the establishment of compulsory attendance laws for school-aged children (Pumariega & Vance, 1999).

In 1935, Flint, Michigan had about 50 schools offer summer and after-hours programs, health and nutrition services, and community education programs. The early 20th century saw school-based health inspection, immunization, and dentistry to immigrant children (Dryfoos, 2002). The 1960s saw the human-service integration movement being reinvigorated, but until the 1980s, services were mostly limited to physical health issues, such as health education, health services, and health environments (Adelman and Taylor, 1997). The 1961 Joint Commission on Mental Health and Illness reported that up to 12% of children under the age of 14 had mental health problems that warranted professional help. They were, however, characterized as character problems that involved delinquency and vice, not psychoses. Poverty, welfare, institutionalization, foster care, broken homes were common denominators. In the Post War era, most mental health care professionals were trained to, and only worked with, veterans who suffered service-related neuropsychiatric diagnosis (Levine, 2015). In 1970, the beginning of school-based mental health centers started to form (Slade, 2003).

A key change in children's mental health service was the deinstitutionalization of people and students with intellectual disabilities. The 1984 landmark lawsuit of *Halderman v. Pennhurst State School and Hospital* signaled the decline of institutionalized individuals with intellectual disabilities or "mental retardation," as it was

commonly referred to at the time when taking in patients (Levine, 2015). The Federal *Individuals with Disabilities Education Act* of 1975 was applicable to this lawsuit. The shift from placing children in institutions to keep them in schools has contributed to the increased need for mental health services in schools.

By 1980, a number of schools initiated the "full-service" community school, primarily out of concern for prevention of teenage morbidity (drugs, violence, etc.) and implemented medical clinics within the school (Dryfoos, 2002). Generally, however, services across the United States were uncoordinated and piecemeal. Programs, such as New Jersey's School-Based Youth Services Program, Healthy Start Initiative in California, and Beacons Schools in New York, began to institutionalize collaborations between schools, public agencies, and private services, albeit difficult to implement (Adelman and Taylor, 1997).

At the turn of the 21st century, Florida, Kentucky, California, New Jersey, New York, and Oregon were exploring the possibility of developing strong state-wide relationships between public agencies, private community agencies, and schools (Adelman and Taylor, 1997).

Today's definition of a full-service school is one that is open to students, families, and community members before, during, and after school hours, seven days a week, all year, as a partnership between the school system and one or more agencies (Dryfoos, 2002).

The first comprehensive study on school mental health was done in 2002 by the United States Department of Health and Human Services. The study surveyed 83,000 public schools, encompassing elementary, middle, and high schools, in a mix of small

and large, urban and rural, and mixed socioeconomic profiles. The study looked at what were the most prevalent mental health issues facing students, and what were the most common interventions that schools utilized. First-ranked mental health problem for all males and females at all levels of school (elementary, middle, and high) were classified as "social, interpersonal, or family." Second-ranked for males at the elementary, middle, and high school levels were "aggression or disruptive behavior." Third-ranked for males at the elementary and middle school levels were "behavior problems associated with neurological disorders." Third-ranked for males at the high school level were "alcohol/drug problems. Second-ranked for females at the elementary and middle school levels were "anxiety." Second-ranked for females at the high school level were "Depression/grief." Third-ranked for females at the elementary and middle school level were "adjustment issues." Third-ranked for females at the high school level were "anxiety." Services in schools most commonly used were: (A) assessment for emotional or behavioral problems/disorders, (B) behavior management consultation, (C) crisis intervention, and (D) referral to specialized program/service. Services in schools most rarely used were:(A) Family support services, (B) group counseling, (C) substance abuse counseling, and (D) medication/medication management. The services and supports most commonly used were also the ones that districts reported the greatest ease in implementing. The services that were more rarely used interestingly appeared on the highly ranked problems that districts encountered (i.e. drug use, group counseling for social support, and family support).

## State and Federal School-Based Mental Health Policies and Laws

The Federal Government's *Individuals with Disabilities Education Act* (IDEA) of 1975, guaranteed education to those who were hospitalized or not. The right of a "free appropriate public education (FAPE) was guaranteed through this federal act. In 2015, approximately 6.4 million students, ages 3 to 21, or 13% of all public education students, receive special education services through IDEA. Because of this, students are mainstreamed, brought out of the institutional model, and mental health services are within the purview of related services that affect learning (Levine, 2015).

The administration of President George W. Bush saw the report of the President's New Freedom Commission on Mental Health. This report studied all aspects of mental health in the United States, in both children and adults. It was noted in the report that one-fifth of Americans can be serviced in the schools (President's New Freedom Commission, 2003).

New York State's School Mental Health Law, the second in the nation behind Virginia (Children's Hospital of Philadelphia, 2018), is a landmark initiative that puts mental health prevention on the same curriculum standing as physical health education. Mental health education is to be delivered like physical education (PE) throughout a pupil's time in school. The law requires minimum instruction for K-6 students. "The elementary school curriculum shall include a sequential health education program for all pupils, grades K-6. In the kindergarten and primary grades, the teacher shall provide for pupil participation in planned activities for developing attitudes knowledge that contribute to their own sense of self-worth, respect for their bodies and

ability to make constructive decisions regarding their social and emotional health, as well as physical health and mental health." (NYSED, 2018)

State juvenile delinquency laws, or steps immediately before such as PINS (Persons in Need of Supervision) or PINS Diversion in New York State, often have consequences where students are placed on formal probation and/or residential placement, where services are provided (Levine, 2015).

**Role of Schools in the Provision of Community Mental Health Services**

It is generally accepted that while schools are primarily responsible for educating children, they are also responsible for interventions, both in the physical and mental health of the youngster, if those impairments impact their education. The collaboration between health professionals and school staff are vital in achieving this (Adelman & Taylor, 2006).

While it is impossible to predict the future, there is greater evidence that the school may become a "full service school" (Adelman & Taylor, 2006), where mental health interventions are integrated into the school building. This is in light of the fact that most schools do not want to be in the mental health field, and that opening the door to being "full service" is ominous to some. Thus, the partnership of agencies and the clear delineations must be made. School-owned services and community-owned services must work together to create a mentally healthy school, but roles must stay defined in the ever-increasing need for health services among school-aged children.

Dr. Eric Slade writes a piece that examines the availability of mental health services in US schools, looking at 3 main services; mental health counseling, physical

examinations, and substance abuse counseling. The findings of the research suggested that availability of resources had variables that included geographic region, size of school, racial composition, wealth, urbanicity, and access to Medicaid funding. The author describes an increase in the need for mental health access in schools, as it is a variable that affects student learning and achievement. Disagreement exists on whether schools should be referral centers for students and families, or if the clinicians and providers should be based at the school, and even school employees. The research suggested that schools in the North and West had a greater likelihood to have mental health services, as opposed to the South and Midwest. The larger the school, the greater correlation to having services as well. These findings had the most statistical significance, although the author would also point out that there was a positive relationship between high minority populations and the presence of mental health services. Slade states that half the schools in the US have no on-site services, and only 10% of schools have access to all three main services. It is the opinion of the author that this issue is a serious one, as it is the school's job to remove barriers to learning, and for many students, mental health and physical health issues present a serious obstacle to achieving that (Slade, 2003).

When looking at the specific issue of school avoidance, Wilkins examines the connection between chronic absenteeism and "non-attenders" and their response to a new alternative school setting. The author outlines the reasons for non-attendees, which included primarily "detachment from school and in the school setting." School refusers, such as truants and school phobia students, are documented and Wilkins briefly summarizes some studies done on these groups. Predictors for school absenteeism,

which include both avoidance and attention-seeking behaviors. The study consists of a series of interviews with 4 students who were previously school non-attenders, who are now in an alternative setting. Interview questions are on students' previous experiences, specific aspects or school that made them not want to attend, and factors that encouraged them to attend in their new alternative school. Wilkins summarized her findings in themes of school climate, academic environment, discipline, and relationships with teachers. Wilkins concluded that students were more comfortable and more likely to attend school when the school climate was less intense and formal, more flexible academically, more understanding of a student's mindset when disciplining, and a perception from students that teachers care about them (Wilkins, 2008).

An article in the *Professional School Counselor,* Schopen describes the definition and use of a brief strategic intervention, a technique that targets unwanted behavior and seeks to replace with wanted behavior in as little time as possible. The author states that this is vital in school avoidance behaviors because the avoidance is caused by stress, absenteeism increases the stress, thereby compounding the problem by avoiding school. Schopen describes the guidance counselor's role in this intervention by utilizing a 4-step process. These steps include meeting with parent and student, identifying barriers the student perceives, removing the barriers and asking the student for cooperation in return, and monitoring progress on a daily basis. The author discusses student progress from this intervention when necessary, and reports 3 instances of student behavior that was successfully modified (Schopen, 1997).

**Components of Evidenced-based School-Based Mental Health Centers**

The term "wraparound services" is used frequently in the literature surrounding school-based mental health. It implies the range of services needed to meet the needs of students. The location of services is a consideration in access. Implementation of "one-stop shopping" with schools being a logical location. It would provide a family service or resource center, at or near a school, including medical, mental health, and social services (Adelman and Taylor, 1997).

A study (Burns, et al., 1995) showed that in the areas of Western North Carolina, both in rural and urban settings, the majority of children receiving mental health care received it in the schools, from either a school counselor or school psychologist. More than 75% of children who received care received it from the education sector. However, only about 40% of severely emotionally disturbed children received any kind of mental health care. Organizationally, the authors conclude that the location of mental health professionals should therefore change to be housed in the school building.

A 2011 study (Blackman, et al., 2016) showed a school-based mental health pilot program that had components of training, staffing, student assessment, implementation of services and program evaluation. The 2010-2011 pilot worked with 75 at-risk youth and their families in a diverse urban school district in North Carolina. Staff reported positive outcomes and behaviors using a program they referred to as the School-Based Support (SBS) program, where services were within the school. The study was conducted to gain administrators' perspectives of the program. The data was collected through qualitative methods, "focusing on school-level changes or issues such as school climate, staff morale, and family involvement." Four major emergent concepts arose; "connecting the

dots, strengths and successes, project significance to school and community, and challenges and future directions." The program, according to principals and assistant principals interviewed, resulted in strengthened ties between the school and community, which led to increased involvement, participation, and success. The conclusion was the need to expand services, particularly to elementary schools in their district, based on experienced success of "closing the gap." The study served to show districts, who are considering school-based mental health supports, positive qualitative feedback.

A 1993 study showed that school-based mental health programs are often times piecemeal together. While it is common for schools to have elements mental health programs, often times there is little coordination between school and community-based programs. The 1993 study by Adelman & Taylor shows one major urban school district in California focused on existing programs and how to best streamline a comprehensive program. The school district had 56 programs, but there was little overall planning and coordination. An evaluation of the district showed that mental health professionals were not used to their greatest capacity, not all schools utilized the same programs even with present resources, and that program efficacy was not a priority (Adelman & Taylor, 1993). Adelman and Taylor identified six functions that mental health specialists should perform. They are 1) Direct service provision: crisis intervention in emergency situations; short-term assessment and treatment, including facilitating appropriate eligibility decisions, referral, placement, and follow-through; prevention through mental health education. 2) Enhancing community resource usefulness: identifying community resources, assisting families to connect with services, working with community resources to be more responsive to the needs of a district's students. 3) Staff development and

support: in-service workshops and consultation. 4) Resource development: organizing existing programs, preparing proposals and developing new programs, and providing maintenance support. 5) Improving community relations: presentations and workshops throughout the community. 6) Supervising mental health professionals-in-training and volunteers: increase District resources and contribute to recruitment.

Administrative organization of specialists is an area of concern. Typically, school administrators focus the functions of mental health providers in direct support of students who are in need. It may be, however, of greater impact to focus the efforts of mental health professionals to indirect services over a broader range of students (Adelman & Taylor, 1993). The study concludes with a proposal where there is a central mental health "facilitator" who helps each school within the district establish their comprehensive plan by using steps of initiating the process, developing mechanisms, and on-going support. In regards to mechanisms, they suggest that schools focus the functions and programs of mental health providers by establishing coordinating committees, program development groups, and resource support teams. The coordinating committee, comprised of key school personnel, catalogs and generates awareness of each program and intervention. The program development group is smaller than the coordinating committee, and is charged with identifying needs and gaps in the program. The resource support team ensures that professional development and staff replacement and recruitment are taking place. The facilitator specialist should focus their efforts, in this system, at a rate of 3 to 4 schools at a time, for a total of 9 to 12 schools per year (Adelman & Taylor, 1993).

The term “full-service school” is credited to Florida’s comprehensive school-based legislation which calls for radical reform of the way varied services are provided (educational, health, and welfare). The goal is one-stop, seamless service provision, in a school or community-based agency, and the empowerment of the target population. Most programs have moved services from one place to another. An example would be a medical unit from a hospital/health department moves into a school through contractual agreement, the staff of a community mental health center reassigned to a school, or a grant to a school creates a coordinator in a center. As the program expands, center staff work with school staff to draw more services and contracts (Adelman and Taylor, 1997).

**Multi-Tier Support School-Based Mental Health Programs**

Teacher intervention is imperative in any initiative to implement mental health supports to school children. A multi-tier support structure, starting with classroom-based interventions, is common and becoming more widely accepted. According to Adelman and Taylor, the early steps to reducing barriers to learning start with enhancing the teachers’ capacity to address problems, and for fostering social, emotional, intellectual and behavioral development (Adelman and Taylor, 2002). The multi-tier support would then include providing structures where the school has the capacity to handle transition concerns for students and families, as many mental health issues may manifest from the change in schedule, placement, school, or other life event. Responding to or preventing crisis, enhancing home involvement, building collaborations within the community, and responding with special assistance to students and families are examples of tiered support (Adelman and Taylor, 2002).

Franklin and Streeter (1995) categorize alternative approaches to multi-tiered interventions. Informal interventions are at the first tier, where teachers and PPS personnel respond to student needs. Coordinated approaches are next, where the intervention is formalized, but still within the school or district. This could include a referral to special education or mandated counseling. Partnerships and collaboration, according to Franklin and Streeter, start to pull in outside organizations for help. Integrated services comprise the most intense setting, where schools move to "full-service" schools. Here is coordination of services, from housing to health clinics.

Continuum of care, that which includes primary prevention and early-age intervention, encompasses health and mental health. This is part of the research of Adelman and Taylor when looking at comprehensive schools. Programs that can treat chronic problems, home and school safety, physical and mental health, transition, social and academic support, and referrals for further care, all to support academic success in full-service schools. The "Enabling Component" is an essential facet of school and community restructuring; it stresses integration of enabling programs and services within instructional and management components. It requires bringing together what is available at school, expanding it by integrating school and community resources, and enhancing access to community programs and services by linking programs at the school. Enabling activity is clustered into 6 basic programmatic areas which address barriers to learning. They are to enhance classroom-based efforts to enable learning, provide prescribed student and family assistance, respond to and prevent crises, support transitions, increase home involvement in schooling, and develop greater community involvement and support (Adelman and Taylor, 1997).

**Leadership, Training and Allocation in School-Based Mental Health**

According to the US Department of Health and Human Services' 2002 report, *School Mental Health Services in the United States,* the study found that a very high percentage of providers were licensed or certified in their fields. The numbers are as follows: School counselors at 87%, school psychologists at 92%, school social workers at 87%, mental health counselors at 83%, substance abuse counselors at 80%, and school nurses at 88%. However, the same study identified the percentage of time devoted to mental health interventions and services: 1) School counselors - 52%, 2) School psychologists - 48%, 3) School social workers - 57%, 4) Mental health counselors - 68%, 5) Substance abuse counselors - 61%, 6) School nurses - 32%, 7) Psychiatrists - 40%.

The Policy Leadership Cadre for Mental Health in Schools, coming out of the Center for Mental Health in Schools at UCLA, describes five "delivery mechanisms and formats." The first is 1) School-financed student support service, where districts hire their own professional staff to provide services. The second is 2) Formal connections with community mental health services, where the service can be located within the school building or provided at agency location. The third is 3) School-district mental health clinics or units, where the district funds and operates their own clinic within the school building. The fourth is 4) Classroom-based curriculum and instruction, typically led by teachers. The fifth and final is 5) Comprehensive, multifaceted, and integrated approaches, where there is a blend of one or more formats, commonly referred to as Systems of Care.

The US Department of Health and Human Services' 2002 report, *School Mental Health Services in the United States,* tells us that the most commonly used agency partnerships, are (1) County Mental Health Agencies, (2) Community Health Agencies, (3) Individual Providers, and (4) the Juvenile Justice System. The least commonly used agency partnerships, according to this study, are (1) Faith-based Organizations and (2) Local Hospitals.

The same report evaluated the frequency of partnerships schools may or may not have used. One third of schools in the study used no outside agency and all services were school-financed and provided. One quarter of schools used no internal professionals, where all services were contracted out. One third of schools utilized a combination of district employees and outside contractors. Finally, one half used a mix of contractual agreements, free services with community-based organizations, and district employees.

The report showed that very few schools run their own school-based health center, approximately 17%, that is either arranged by agreement or contract, or staffed by district employees. For those schools that ran a full-service, or elements of a full-service model, it was more prevalent in large, urban schools.

**Current Barriers to the Provision of Mental Health Services in Schools**

The US Department of Health and Human Services' 2002 report, *School Mental Health Services in the United States,* outlines some of the barriers and funding sources for these services. According to the study, the most common sources of funding were (1) The Federal Individuals with Disabilities Education Act, (2) State Special Education Funds, (3) Local Funds, primarily district budget and taxes, (4) State General Funds, and

(5) Medicaid Reimbursement. Some other sources of funding, but less common, were (1) Federal Title IV Safe and Drug-free Schools and Communities, (2) Federal Title 1 Federal Support for Low Income Students, and (3) Federal Safe Schools Healthy Students Initiative.

The most common barrier reported by schools was the financial constraints on families. After a student is identified, assessed, and crisis response has intervened, long-term care is usually the responsibility of the parents, and financial restraints often prohibit care. The connection between on-going mental health issues and poverty underscore this study's claim. Second and third most common barriers are "inadequate school mental health resources" and "competing priorities take precedence." Staffing, funding, and academic initiatives all contribute to this study result (USDHHS, 2002).

The funding model, according to Dryfoos, 2002, is for the schools to pay for educational programs, and the partnering agency pays for the support services. The burden does not fall exclusively on the district. The most common support contributors are health, mental health, and social services. Lesser obstacles include student privacy, labeling and diagnosing, and collaborative working relationships between school personnel and mental health workers (Leever, et. al., 2004).

Another barrier is that of "who's responsible." The issue of whole community engagement compared to only professionals in human service agencies may get in the way of attempting to solve core problems. School-linked service initiatives produced tension between school district pupil services personnel and their counterparts in community-based orgs when they are brought in from "the outside." This can be viewed by PPS staff as discounting their schools or a threat to their jobs, creating a lack of

cohesiveness. There can be a lack of effective mechanisms for coordination and integration of programs and funding lead to piecemeal design and delivery and disjointed implementation (Adelman and Taylor, 1997).

**Legal Cases Regarding Trauma-impacted Students**

Several lawsuits involving school districts' response to student trauma contributes to the purpose of the study. Three recent lawsuits in California, Arizona, and New York have argued that chronic and pervasive trauma may qualify as a disability under IDEA or Section 504. A 2015 lawsuit against the Compton Unified School District, California, argued that the district did not provide adequate support to plaintiffs. The case *P.P. et. al. v. Compton Unified School District* claimed that those students who were subject to ongoing trauma outside of school were not provided with a classification of a disability under the Americans with Disabilities Act and Section 504, thereby contributing to their academic failures. The Compton lawsuit resulted in a settlement between sides to implement trauma-informed practices districtwide, as the concern grew for classifying every student who may have experienced trauma. In 2016, a similar lawsuit was filed against the US Bureau of Indian Education, *Stephen C. v. the Bureau of Indian Education*, that claimed students (9 plaintiffs) on the Havasupai reservation in Arizona experience chronic and pervasive trauma and were not provided with the proper special education and mental health supports. While the two sides were in settlement talks, a judge ultimately ruled on the lawsuit that came to a decision in 2018, siding with the plaintiffs, stating that the Bureau of Indian Education failed to meet those students' needs and contributed to historic oppression through intentional underfunding and

mismanagement. In New York, *Jane Doe et. al. v. New York City Department of Education,* argued that 4 plaintiffs were suffering from behavioral changes, emotional changes, physical impairments, and learning difficulties due to sexual harassment and assaults. The suit claimed that the Department of Education did not extend a response to trauma and protecting students from further contact with their assailants in school under their special education program. The lawsuit alleges that the Committee on Special Education refused to address the girls' concerns of academic and emotional difficulties outside of the context of their original diagnosis (learning disability), and dismissed the latter diagnosis of anxiety (edweek.org, Sparks, 2019). These three lawsuits are new case law on trauma-informed systems and practice.

**Trauma-Informed Schools**

In light of the barriers to the delivery of mental health services, and the potential legal trouble that may be brought forward by not providing services effectively to trauma-impacted students, there has been recent literature in the topic of trauma-informed school systems. The essence of trauma-informed practice is recognizing the trauma woven into some students' lives is part of educating the whole child (Educational Leadership, 2017). The National Child Traumatic Stress Network identifies the following situations that can affect traumatic stress in children and affect their learning and behavior: physical or sexual abuse; abandonment; neglect; the death or loss of a loved one; life-threatening violence in a caregiver; witnessing domestic violence; automobile or other serious accidents; bullying; life-threatening health situations and/or painful medical procedures; witnessing or experiencing community violence (shootings,

stabbings, robbery, or fighting) in the home, school and/or neighborhood; witnessing police activity or having a close relative incarcerated; life-threatening natural disasters; acts or threats of terrorism (viewed in person or on television); living in chronically chaotic environments in which housing and financial resources are not consistently available (NCTSN Child Trauma Toolkit for Educators, retrieved 9/30/2019).

In looking at traumatic incidents, the number of Adverse Childhood Experiences (ACEs) that a student encounters affects all aspects of health and learning. The CDC-Kaiser ACE Study (1997) examined the likelihood of an adult experiencing negative outcomes, such as cognitive impairment, health problems, and early death, given their number of Adverse Childhood Experiences. ACEs were categorized into 3 groups: abuse, neglect, and household challenges. Abuse questions asked study participants about emotional, physical, and sexual abuse. Neglect included emotional and physical neglect. Household challenges included mother/parent treated them violently, substance abuse in the household, mental illness in the household, parents were separated or divorced, or a household member was incarcerated (CDC, retrieved October 9, 2019). The study showed that the increase in a person's ACE score, the more likely they were to encounter health, mental health, and learning problems.

The CDC-Kaiser ACE study also looked at generational and historical trauma, and served as the bottom risk factor in their pyramid conceptual framework that led to early death at the top of the framework. The role of historical trauma must also be understood by educators. Recent studies also suggest that generational trauma may be genetic as well. A study in mice at Emory University looked at the concept of epigenetics, which is the passing of genetic markers through environmental

experiences. The study introduced male mice to the smell of cherry blossoms, followed by mild shocks. The mice were conditioned to experience fear from the smell. Several weeks later they were bred with females, and the offspring were fearful of the smell without ever experiencing the shock. The study suggests that the passing down of trauma and fear may be possible in mammals (The Washington Post, retrieved September 27, 2019), and a new area of investigation for genetic researchers.

However a student experiences trauma, whether first hand or is susceptible to amplified effects due to genetics, recent literature underscores the need for teachers to be trauma-sensitive. When risk factors are high, protective factors like positive relationships between teachers and traumatized children provide students with opportunities to "get to neutral" (Educational Leadership, retrieved September 29, 2019).

Trauma-informed practices have been encouraged by educators, policy-makers, special education law, and even federal and state grants (Education Week, retrieved September 29, 2019) over the last decade, and the number of students who would be identified as traumatized is high. Nearly half of all US children have been exposed to at least one traumatic event, and more than 1 in 5 have been exposed to several. Manmade and natural disasters exposure make this number potentially high, so rather than finding the individual students, practitioners are suggesting a school-wide systems approach to being trauma-sensitive, where "it is a process, not a program" (Education Week, retrieved September 29, 2019).

The National Child Traumatic Stress Network highlights the essential elements of a Trauma-Informed School System: 1) Identifying and assessing traumatic stress, 2) Addressing and treating traumatic stress, 3) Teaching trauma education and awareness,

4) Having partnerships with students and families, 5) Creating a trauma-informed learning environment, with social/emotional skills and wellness, 6) Being culturally responsive, 7) Integrating emergency management and crisis response, 8) Understanding and addressing staff self-care and secondary traumatic stress, 9) Evaluating and revising school discipline policies and practices, and 10) Collaborating across systems and establishing community partnerships. These elements represent the need to care for individual traumatized student and for the systems to support all students (The National Child Traumatic Stress Network, retrieved September 29, 2019).

The concept of educators' secondary traumatic stress (STS) is important to realize as well. As educators are more trauma-sensitive and have interactions with traumatized students, educators may experience undesirable effects such as disengagement, personalizing, and profession burnout (Lawson, et. al., 2019). Leaders must build in supports for staff self-care as an element of a trauma-informed system.

The National Dropout Prevention Center's Trauma-Skilled Schools Model (TSS Model) is one of the nationally recognized trauma-informed school systems and is a response to the literature that suggests trauma-impacted students struggle in learning environments. The rationale is to move from "trauma-informed" or "trauma-sensitive" to a "full-scale trauma-skilled school" (Gailer, et. al., 2018) because of the number of trauma-impacted students. There is difficulty in identifying every student, particularly given the increasing instances of "virtual trauma" that students witness in traditional and social media. This is known as secondary trauma. The TSS Model is a five-step process for implementation and maintenance, and NDPC suggests a two-year implementation period. Step 1 is the Knowledge step, where professional development aims to teach staff

of the impact trauma has on students. Step 2 is the Build Resilience step, where 5 essential resiliency factors are focused on. Students should feel connected, secure, achievement, autonomy, and fulfillment. Step 3 is the Skill Acquisition step, where all personnel will be trained in the 4 essential strategies. Prevention strategies teach educators to identify and avoid trauma triggering episodes. Intervention strategies are employed when a student has an episode. Recovery strategies for after an event to help the student who had the episode and students who witnessed it. Lastly, referral strategies for ongoing support for students who need support above the Tier 1 intervention of the teacher. Step 4 is the Assessment and Implementation step. District leaders would evaluate all policies to see if they may have unintended consequences for trauma-impacted students, consider the school's practices and culture, and properly prepare all people involved. Step 5 is the Maintenance and Validation step, where the trauma-skilled plan and team is involved in ensuring ongoing program success.

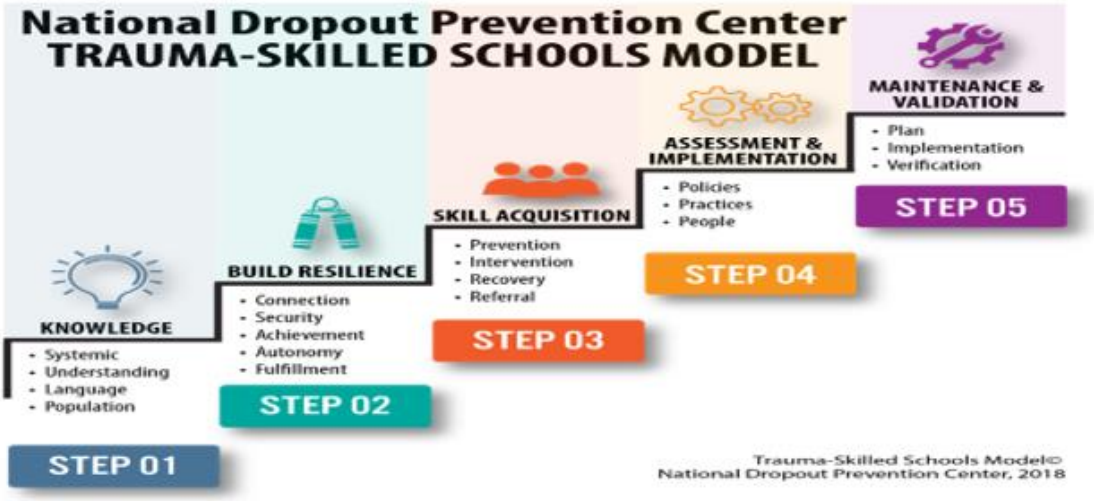
**Conceptual Framework**

The Trauma-Skilled Schools Model will serve as the conceptual framework for this study. A review of the literature shows that school districts have historically sought to identify issues in students, be them mental health, behavioral, attendance, etc., and seek to implement intervention strategies to address that individual student. The most recent literature shows that the prevalence of mental health and behavioral issues are rapidly increasing in frequency and intensity, and much of the root cause is in traumatic experiences (both perceived and actual) in students' lives. Due to the increased difficulty in identifying, diagnosing, and treating these behaviors, full-school trauma-informed

practice has gained traction in recent years in both theory and evidence-based practice. The National Dropout Prevention Center has been on the frontline in this research, and has developed the Trauma-Skilled Schools Model to respond to this changing student phenomenon. The TSS Model© Step 01 will serve as the conceptual framework for this study in answering the research questions and analyzing the data.

Figure 2.1

Trauma Skilled Schools Model



# CHAPTER III

# METHODOLOGY

## Introduction

This study will examine the readiness of school districts in Suffolk County to adopt the National Dropout Prevention Center's Trauma-Skills School Model. A review of the literature shows that most responses to mental health prevention and intervention occurs in the form of identifying and responding to individual students. The most recent literature shows that, due to the increase in number of students and the difficulty in identifying those students, a model called the Trauma-Skills School Model (TSS Model) creates an environment in a school where all students are positively impacted on a Tier 1 Intervention (National Dropout Prevention Center, 2018). The study will explore the depths in which schools already have trauma-informed awareness and what gap exists to implement a TSS Model. The research on implementing a model of trauma-informed practice is lacking, so it is the objective of this study is to examine readiness of school districts in Suffolk County, New York to do so. The following research questions will be answered:

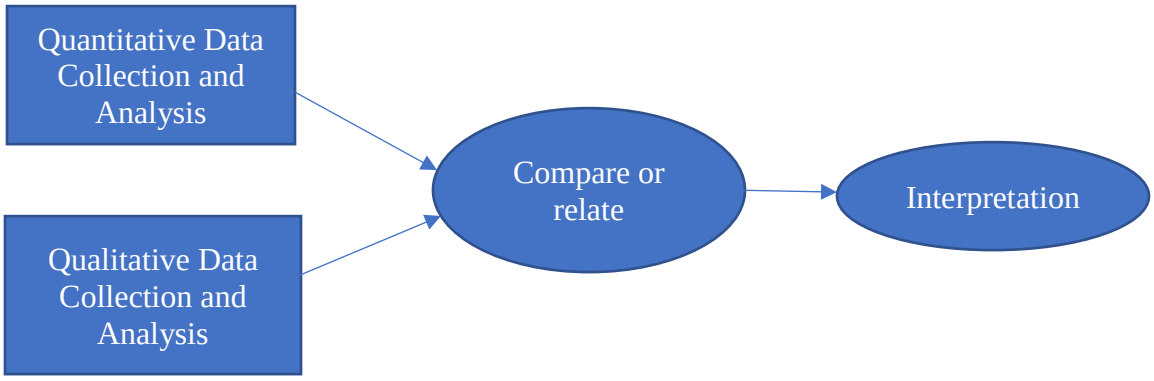
1. What elements of trauma-informed practice do the Guidance Directors in Suffolk County already know, and what elements are currently being practiced?
2. What gaps exist between current levels of knowledge and practice need to be met to implement a Trauma-Skills School (TSS) Model?

## Rationale for Research Approach

This study will utilize a mixed method research approach due to the importance of quantitative and qualitative data analysis. The study will be a case study using a convergent parallel design of mixed methods, simultaneously collecting quantitative and qualitative data, giving both method equal importance to fully examine the research questions. The results will provide the researcher data to make an interpretation as to whether the methods support or contradict each other, contributing to the study's validity (Creswell, 2015). Below is the figure Creswell gives for the convergent parallel design (p. 541).

Figure 3.1

Convergent Parallel Design




## Research Setting and Sample

The research will take place in Suffolk County, New York, where the directors, administrators, and lead counselors of guidance will be invited to participate in the study. Invitations to participate in both the quantitative and qualitative methods will be distributed to approximately 50 members of the Suffolk Directors of Guidance (SDOG)

group. The Suffolk Directors of Guidance (SDOG) is a professional organization in Suffolk County, Long Island, New York that offers networking, collaborating, and professional development in regard to standards and practice in school counseling. The quantitative portion of the study will be a cross sectional survey sent to every member of this group. The members of this group generally have supervision and/or direct involvement in school counseling, which includes school guidance counselors, school social workers, school psychologists, and/or pupil personnel services. The members of the SDOG that represent this sample are involved in school climate, administration, and/or direct student counseling. There are 57 school districts in Suffolk County, however, there are a number who are not a part of this group, as they are K-6 or K-8 districts with no lead guidance counselor or director. The sample will include data from a wide range of school districts, ranging in size from 200 to 10,000, with mixed socio-economic profiles, diversity, English language learners, and state performance.

This study will be subject to approval of the University Institutional Review Board (IRB) and will follow all University and School of Education protocol and procedures. It will follow all conventions, standards, and ethics of educational research, in regards to participants, methods of study, and analysis, as set forth by tradition, precedent, and the University.

**Quantitative Method**

A survey instrument will be distributed to all members of the SDOG group. The survey instrument will include questions that address both research questions, developed and adapted with the assistance of the National Dropout Prevention Center (NDPC). The

NDPC currently utilizes a survey instrument to measure a school or district readiness to implement their own TSS Model, and this instrument has been modified for the purpose of this study (see Appendix A).

**Qualitative Method**

A focus group interview session will be conducted, with select interview participants from the SDOG group, with the aim of answering both research questions. The focus group will be representative of the following breakdown of districts: one large, high-performing district; one small, high-performing district, one large, low-performing district, one small, low-performing district. The focus group questions will be developed with the assistance of the National Dropout Prevention Center (NDPC). The NDPC currently utilizes a focus group questionnaire instrument to measure a school or district readiness to implement their own TSS Model, and this instrument has been modified for the purpose of this study (see Appendix B). The questions and answers in the focus group will be recorded and text transcribed and coded.

**Data Analysis Methods**

The data analysis of a convergent parallel design of mixed methods will be a side-by-side analysis of the quantitative and qualitative data. According to Creswell (2015) this analysis is the standard approach to a convergent design study. The themes that will emerge from both methods will be used to fully examine the research questions, and to see if the 2 methods result in supporting or conflicting data.

For the quantitative method, a questionnaire will be distributed to sample and the data will be collected and analyzed using a Survey Monkey, a computational program. The response options in the survey instrument will be provided in primarily ordinal scales, where the responder will rank most important to least important and where there is "implied intrinsic value" (Creswell, 2015). The data will be reported and aggregated to show areas of strengths and weaknesses within the sample group's knowledge of trauma-informed practice.

For the qualitative method, a focus group will be conducted and the data will be analyzed by Dedoose, a Computer-Assisted Qualitative Data Analysis Software, CAQDAS (Saldana, 2013). The focus group interview questions and answers will be recorded and transcribed. The text of the transcript will be assigned codes and patterns, themes, and frequency will be analyzed (Saldana, 2013).

The data analysis in both the qualitative and quantitative methods will provide the researcher with the number of instances where specific themes come up as gaps or weaknesses in the knowledge step of the conceptual framework and answer research questions.The steps that were conducted to determine if a mixed method approach was appropriate, and the steps in study were undertaken properly, was adapted from Creswell (2015, p. 555).

**Validity of Study**

The researcher is in communication with the developers of the Trauma-Skilled Schools (TSS) Model, upon which the conceptual framework of this study is based on, to ensure the methodology and instruments are true to the framework's principles and

protocols. The instruments were modified to properly answer the research questions and for the purpose of the study, but vetted by the organization from which the program was created.

The sample and participants will be assured of anonymity in their participation in the study. All instrument materials will be kept in secure locations to prevent tampering and/or the identity of participants confidential. The sample will be notified of the security measures that will be employed.

**Limitations**

This study seeks to evaluate the readiness of school districts in Suffolk County, New York in implementing a trauma-skilled school model, using the National Dropout Prevention Center's TSS Model as the conceptual framework for the study. The limitations of this study will include whether all districts voluntarily participate in the study, in both the quantitative and qualitative methods of the mixed method approach. The researcher seeks to secure participation of all districts for the quantitative survey method, and select participation of a cross sectional sampling of Suffolk County for the qualitative focus group method. The researcher anticipates less than 100% participation in the quantitative approach, and may need to adjust selectivity in the qualitative methodology, dependent on participants.

Further, the study's sample is the SDOG group, which is generally accepted as leaders or lead counselors involved in mental health interventions in schools, but there may be districts where the leader in mental health initiatives in the representative districts that are not member of the SDOG group.

**Summary**

The researcher will utilize convergent parallel mixed methodology to obtain the answers to the research questions. The following table shows the methods in which data was collected.

Table 3.1

Research Questions and Methodology

| **Research Question** | **Data** | **Method** |
|---|---|---|
| What elements of trauma-informed practice do the Guidance Directors in Suffolk County already know, and what elements are currently being practiced? | Survey/Focus Group Interview | Quantitative/Qualitative |
| What gaps exist between current levels of knowledge and practice need to be met to implement a Trauma-Skills School (TSS) Model? | Survey/Focus Group Interview | Quantitative/Qualitative |

Mixed method research utilizes both quantitative and qualitative data in a single study. This study, as a convergent parallel design, compiled the data at the same time, combining both research questions into both methods, in order to get a full and complete analysis of the questions. Where there is a limitation or weakness in one method, the other method can support and enhance the other. Data will be analyzed at the same time as well.

# CHAPTER IV

# FINDINGS

## Introduction

The study was conducted to learn of the preparedness and knowledge base of Suffolk County school districts to implement trauma-informed approaches and systems. The study took place over a 3-month period that included a survey to the sample group and a focus-group of selected participants in the Suffolk Directors of Guidance. The researcher utilized a survey developed by the National Dropout Prevention Center, who authored the Trauma-Skills School (TSS) Model. The survey (see Appendix A) was delivered to approximately 50 members of the Suffolk Directors of Guidance group, with a response rate of 15 participants through Survey Monkey. Of the 15 respondents, 5 districts volunteered to participate in a focus group to explore the research questions in a qualitative approach. Of the 5 districts who volunteered, 3 ultimately participated. The focus group participants were provided with background information on the TSS Model and the focus group questions (see Appendix B) prior to the interview. Consent to participate (see Appendix D) was provided and obtained for participants. The study took place during the COVID-19 Pandemic; therefore, the consent reflected a focus group interview using Zoom Meeting.

## Research Questions

The qualitative and quantitative research procedures are meant to simultaneously address the two research questions, in a mixed-method approach, which are as follows:

1. What elements of trauma-informed practice do the Guidance Directors in Suffolk County already know, and what elements are currently being practiced?
2. What gaps exist between current levels of knowledge and practice need to be met to implement a Trauma-Skills School (TSS) Model?

The body of this chapter will be organized such that each research question will be explored using both quantitative and qualitative data simultaneously, but the outline of how the data was compiled is discussed as follows.

**Focus Group Interview**

The focus group consisted of 3 districts. One would be considered affluent, large, and homogeneous in population, the second would be considered affluent, small, and homogeneous in population, and the third would be considered mixed socio-economic status, small, and diverse in population. A fourth participant, who would have represented low socio-economic, large, and diverse in population, ultimately could not participate in the focus group.

Focus group questions (see Appendix B) were adopted from the TSS Model of implementation and were chosen to help answer the two research questions. The focus group questions had to do with current staff knowledge of trauma-informed practice, professional development and training, staff and organizational perception of the practice, organizational procedures, and barriers to implementation. The focus group interview, which lasted 76 minutes, followed the set questions (see Appendix B) with 2 additional questions that the researcher asked as a result of the conversation. The additional questions were, “What is the staff perception…that poor learning is attributed to

trauma…?" for Research Question 1, and "In one word, what could you identify as the biggest barrier for implementation [of the TSS Model]?" in Research Question 2. The focus group had adequate participation from all members and the discussion was lively.

The script from the Zoom Meeting Focus Group was transcribed and uploaded into Dedoose, a CAQDAS (Computer Assisted Qualitative Data Analysis Software) program. Coding was done and qualitative data analysis was performed.

Prior to computer analysis, the researcher conducted a First Cycle Coding process (Miles, et.al, 2014), also referred to as deductive coding, based off the focus group interview experience. After the script was carefully reviewed, second cycle codes, or inductive coding, were developed. Both Descriptive Codes, those that capture the basic gist of the code, and In Vivo Codes, those that utilize the exact language of the participants, was utilized. The following table show the coding process and identification:

Table 4.1

First and Second Cycle Codes

| First Cycle Codes (Deductive) | Second Cycle Codes (Inductive) |
|---|---|
| Trauma | School Climate |
| Behavior | Reactive/Proactive |
| School performance | Target particular students |
| Mental health | Special Education |
| Adverse Childhood Experiences (ACEs) | Brain patterning |
| Training and Professional Development | Resiliency |
| Knowledge | Perception – Negative |
| Staff/Providers | Personnel who gets trained |
| Teachers | Some teachers are better at this than |
| Trauma-Informed Practice | others |

| | |
|---|---|
| Gaps in practice and goals | Board of Education<br>Diagnosis/Diagnoses<br>Homogeneous training<br>Shift for faculty<br>Instructional adjustment<br>Contractual limitations<br>Referral of students<br>COVID-19 trauma impact on all students<br>Scheduling and building structure<br>Adult connection<br>Existing programs<br>Barriers to implementation |

After the inductive coding process, some of the codes became sub codes to the parent codes when entered into Dedoose.

*Code Occurrence*

After the coding process was completed and codes assigned to portions of text, the researcher ran a code occurrence query in the CAQDAS. A total of 137 sections of text were coded, with a total of 28 codes. Some codes from the First Cycle Coding process were not ultimately used to code specific text. The most frequent codes were "Barriers to Implementation," "Teacher Resistance," "Some teachers are better at this than others," "Contractual Limitations," "Perception-Negative," "Scheduling or Building Structure," "Shift for Faculty," "Target Particular Students," "Training and Professional Development," and "Trauma of all Students COVID-19." The following table shows the frequency of codes:

Table 4.2

Code Occurrence

| | |
|---|---|
| Barriers to Implementation | 9 |
| Secondary Trauma | 1 |
| Teacher Resistance | 7 |
| Some teachers are better at this than others | 9 |
| Adult Connection | 5 |
| Adverse Childhood Experiences | 3 |
| Behavior | 1 |
| Board of Education | 1 |
| Contractual Limitations | 6 |
| Diagnosis | 1 |
| Existing Programs | 1 |
| Homogeneous Training | 5 |
| Knowledge | 4 |
| Mental Health | 3 |
| Perception - Negative | 6 |
| Referral of Students | 1 |
| Resiliency | 4 |
| Scheduling or Building Structure | 13 |
| School Climate | 1 |
| School Performance | 2 |
| Shift for Faculty | 11 |
| Special Education | 4 |
| Staff or Providers | 1 |
| Target Particular Students | 7 |
| Trained Personnel | 1 |
| Training and Professional Development | 20 |
| Trauma of All Students - COVID 19 | 6 |
| Trauma-Informed Practice | 2 |
| Total | 137 |

*Code Co-Occurrence*

The co-occurrence of codes was evaluated using Dedoose, the CAQDAS program. The researcher would code larger portion of texts and then identify smaller pieces of text with more specific codes. The portions of text that had the largest amount of code co-occurrence was "Training and Professional Development," "Scheduling or Building Structure," and "Barriers to Implementation."

Table 4.3

Code Co-Occurrence

| | |
|---|---|
| Barriers to Implementation | 11 |
| Teacher Resistance | 4 |
| Some Teachers are better at this than others | 7 |
| Contractual Limitations | 4 |
| Homogeneous Training | 4 |
| Perception - Negative | 5 |
| Scheduling or Building Structure | 14 |
| Shift for Faculty | 7 |
| Special Education | 4 |
| Target Particular Students | 7 |
| Training and Professional Development | 19 |

The researcher examined the number of times that codes co-occurred with other codes. The table that follows is of the code co-occurrence with each of the most common codes throughout the text in the focus group script. The totals in the x and y columns reflect the number of times that code co-occurs with any code, including the most common shown, and the less common codes. The figure that shows the co-occurrence matrix is as follows:

Table 4.4

Most Frequent Code Co-Occurrence

| | Barriers to Implementation | Teacher Resistance | Some Teachers better at this than others | Contractual Limitations | Homogeneous Training | Perception-Negative | Scheduling or Building Structure | Shift for Faculty | Special Education | Target Particular Students | Training and Professional Development | **TOTALS** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Barriers to Implementation | x | 4 | 2 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | **11** |
| Teacher Resistance | 4 | x | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **4** |
| Some Teachers better at this than others | 2 | 0 | x | 0 | 0 | 1 | 3 | 0 | 0 | 0 | 0 | **4** |
| Contractual Limitations | 2 | 0 | 0 | x | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **7** |
| Homogeneous Training | 0 | 0 | 0 | 0 | x | 0 | 0 | 1 | 0 | 0 | 2 | **4** |
| Perception-Negative | 0 | 0 | 0 | 1 | 0 | x | 1 | 0 | 0 | 0 | 1 | **5** |
| Scheduling or Building Structure | 0 | 0 | 3 | 0 | 0 | 1 | x | 0 | 0 | 2 | 2 | **14** |
| Shift for Faculty | 1 | 0 | 0 | 0 | 1 | 0 | 0 | x | 0 | 1 | 3 | **7** |
| Special Education | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | x | 2 | 2 | **4** |
| Target Particular Students | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 2 | x | 1 | **7** |
| Training and Professional Development | 1 | 0 | 0 | 2 | 2 | 1 | 2 | 3 | 2 | 1 | x | **19** |
| **TOTALS** | **11** | **4** | **4** | **7** | **4** | **5** | **14** | **7** | **4** | **7** | **19** | |

**Themes from the Focus Group Interview**

The themes that emerged from the qualitative data analysis, in context of the research questions and the theoretical framework of organizational leadership, had much to do with building and district structure, training and professional development, and barriers to implementation.

*Theme 1*: Training and Professional Development. The co-occurrence of various codes with "Training and Professional Development" was 19 occurrences. The research questions regarding training of staff in the impact of trauma-informed approaches prompted focus group participants to examine the issue of previous, current, and future training opportunities, both for all staff (such as classroom teachers and support staff) and targeted providers (such as special education and mental health related personnel). Highest co-occurrence was "Shift for Faculty" with 3, followed by 2 co-occurrences with "Contractual Limitations," "Homogeneous Training," "Scheduling or Building Structure," and "Special Education." Here is an excerpt of a co-occurrence of "Training and Professional Development" and "Special Education":

> *"We had our entire mental health cast. So that includes the counselors, social workers and psychologists attended a... I want to say at least two workshops on superintendent's conference day about trauma informed practices. So, they brought that back and then turnkey trained it to the entire Special Education Department, and started implementing some changes to instruction/behavioral responses, if you will, to behaviors. I don't necessarily think that we're at a place where we could call ourselves a trauma-informed school."*

*Theme 2*: Scheduling and Building Structure. The co-occurrence of various codes with "Scheduling and Building Structure" was 14 occurrences. The most common was "Some teachers are better at this than others" with 3 occurrences, and with 2 each for "Target Particular Students" and "Training and Professional Development." There was a lot of discussion about the set-up of a building, from physical space to scheduling to staff responsibility of particular students. How a new system such as the TSS Model would fit into existing structures and systems was a common point of discussion, and where barriers to implementation was discussed explicitly and indirectly. One such passage to highlight this was:

> *"I think I mentioned before we've adopted an MTSS model. Originally, it was born out of the PBIS model, and then we moved into the multi-tiered systems of support. I feel like it depends on which level I think we have it really down pat at our elementary schools. Middle school, mostly, I think they've done a great job at addressing RTI and then where that sort of dovetails in to the behavioral. I think we're finally starting to have those conversations at the middle school where we recognize you better have a social emotional component or something within that RTI model."*

*Theme 3*: Barriers to Implementation. The third most common co-occurring code was "Barriers to Implementation" with 11 occurrences. The most common co-occurring codes were "Teacher Resistance" with 4, "Some Teachers are better at this than others" and "Contractual Limitations" with 2 each. All 6 of these codes could be re-coded to be a parent code and are all similar. This theme is most notable to the research since it is had the strongest number of co-occurrences and generated the most decisive discussion

during the focus group. When directly asked to summarize, at the end of the discussion, what is the biggest barrier to implementation, which directly addressed Research Question 2 of what gaps exist and how to close those gaps, all 3 participants cited teacher willingness to participate as the greatest barrier to implementation. The following is an excerpt highlighting this:

> *"In one word, what would be the biggest barrier to implementing this system, would you say after hearing everything that we talked about? What would be the number one largest barrier?*
>
> *Participant A: I would say buy-in. Teacher buy-in.*
>
> *Participant B: I would say the same thing. Knowing what we went through with advisory, teacher buy-in is the hardest sell of all.*
>
> *Participant C: Yes. I would say... This is probably a different way of saying the same thing. But I would say fixed mindsets would be the biggest barrier."*

These 3 themes were selected as the most common, but the researcher notes that others are frequent and important, such as "Contractual Limitations," "Shift for Faculty," "Target Particular Students," "Negative Perception," and "Adult Connection" during the discussion of the focus group. Much of the conversation during the focus group centered around how the community and staff would be receptive to a system-wide change in how students are treated, from instructional practices to behavior management. There was conversation about the negative perception of the term "trauma" and how teachers' resistance, particularly on the secondary level, would be a major barrier to implementation because it is a shift for them from their traditional role of curriculum and

instruction delivery. While it was acknowledged that many students and teachers have and seek out "Adult Connection," it is difficult to create such a system where every student is guaranteed that connection, and not all teachers embrace this responsibility as their own.

Another important theme that was touched on but not explored in depth was that of the trauma impact of the COVID-19 Coronavirus pandemic, during which this research took place. Discussion of the impact of this on student's social/emotional health, potential increase in anxiety and school phobia diagnoses, and behavioral concerns once students return to school are all potential topics for future research.

**Research Question 1 – Focus Group**

When the three participants, who were Directors/Chairs of Guidance were asked directly about their knowledge of trauma-informed practice, the effects of Adverse Childhood Experiences, and the effect on learning, one was able to clearly articulate it and stated their own personal training. With this sample, there was a 33% (1 in 3) rate of "elements of trauma-informed practice do the Guidance Directors in Suffolk County already know." Below is an excerpt of discussion regarding these practices:

> *Participant B: "I would say that my counselors are very unfamiliar"*
>
> *Participant C: "I know I wasn't that familiar with it, and when I read this information that you gave us, and I was like, "Okay." It was a little overwhelming."*

Participant A had been to training, along with the "*entire mental health cast,"* which included special education teachers, counselors, psychologists, and others, in trauma-

informed practices. That district, while not a full TSS Model school, where all teachers and staff are trained, has the greatest knowledge and practice in the sample group.

Participants B and C both had knowledge of personnel in their buildings, both social workers, who had been trained and were implementing trauma-informed practice, but no system level implementation, and guidance counselors had little to no knowledge.

The theme of "Training and Professional Development", which was co-occurring with many codes, indicates varied degree of training and knowledge among providers, signaling a wide range of "what do they know and practice."

**Research Question 2 – Focus Group**

When asked what the great obstacle to implementing the TSS Model, the unanimous answer was "Teacher Buy-In." The gaps primarily focused on "Scheduling and Building Structure" and "Professional Development and Training," but to meet those gaps, "Teacher Resistance" was the most prominent theme, occurring at least 4 times, and being the most emphasized. "Barriers to Implementation" co-occurring with teacher compliance, such as "Contractual Limitations" and "Teacher Resistance" was a strong outcome. "Scheduling and Building Structure" co-occurring with "Targeting Particular Students" and other various teacher compliance was another. Lastly, "Adult Connection" signaled an important theme, as it is high on the priority list to implement the TSS Model, and there was report of varying degree of teachers or staff who believe this to be part of their job, and the structure necessary to ensure all students have this as a guarantee.

**Survey**

The survey consisted of 54 questions that took approximately 20 minutes to answer. There were then 9 demographic questions asked of the participants' corresponding districts. Survey questions were focused on respondents' knowledge of trauma-informed systems, the impact of trauma on students, the current state of professional development in their district, and the perception of whose responsibility it was to address student performance as it relates to their mental health.

The full responses of the survey questions can be found in Appendix C. Of the 15 participants, the researcher found that not all participants answered all questions, and the number of "skipped" questions is reflected in the full survey response, but primarily, most questions were answered by at least 13 participants.

For the survey analysis, the researcher grouped the 63 total survey questions into the following categories:

Questions 1-10 – *Knowledge of Trauma*

Questions 11-23 – *Training and Professional Development*

Questions 24-27 – *Adult Connection*

Questions 28-40 – *Instructional Integration*

Questions 41-48 – *Staff Assigned or Best/Worst Prepared to Implement*

Questions 49-54 – *Mental Health Knowledge, Referral, and Efficacy*

Questions 55-63 – *Demographic Information on Participants' Districts*

Within each of these categories, the researcher selected particular survey questions to help answer the research questions. The following chart shows which categories of

survey questions relates to which research question, and which particular Survey Question was highlighted to help summarize the category:

Table 4.5

Research Questions and Survey Response Categories

| Research Question | Survey Category |
|---|---|
| What elements of trauma-informed practice do the Guidance Directors in Suffolk County already know, and what elements are currently being practiced? | *Knowledge of Trauma*<br>Questions 2, 3, 5, and 10<br>*Training and Professional Development*<br>Questions 11 and 13 |
| What gaps exist between current levels of knowledge and practice need to be met to implement a Trauma-Skills School (TSS) Model? | *Training and Professional Development*<br>Questions 11 and 13<br>*Adult Connection*<br>Questions 24 and 26<br>*Instructional Integration*<br>Questions 28, 32, 39, and 40<br>*Staff Assigned or Best/Worst Prepared to Implement*<br>Questions 41, 42, and 47 |

The summaries, results and highlighted questions and answers of the categories are as follows, separated by Research Question:

**Research Question 1 - Survey**

*Knowledge of Trauma*

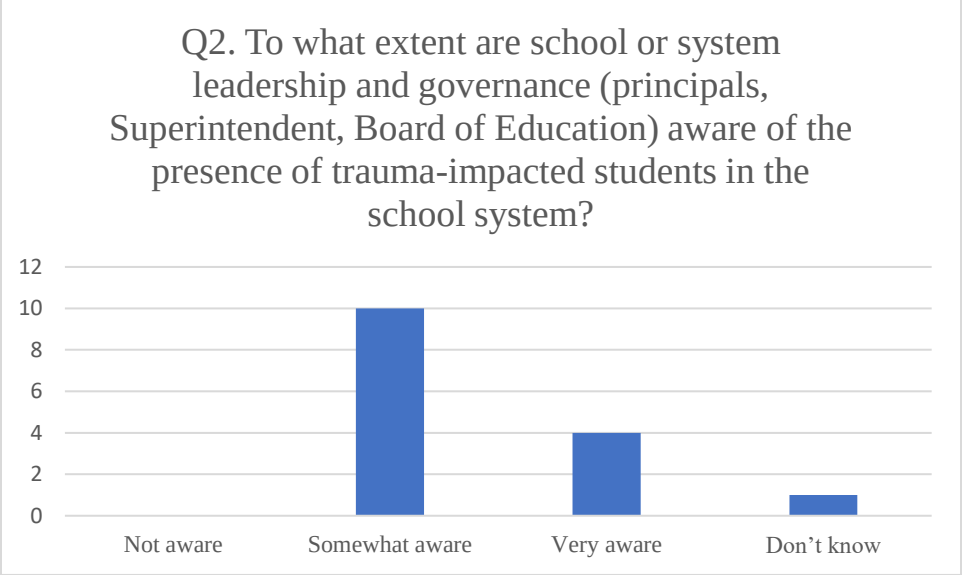
In Questions 1-10, the survey asks participants on what their current districts' knowledge is of the impact of trauma on students' performance, and the numbers of students that they feel are impacted by trauma. The first part of the research question,

"what elements do…already know" is addressed in this category. The answers are summarized by district leaders and policy-makers being "somewhat aware" or "moderate degree of understanding" of these topics. The researcher will highlight Survey Questions 2, 3, 5, and 10 to broaden that understanding.

In Question 2, the participants are asked, "To what extent are school or system leadership and governance (principals, Superintendent, Board of Education) aware of the presence of trauma-impacted students in the school system?" 10 of 15 responded with "Somewhat aware." The full chart and response are as follows:

Figure 4.1

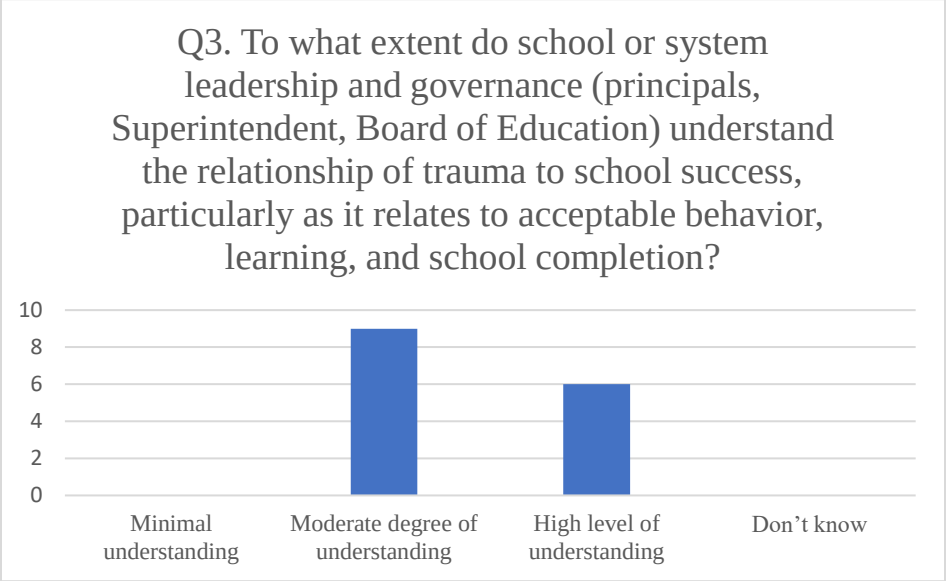
Survey Question 2




In Question 3, the participants are asked about their understanding of the relationship between trauma and school performance, and 9 of 15 responded with "Moderate degree of understanding." The full chart and response are as follows:

Figure 4.2

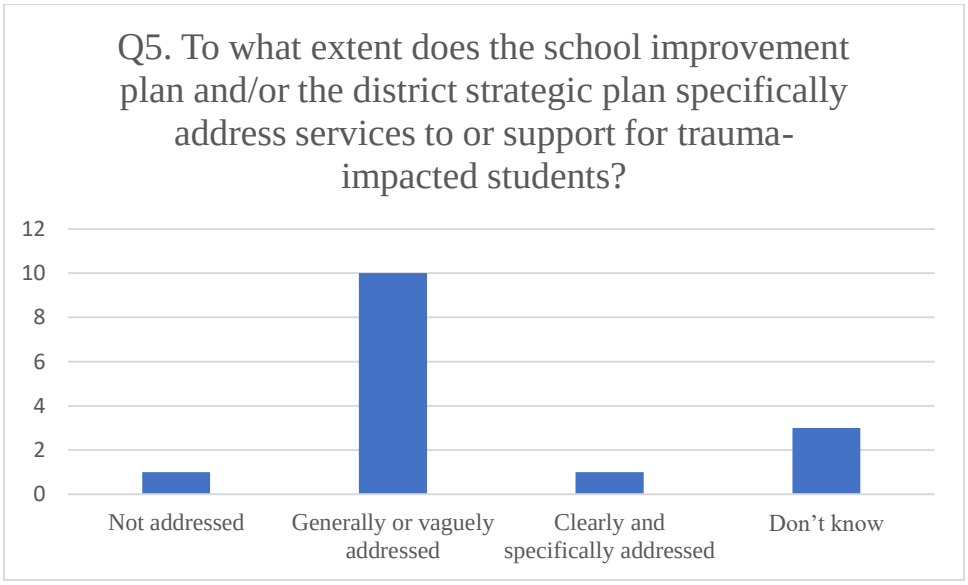
Survey Question 3




Question 5 asks participants about current district plans' inclusion of trauma topics. Respondents answered, 10 of 15, with "Generally or vaguely addressed." The full chart and response are as follows:

Figure 4.3

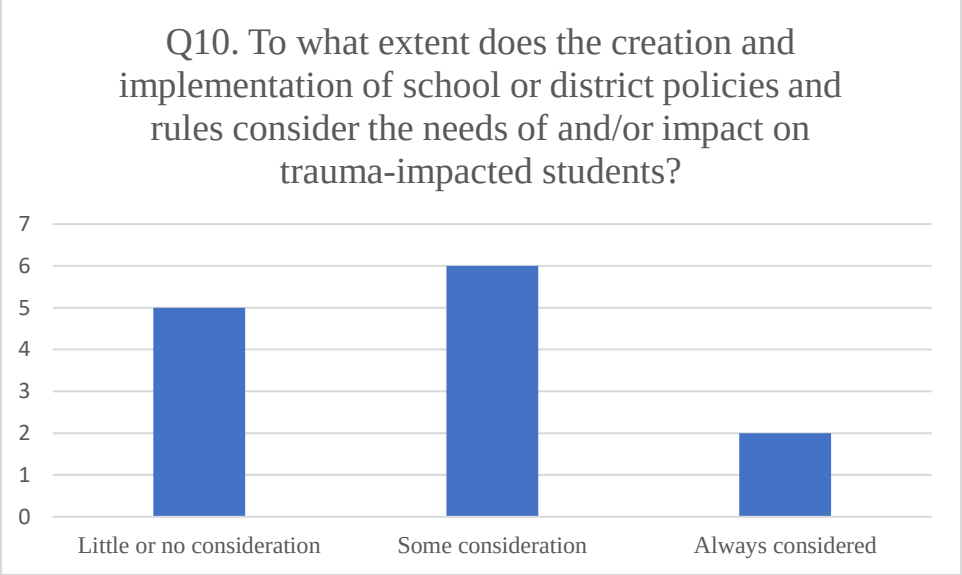
Survey Question 5



In Question 10, participants are asked how frequently are trauma-impacted students considered when implementing a new policy or procedure. Only 2 of 13 answered "Always considered." The full chart and response are as follows:

Figure 4.4

Survey Question 10




The survey questions that are grouped under *Knowledge of Trauma* helps the researcher understand what levels of trauma-informed practice are currently known, and to summarize, they are "moderate" or "some." The next category will further explore the first Research Question.

*Training and Professional Development*

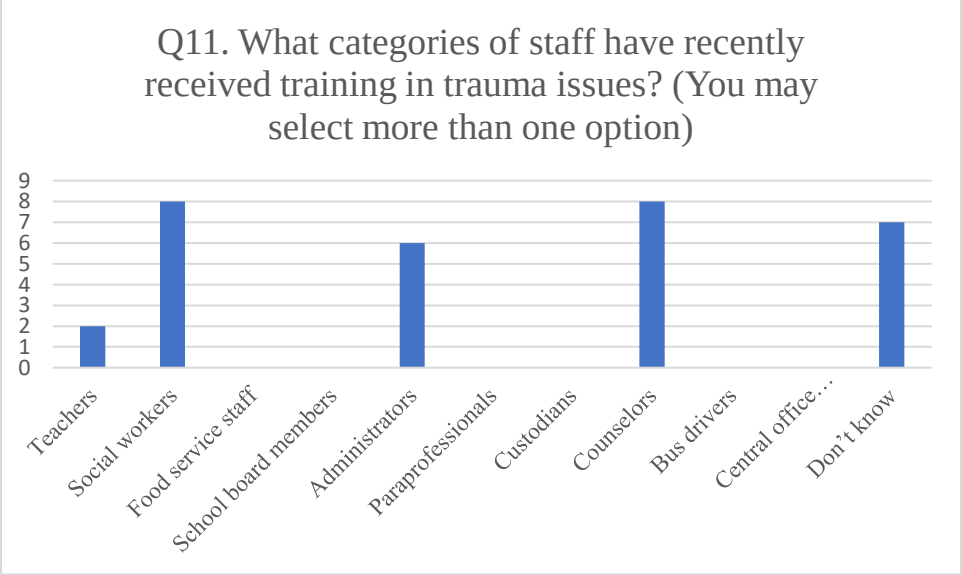
Survey Questions 11-23 ask participants of the current levels of training in their districts on trauma-informed practice. The second part of the first research question, "what elements are currently being practiced" is explored in this category of survey questions and responses. The responses show that approximately half the districts

surveyed are knowledgeable that some staff, most notably school social workers, have some training in trauma-informed practices, while the other half of districts do not know the extent or existence of any training. Survey Question 11 and 13 were selected to highlight some of the notable data. Survey Question 11 will also be used in the review of Research Question 2.

In Question 11, districts are asked who has had training. The school social worker is the response for 8 of 13 respondents, and "I don't know" is the response for 7 of 13. Notably (to be reviewed in Research Question 2), classroom teachers make up 2 of 13 for those trained. The full chart and response are as follows:

Figure 4.5.1

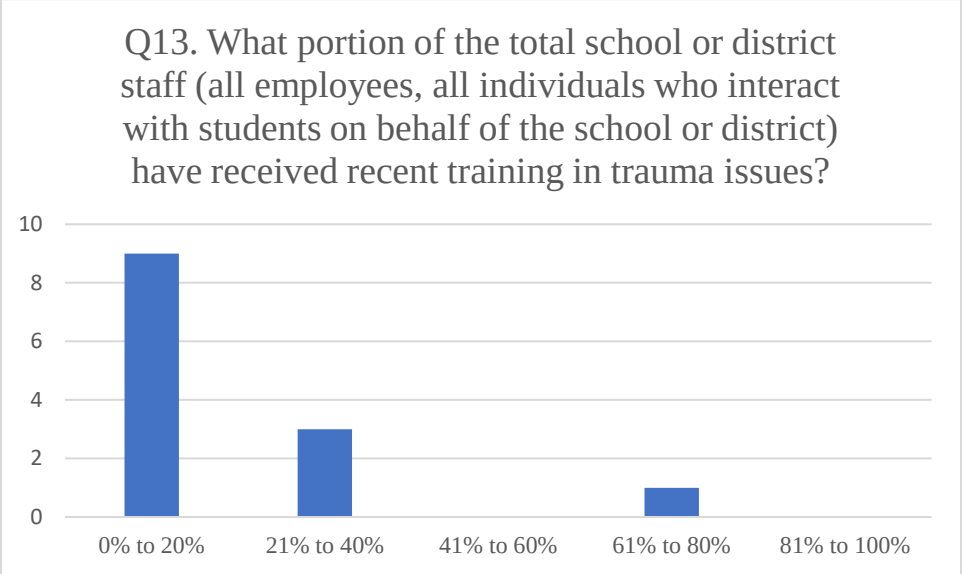
Research Question 11




In Question 13, respondents are asked what the percentage of all staff is who are trained in trauma-informed practice. Of those who responded, 9 indicated that only "0%-20%" of total staff had been trained. This will also be reviewed in Research Question 2. The full chart and response are as follows:

Figure 4.6.1

Survey Question 13




In Research Question 1, the elements of trauma-informed practice known and practiced by respondents is varied. It is more widely known and practiced by district social workers then school guidance counselors and administrators, but there is "moderate" knowledge and implementation of such.

**Research Question 2 - Survey**

*Training and Professional Development*

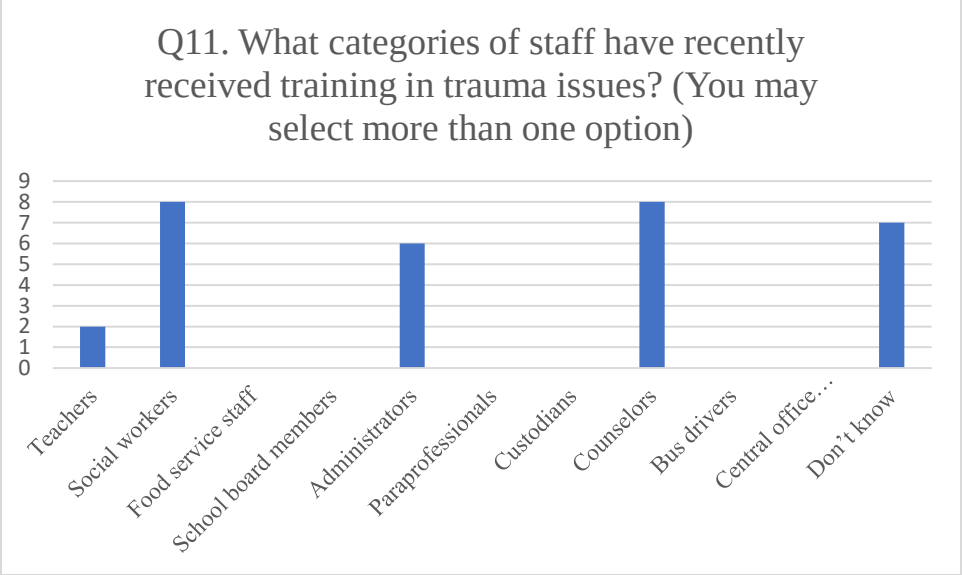
Survey questions 11-23 ask participants of the current levels of training in their districts on trauma-informed practice. What "gaps exist between current levels of knowledge and practice" is explored in this category of survey questions and responses. The responses show that approximately half the districts surveyed are knowledgeable that some staff, most notably school social workers, have some training in trauma-informed

practices, while the other half of districts do not know the extent or existence of any training. The TSS Model has an important feature that calls for all staff, including teachers, faculty, and even support staff, be trained in trauma-informed approaches. Survey Question 11 and 13 were selected to highlight some of the notable data.

In Question 11, districts are asked who has had training. The school social worker is the response for 8 of 13 respondents, and "I don't know" is the response for 7 of 13. Notably, classroom teachers make up 2 of 13 for those trained, and all support staff have had no training. The full chart and response are as follows:

Figure 4.5.2

Survey Question 11

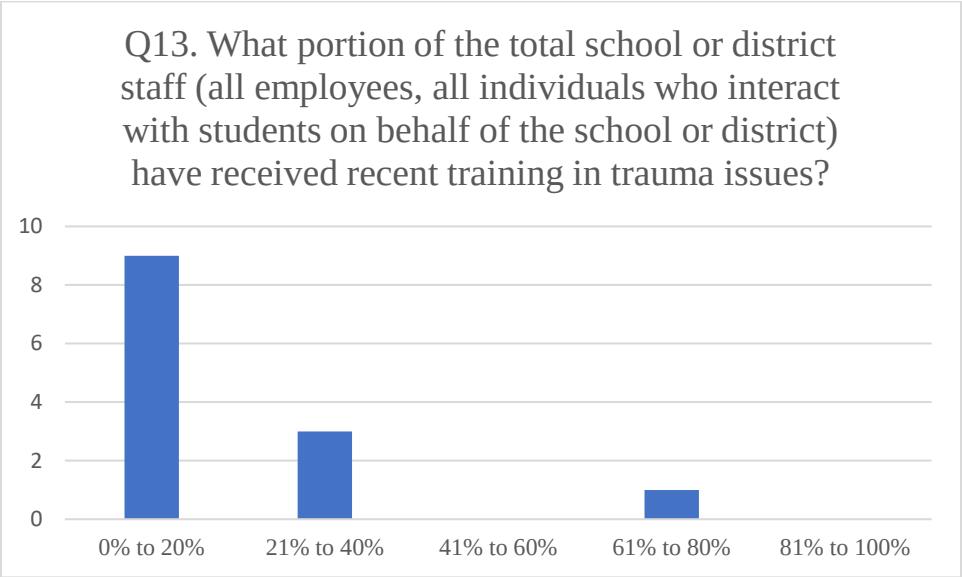



In Question 13, respondents are asked what the percentage of all staff is who are trained in trauma-informed practice. Of those who responded, 9 indicated that only "0%-20%" of total staff had been trained. Similarly, to the previous chart, this shows that not all staff has been trained, which is an important element in the TSS Model. This

highlights the important need to widespread training to address the "gap" that exists as the Research Question suggests. The full chart and response are as follows:

Figure 4.6.2

Survey Question 13



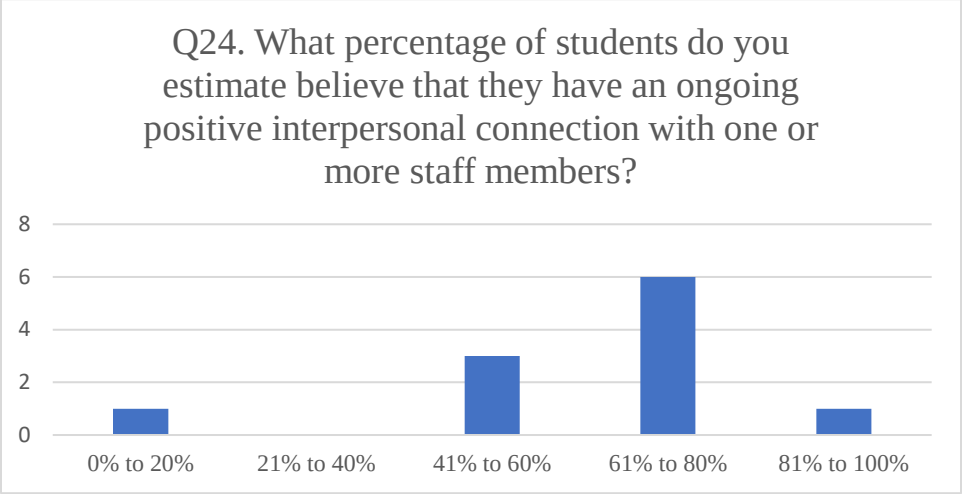

*Adult Connection*

Survey Questions 24-27 explore the connection between students and a trusted adult in the school building. This is an important element of the TSS Model to ensure that students' academic and social/emotional performance is optimized by mitigating effects of trauma. Questions 24 and 26 were selected to highlight the responses.

In Question 24, respondents showed a strong indication of student connection when asked about personal connection with students, but clearly not 100%. This highlights the "gaps" needed to address to implement the full TSS Model. The full chart and response are as follows:

Figure 4.7

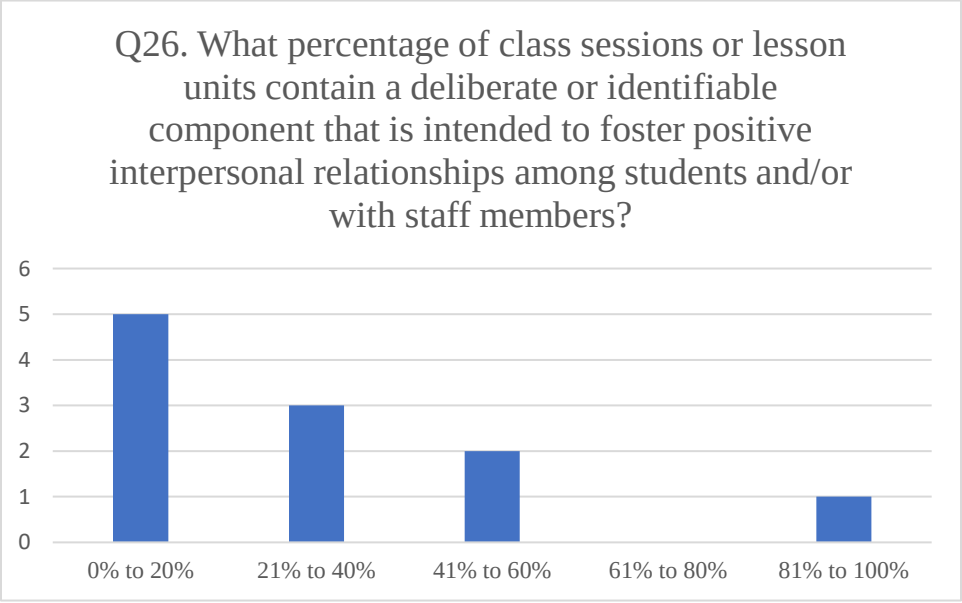
Survey Question 24




In Question 26, the survey asks participants to identify what percentage of class lessons has something built in, by the teacher, to foster a positive, interpersonal relationships with students. The results show that most teachers do not do this element of the TSS Model. The full chart and response are as follows:

Figure 4.8

Survey Question 26



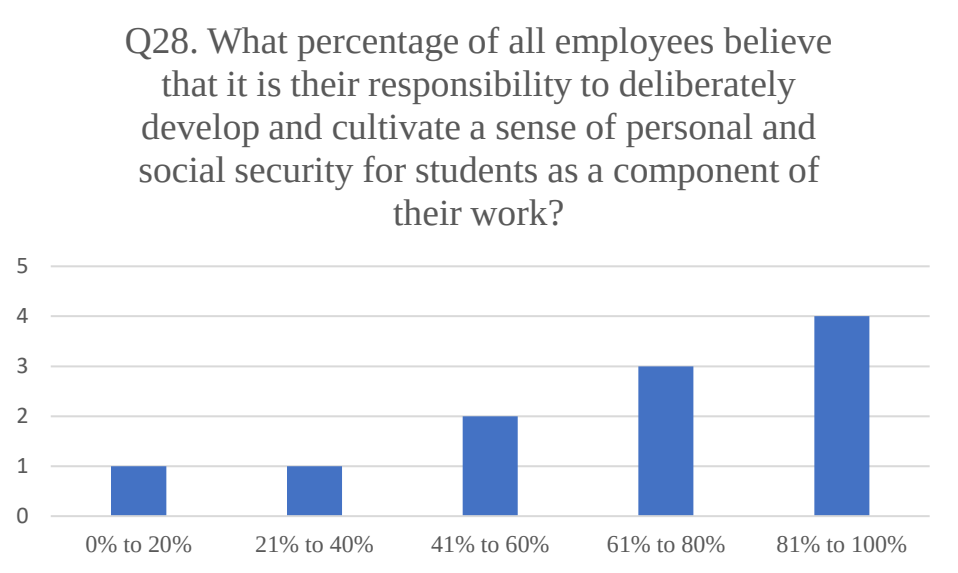
*Instructional Integration*

Survey Questions 28-40 explore the integration of trauma-informed practices with teacher instructional practices. Elements of the TSS Model such as a sense of achievement, personal security, belonging and inclusion, autonomy, choice in instruction and assessment demonstration, community involvement, and mitigating or exacerbating confrontation and stress are all explored in this set of questions. Summarily, many of the responses have a higher response rate in the "41%-60%" range, suggesting many of them are on a bell curve, but there were some outliers. The researcher chose Questions 28, 32, 39, and 40 to highlight this category.

In Question 28, respondents were asked to identify what percentage of employees believe that it is their responsibility to cultivate personal security through their work. The results trended to the strong side. The full chart and response are as follows:

Figure 4.9

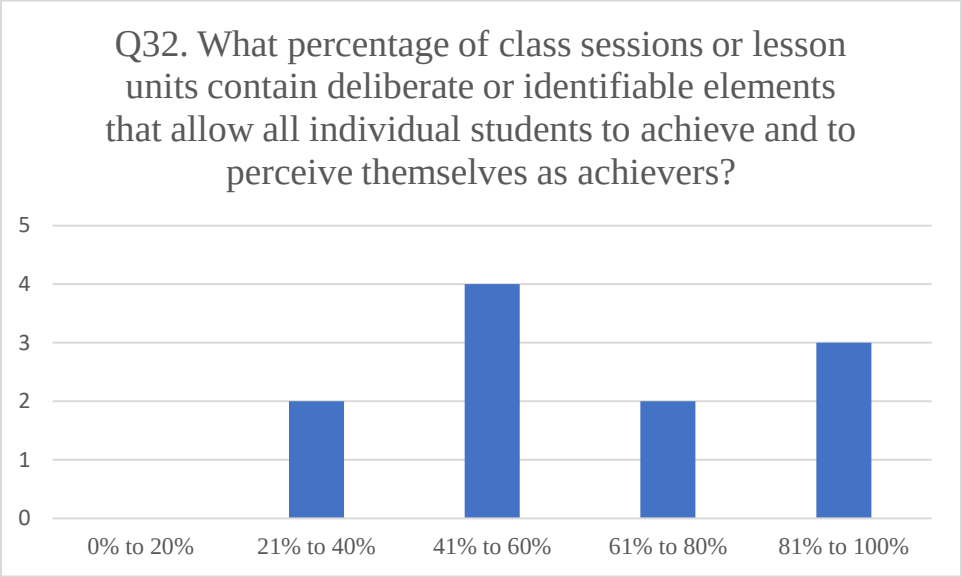
Survey Question 28



In Question 32, participants were asked to identify the percentage of class lessons that had elements built in to allow individual students to perceive themselves as achievers. The responses followed a bell curve, where the majority fell in the middle percentage points. The full chart and response are as follows:

Figure 4.10

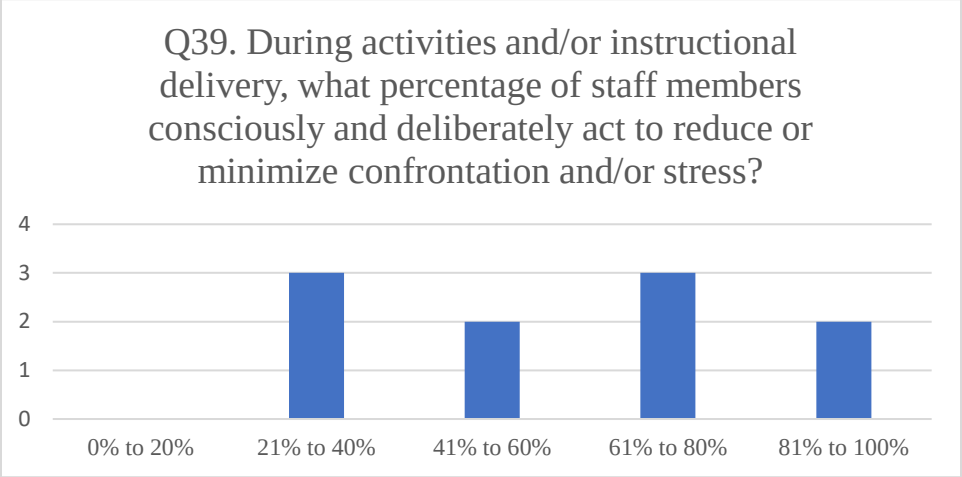
Survey Question 32




In Question 39, participants identify the percentage of staff who consciously act to reduce student confrontation and stress. The results were very mixed across the spectrum, showing that some faculty do, and some do not. The full chart and response are as follows:

Figure 4.11

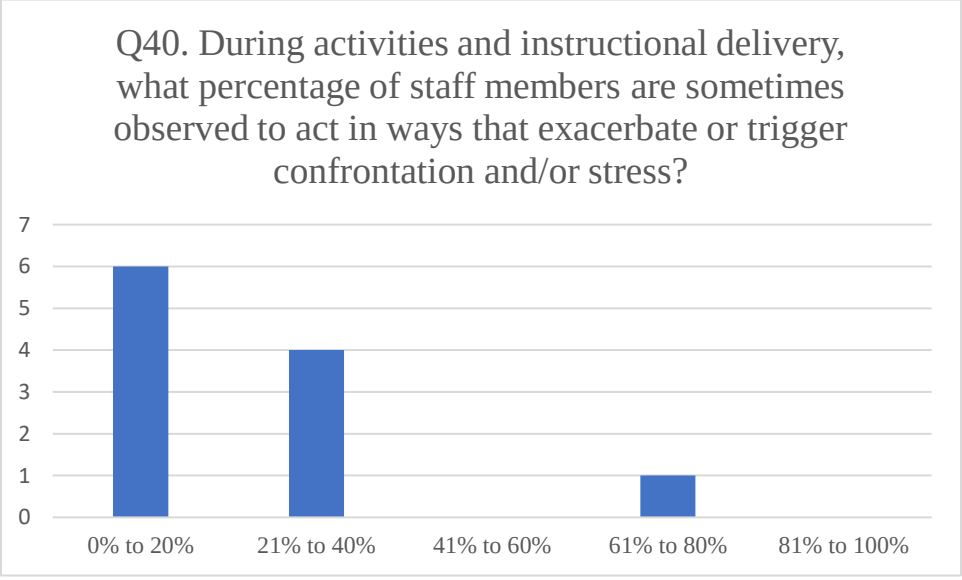
Survey Question 39




In Question 40, respondents are similarly asked what the percentage of teachers exacerbate stress or confrontation. The results are promising to be in line with filling the gap between the current levels of practice and the TSS Model in Research Question 2, where most teachers comply with this. The full chart and response are as follows:

Figure 4.12

Survey Question 40



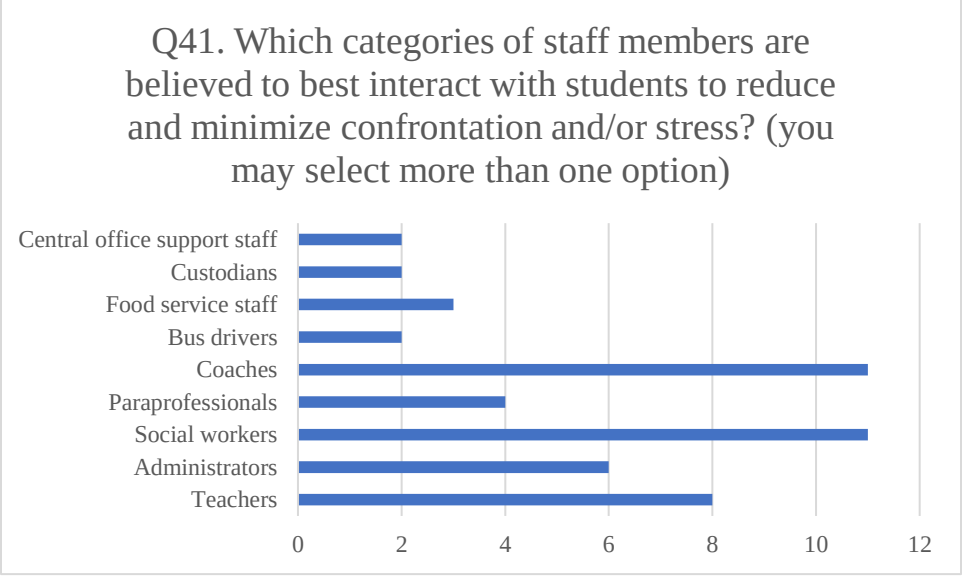
*Staff Assigned or Best/Worst Prepared to Implement*

Survey Questions 41-48 explore what staff are best qualified, equipped, or known to be the purveyors of traits of trauma-informed practice. Again, the TSS Model calls for all staff to be uniformly trained and equipped to mitigate or handle incidents of trauma-induced stress and performance, so the results point to the "gap" referred to Research Question 2. Survey Questions 41, 42, and 47 were chosen to highlight responses in this category.

In Question 41, coaches and social workers are identified as the strongest staff members to handle student stress and confrontation. The full chart and response are as follows:

Figure 4.13

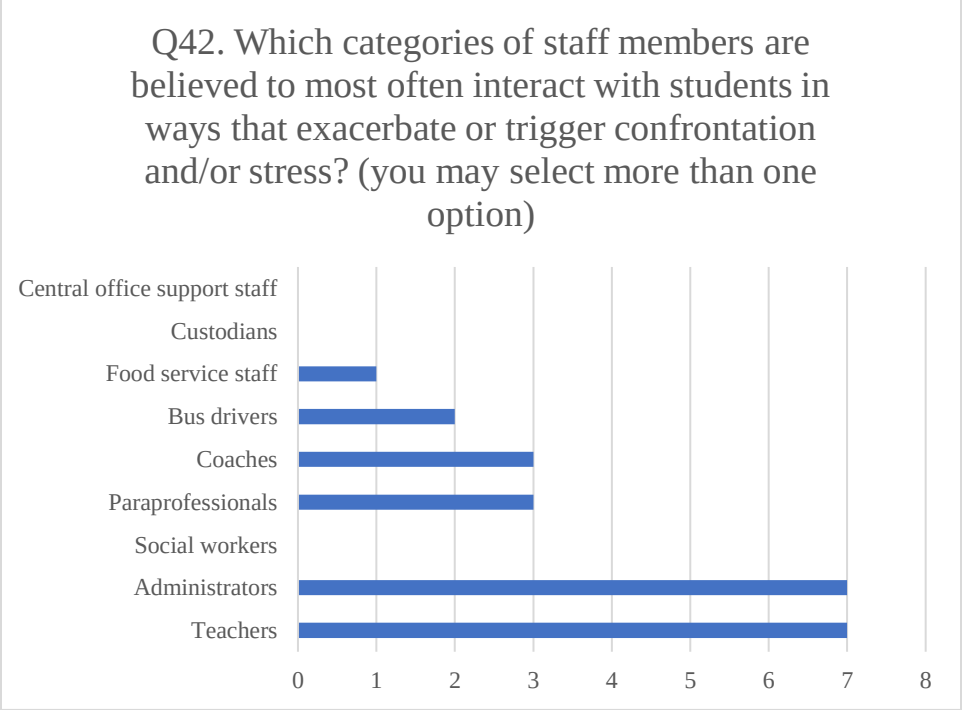
Survey Question 41



In Question 42, respondents are asked to identify what categories of staff most often exacerbate student confrontation or stress. Teachers and administrators were selected as the most common. The full chart and response are as follows:

Figure 4.14

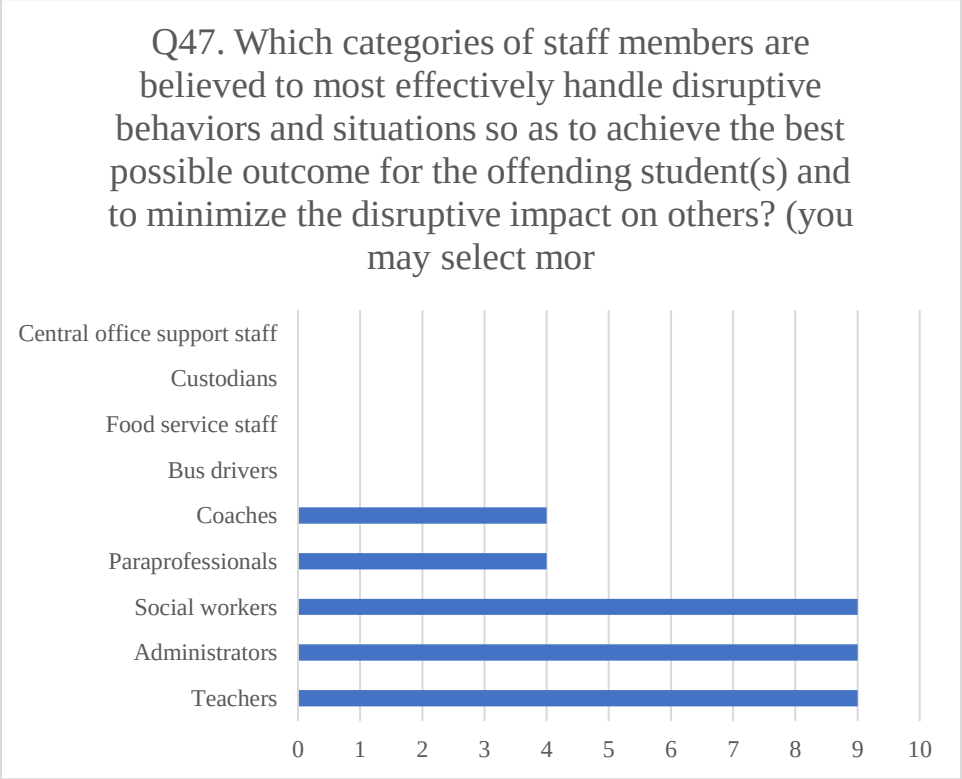
Survey Question 42




In Question 47, respondents are asked what groups of staff are the best at effectively handling behaviors and situations. The respondents put social workers, teachers, and administrators all on the same level as handling these disruptions. The full chart and response are as follows:

Figure 4.15

Survey Question 47




For Research Question 2, these categories, *Training and Professional Development, Adult Connection, Instructional Integration,* and *Staff Assigned or Best/Worst Prepared to Implement,* help the research understand where the gaps are that exist between current levels of practice and those needed to implement the TSS Model. Summarily, the data shows that the gap exists in the training of all staff and the expectation that trauma-informed approaches need to be the responsibility of all staff and throughout the core instruction.

**Summary of Data Analysis**

The study utilized a mixed method approach using National Dropout Prevention Center's instruments of adapted Survey Questions and Focus Group Questions. The table below shows a summary of the research questions, the method used, the data that was conducted, and highlight or summary of analysis:

Table 4.6

Summary of Data Analysis

| Research Question | Method | Data | Analysis |
|---|---|---|---|
| 1. What elements of trauma-informed practice do the Guidance Directors in Suffolk County already know, and what elements are currently being practiced? | Qualitative | Focus Group Questions | *Training and Professional Development* co-occurring with many codes, indicates varied degree of training and knowledge among providers<br><br>1 of 3 participants was very familiar with and trained in trauma-informed practice (33%) |
| | Quantitative | Survey Questions | - *Knowledge of Trauma*<br>- *Training and Professional Development*<br><br>10 of 15 (67%) of respondents were "somewhat aware" and had strategic district plans that "vaguely" considered trauma-informed practice |
| 2. What gaps exist between current levels of knowledge and practice need to be met to implement a Trauma-Skills School (TSS) Model? | Qualitative | Focus Group Questions | *Barriers to Implementation* co-occurring with teacher compliance, such as *Contractual Limitations* and *Teacher Resistance*<br><br>*Scheduling and Building Structure* co-occurring with *Targeting Particular Students* and other various teacher compliance |

| | | | |
|---|---|---|---|
| | | | 3 of 3 participants (100%) stated "Teacher Buy-in" constitutes greatest gap |
| | Quantitative | Survey Questions | *Training and Professional Development* – 9 of 13 (69%) of respondents state 0%-20% relevant staff are trained<br><br>*Adult Connection* – 6 of 11 (55%) of respondents state that 60%-80% of students have a trusted adult<br><br>*Instructional Integration* – 4 of 11 (36%) of respondents state that 80%-100% of faculty incorporate into lessons<br><br>*Staff Assigned or Best/Worst Prepared to Implement* – Respondents chose coaches and social workers, 11 of 13 (85%) as best prepared, and respondents chose teachers and administrators, 11 of 13 (85%) as staff who can exacerbate issues |

# CHAPTER V

# DISCUSSION AND ANALYSIS

## Introduction

This study was conducted to investigate the knowledge level and preparedness for school districts in Suffolk County, New York, to implement a trauma-informed school system such as the TSS Model. The research evaluated the current levels of knowledge and training, and what are the existing gaps and barriers to implementation. The research was conducted using the Suffolk Directors of Guidance as the participant group, an organization of approximately 50 members. Of the 50 members invited to participate, 15 responded to a survey utilizing an instrument developed by the National Dropout Prevention Center, creators of the TSS Model. Of the 15 survey respondents, 4 volunteered to participate in a focus group interview, from which 3 ultimately participated in the focus group utilizing a Zoom Meeting.

## Implication of Findings

The qualitative and quantitative research procedures are meant to simultaneously address the two research questions, in a mixed-method approach, examining the questions with both methodologies simultaneously. which are as follows:

1. What elements of trauma-informed practice do the Guidance Directors in Suffolk County already know, and what elements are currently being practiced?
2. What gaps exist between current levels of knowledge and practice need to be met to implement a Trauma-Skills School (TSS) Model?

The summation of the analysis, by research question, is as follows:

In Research Question 1, respondents are asked what elements of trauma-informed practice to guidance directors know, and what elements are being practiced. The results show that 33%-67% of guidance professionals are familiar with trauma-informed practice, when explored with both a quantitative and qualitative measure. It is noteworthy that one of the expected participants in the focus group was an individual whom is familiar with and has trained staff in trauma-informed practice, and could have moved the data to 50%-67%. The elements that are being practices, as evidenced again in both the qualitative and quantitative measures, are those that an individual PPS provider, typically a school social worker, has been trained in and chooses to utilize in his/her practice. Some Suffolk Directors of Guidance were very familiar with trauma-informed practice, and some had never heard of the elements of this model. There was no system-wide trauma-informed model of implementation in any school in Suffolk County, but there was evidence of "elements" being practiced, as the Research Questions suggests.

In Research Question 2, the gaps between current knowledge and practice and what is needed to implement the TSS Model was explored. Issues that were explored were "Negative Perception," "Training and Professional Development," "Teacher Resistance," "Instructional Integration," and "Adult Connection," among others. The gaps that exist are the number and category of staff that needs to be trained, and the staff, particularly teachers, "buy-in" of the system. All students would need to be treated in a way, and all policies would need to be looked at, through a TSS Model lens, not just

"Target Particular Students." Current levels of training are very low, which is to be expected of a relatively new modality. But the greatest gap to implementation were found in "Barriers to Implementation," which encompasses many themes explored in the study, including and particularly "Scheduling and Building Structure" and "Teacher Resistance."

One code that appeared one time in the focus group interview was "Diagnosis." While this code did not have the substance to be noteworthy in the study, there is a broad implication with this topic. Districts nationwide experienced increased special education and Section 504 referrals with the greater understanding of autism spectrum disorder (ASD) and attention deficit hyper-activity disorder (ADHD). Both anecdotally and statistically, as the researcher described in the Review of the Literature, there has been a spike in mental health disorders, most particularly anxiety and depression. Trauma or post-traumatic stress disorder (PTSD) was a diagnosis most regularly reserved for combat veterans or victims of severe ongoing physical abuse, but in my practice, it is a diagnosis more regularly being used for school-aged children. This could be a new wave of referrals that districts may need to be ready for, with the increase of trauma-influenced students in our buildings.

Lastly, the research was conducted during the Coronavirus COVID-19 pandemic, which was a topic of discussion in the focus group. Suddenly, the idea of widespread "trauma" was not such a foreign concept for the participants. The idea that students would be coming back to school in a "new normal" after having not been allowed in their school buildings for nearly 4 months, or potentially longer than the following fall, had the guidance directors in the focus group worried for students and staff.

**Relationship to Prior Research**

The outcome of this study reminds me of the question that Adelman and Taylor raised in 1997 of "who's responsible." We understand systems of teachers' responsibility for the effective delivery of curriculum, instruction, and assessment. We also understand the need for school pupil personnel staff such as counselors, social workers, and psychologists. What is evident through this study is that there remains a definitive line of separation between the academic and social-emotional learning components, albeit getting more and more blurry with the evidence that some teachers embrace or reject this responsibility. The literature too shows that the line is becoming more and more blurry, as evidenced by state initiatives, federal grants, special education law, and policy-makers (Education Week, retrieved 9/29/2019). The trends in Suffolk County, New York, seem to be following the national trends and calls for best practice, by combining the practice of academic excellence and social-emotional learning in the classroom.

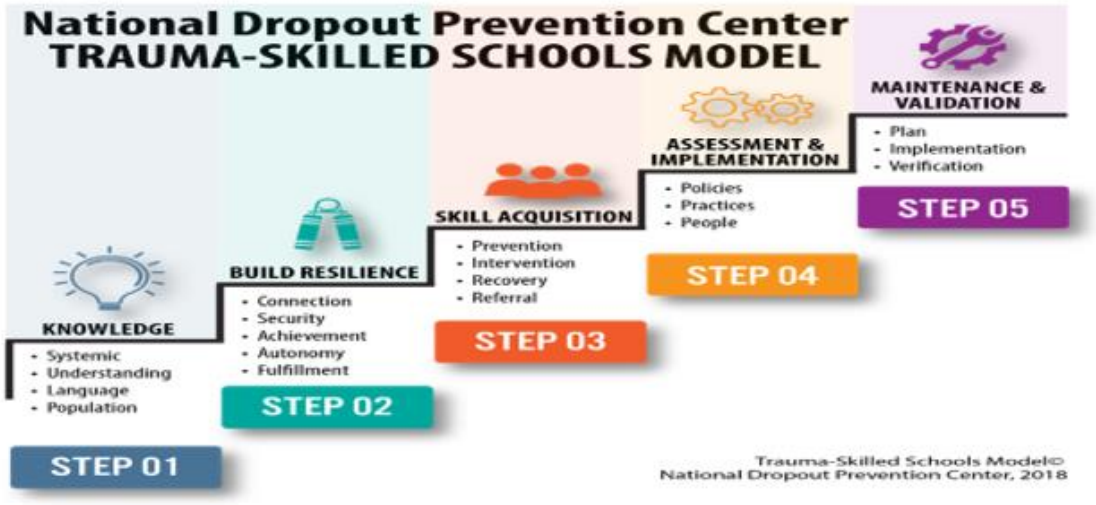
As discussed briefly in the Review of the Literature, there are several instances of litigation involving students' trauma, whether caused by outside circumstances, actions of the district, or negligible inaction taken by the district to mitigate the effects of trauma. The risk involved of districts deciding to ignore students' claims of trauma and the impact it has on learning is becoming more of a reality, and it can be costly. In the case of the Compton Unified School District, part of the settlement was to implement a district-wide training program for all staff in the effects of trauma on student performance, similar to the TSS Model. If a district experiences claims of trauma on a large scale, or operates in a historically underrepresented community, as shown in the Compton and Havasupai cases, it would behoove them to consider such training.

## Conceptual Framework

The Trauma-Skilled Schools Model served as the conceptual framework for this study. A review of the literature shows that school districts have historically sought to identify issues in students, be them mental health, behavioral, attendance, etc., and seek to implement intervention strategies to address that individual student. The most recent literature shows that the prevalence of mental health and behavioral issues are rapidly increasing in frequency and intensity, and much of the root cause is in traumatic experiences (both perceived and actual) in students' lives. Due to the increased difficulty in identifying, diagnosing, and treating these behaviors, full-school trauma-informed practice has gained traction in recent years in both theory and evidence-based practice. The National Dropout Prevention Center has been on the frontline in this research, and has developed the Trauma-Skilled Schools Model to respond to this changing student phenomenon. The TSS Model© Step 01 served as the conceptual framework for this study in answering the research questions and analyzing the data.

Figure 5.1

Conceptual Framework



## Theoretical Framework

The given culture in a particular learning community is the determinant of behavior within the community. Behavior influences the expectations of the community, as it is based in past learned experiences. The collective behavior of the community creates the learning systems, reflecting the values of the community. Both the systems and expectations then further strengthen and influence of the culture.

The theoretical framework of this study is based off the Organizational Theory of Lee Bolman and Terrence Deal. Bolman and Deal (2003) describe organizations within four frames; the structural frame, the human resource frame, the political frame, and the symbolic frame. These frames help leaders and participants in organizations understand the structure, where the strengths and weaknesses are, and thereby implementing change.

When we look at the problem of mental health issues in students' lives today, and how those issues impact student learning, this study looks at the problem through the theoretical framework of how to improve organizational structure to address the problem. As this study examined, the issues of mental health and systems to address the widespread impact of trauma on many students, school system adjustment takes some skill. We are forced, and it benefits us, to look at the problem through an organizational lens. Bolman and Deal help us look at the structural, human, political, and symbolic frames that would need to be considered as one looks at how ready a district would be to implement a full-school trauma-informed model such as the TSS Model. After having done the research, the frame that may take the greatest skill to negotiate is the political one, given the many references to teachers' abilities, rights, preferences, contractual limitations, and perception.

## Limitations of the Study

The study's limitations were that it had a very broad sample with varied knowledge and experience with trauma-informed approaches. Had the study been with social workers, there would have likely been a higher instance of knowledge and practice. Or had the study looked at districts that have trauma-informed approaches already implemented to examine the gaps between current levels and optimum TSS Model implementation, the study would have been very different. Albeit the case, the study was worthwhile due to the fact that many districts do not have any trauma-informed "systems," the researcher did make some recommendations for future study.

## Recommendations for Future Study

The two recommendations for future study would be to explore the correlation between socio-economic factors and the research questions, and to explore the frequency of trauma-impacted students and staff as a result of the COVID-19 pandemic.

The survey in this study included several demographic questions asked of the Directors to describe their size, ethnic, and economic makeup of the student body. A study could be conducted to evaluate the occurrences of trauma diagnoses at different schools, the training levels in trauma-informed practice, and the perception of faculty in this vain.

In this study, the topic of widespread trauma impact and/or diagnoses due to the COVID-19 and school closures was brought up. A study exploring the frequency of cases of trauma diagnoses, school avoidance, or behavioral instances for a period of time after schools and businesses reopen could be another worthy study to consider.

**Recommendations for Future Practice**

As practitioners and educators brace themselves and their students for the post-COVID-19 world, with the associated fear and anxiety that will be amplified in an already anxious world, the preparation of a trauma-sensitive approach to school leadership and administration may be well warranted. As this study has shown, there is strong knowledge of and confidence in trauma-informed approaches in the social work department of schools, moderate levels of such in school guidance counseling departments, and little levels of such in faculty and staff. Lessons that administrators may take away in future practice to implement systems of trauma-informed approaches would center around teacher professional development, contractual limitations and negotiations, and organizational/building structure focus. If a district were to implement a plan such as the TSS Model, several distinct steps would need to take place. The first would be the community acceptance of such a plan, from the board of education to district leaders to faculty. The reason to undertake this, the existence of student mental health issues that manifest in school avoidance or learning behaviors that have root in trauma or perceived trauma, would need to be understood and clearly communicated. The groundwork for teacher and staff training, including contractual limitations, would need to next be laid. It should be understood and articulated that student performance, where academic and social-emotional learning are intertwined and inseparable, is everyone's responsibility. Providing faculty with the data and research that supports this is vital. The last step would be the organizational structure, where school policies are reviewed and there are opportunities for positive student-adult relationships. It is helpful for school administrators to see that as not simply a program to implement, but a way of

training teachers and staff to view student performance and the role of social-emotional learning, including trauma, as interrelated.

## Conclusion

As a result of this study, we now know that there is general knowledge of role of social-emotional learning in the counseling, social work, and academic departments in the sample group from Suffolk County, New York. We learned that there is little knowledge of trauma-informed practice, and the connection between implementing trauma-sensitive approaches and student learning, aside from specific personnel such as school social workers. The bigger picture, where faculty and staff are aware, trained, and competent to implement some of the tenants of a system such as the TSS Model, gaps were identified as a result of the study. We now know that the most formidable gap or obstacle will be the willingness from all staff to accept this as their responsibility. Moving from a system of compartmentalized counselors and teachers, each with their own distinct role and responsibility, within the confines of a contract, and the need for greater professional development and training was the demonstrable outcome of this study.

## Epilogue

As I reflect on the research process and the topic of this study, it became clear to me that this phenomenon is ever-growing. Students either experience more stress than ever, or respond to stress more poorly than ever; the cause of trauma was not the focus of this study, but the presence of it, both anecdotally and statistically, makes us in education

pause and think. Why does this happen? How can I help my students? How can I, as an administrator, help my teachers? Is this the silver bullet for a school we all dream of? While the research process, at times, left me with more questions than answers, it made me a better thinker, and here are a few thoughts.

Students need positive adult connection. There is simply no other ingredient more important than this in the recipe of student success. If they do not get it at home, they need it in school. If they do not get it in school, usually behavioral, academic, and/or social concerns will arise.

Teachers and staff need support, training, and to "buy-in" to efforts where student social/emotional learning (SEL) translates into academic success. Not all students need this; many get it from home. But for those who do not receive it, teachers can support. Or coaches. Or custodians. Or secretaries. Or whomever students spend time with. Even the In-School Suspension teacher.

And for my personal takeaway, good decisions are based in good information. The process of this study made me a better questioner in finding answers. Developing the questions was an exercise in this process that was just as important in answering the questions, and it is something that I have already taken into my professional life.

Appendix A

Survey to Assess Readiness to Implement TSS Model

1. **Which of the following describes the school's or district's primary reason(s) for understanding the Trauma-Skilled Schools Model?** ***(You may select more than one option)***
    a. State, local, or legal mandate
    b. Need to improve graduation rates
    c. Need to improve student behavior
    d. Awareness of adverse childhood experiences (ACEs) among student population
    e. Need to improve student academic performance
    f. Awareness of the impact of adverse childhood experiences (ACEs) on school performance
2. **To what extent are school or system leadership and governance (principals, Superintendent, Board of Education) aware of the presence of trauma-impacted students in the school system?**
    a. Not aware
    b. Somewhat aware
    c. Very aware
    d. Don't know
3. **To what extent do school or system leadership and governance (principals, Superintendent, Board of Education) understand the relationship of trauma to school success, particularly as it relates to acceptable behavior, learning, and school completion?**
    a. Minimal understanding
    b. Moderate degree of understanding
    c. High level of understanding
    d. Don't know
4. **Who is perceived by school and/or system leadership to be primarily responsible for addressing the needs of trauma-impacted students?**
    a. Administrators
    b. Social workers
    c. Classroom teachers
    d. Counselors
    e. Special education teachers
    f. Mental health providers
5. **To what extent does the school improvement plan and/or the district strategic plan specifically address services to or support for trauma-impacted students?**
    a. Not addressed
    b. Generally or vaguely addressed
    c. Clearly and specifically addressed
    d. Don't know

6. **When the school or district identifies trauma-impacted students, what actions, services, or interventions result from that identification?** ***(You may select more than one option)***
    a. Referral to school counselors
    b. Referral to school social workers
    c. Referral to outside agencies
    d. Staff members serving the student are informed
7. **What resources exist within the school or district to serve or to meet the needs of trauma-impacted students?** ***(You may select more than one option)***
    a. School counselors
    b. School social workers
    c. Mental health agencies
8. **What resources exist external to the school or district that are regularly accessed and used to serve or to meet the needs of trauma-impacted students?** ***(You may select more than one option)***
    a. Community mental health agencies
    b. Faith community supports
    c. Family support agencies
    d. Don't know
9. **What percentage of the school's or district's student population is believed to be trauma-impacted?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
10. **To what extent does the creation and implementation of school or district policies and rules consider the needs of and/or impact on trauma-impacted students?**
    a. Little or no consideration
    b. Some consideration
    c. Always considered
11. **What categories of staff have recently received training in trauma issues?** ***(You may select more than one option)***
    a. Teachers
    b. Social workers
    c. Food service staff
    d. School board members
    e. Administrators
    f. Paraprofessionals
    g. Custodians
    h. Counselors
    i. Bus drivers
    j. Central office support staff
    k. Don't know

12. **What was the primary theme of trauma training?** ***(You may select more than one option)***
    a. Types of trauma
    b. Impact of trauma
    c. Frequency of trauma among students
    d. School climate changes to meet student needs
    e. Referral of trauma-impacted students for mental health services
    f. Instructional changes to meet student needs
    g. Impact of trauma on school behavior
    h. Don't know
13. **What portion of the total school or district staff (all employees, all individuals who interact with students on behalf of the school or district) have received recent training in trauma issues?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
14. **Was the training or professional development provided generic to all categories of employees or was it customized to the work and responsibilities of the personnel that were trained?**
    a. Totally generic
    b. Somewhat customized
    c. Totally customized
    d. No training delivered
    e. Don't know
15. **To what extent did the training or professional development provided to school personnel focus on the types and specifics of trauma incidents?**
    a. Minimal emphasis on trauma incidents
    b. Moderate emphasis on trauma incidents
    c. Heavy emphasis on trauma incidents
    d. No training delivered
    e. Don't know
16. **To what extend did the training or professional development in trauma provided to school personnel focus on the importance of secondary trauma (perceived, observed, virtual, or second-hand?**
    a. Minimal emphasis on trauma incidents
    b. Moderate emphasis on trauma incidents
    c. Heavy emphasis on trauma incidents
    d. No training delivered
    e. Don't know
17. **To what extend was the training or professional development provided to school personnel customized to consider the demographics, contexts, and likely trauma scenarios of the school's or district's specific population?**
    a. Totally generic
    b. Somewhat customized

c. Totally customized
d. No training delivered
e. Don't know

18. **To what extent did the training or professional development provided to school personnel focus on the effects of trauma on student thought processes (mindsets, perceptions, assumptions, and thought patterns)?**
    a. Minimal focus
    b. Moderate focus
    c. Significant focus
    d. No training delivered
    e. Don't know
19. **To what extent did the training or professional development provided to school personnel focus on the impact of trauma on the student's school behavior?**
    a. Minimal focus on behavior
    b. Moderate focus on behavior
    c. Significant focus on behavior
    d. No training delivered
    e. Don't know
20. **To what extent did the training or professional development provided to school personnel focus on the impact of trauma on learning, demonstration of learning, and academic performance?**
    a. Minimal focus on learning
    b. Moderate focus on learning
    c. Significant focus on learning
    d. No training delivered
    e. Don't know
21. **Did the training or professional development in trauma include, or result in, those trained agreeing on a common language and agreed-on understandings about the impact of trauma on school behaviors and learning?**
    a. Minimal inclusion of common language and understandings
    b. Moderate inclusion of common language and understandings
    c. Significant inclusion of common language and understandings
    d. No training delivered
    e. Don't know
22. **What portion of staff members trained in trauma issues clearly articulate the influence of trauma on school behavior, on learning, and on long-term school success?**
    a. Few can articulate
    b. Some can articulate
    c. Most can articulate
    d. No training delivered
    e. Don't know
23. **To what extent did the training or professional development in trauma include, or result in, discussion about needed changes in school practices and/or in instructional practices?**

a. Very little discussion
b. Some discussion
c. Significant amount of discussion
d. No training delivered
e. Don't know

24. **What percentage of students do you estimate believe that they have an ongoing positive interpersonal <u>connection</u> with one or more staff members?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
25. **What percentage of all employees believe that it is their responsibility to deliberately develop and cultivate positive interpersonal <u>relationships</u> with students as a component of their work?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
26. **What percentage of class sessions or lesson units contain a deliberate or identifiable component that is intended to foster positive interpersonal <u>relationships</u> among students and/or with staff members?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
27. **What percentage of students believe that they are emotionally, socially, and physically <u>safe</u> and at school and during school activities/events?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
28. **What percentage of all employees believe that it is their responsibility to deliberately develop and cultivate a sense of personal and social <u>security</u> for students as a component of their work?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
29. **What percentage of class sessions or lesson units contain a deliberate or identifiable component that is intended to foster a sense of <u>belonging and inclusion</u> among students?**

a. 0% to 20%
b. 21% to 40%
c. 42% to 60%
d. 61% to 80%
e. 81% to 100%

30. **What percentage of students believe that they are achievers in academics and in school activities/events?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
31. **What percentage of all employees believe that it is their responsibility to deliberately develop and cultivate a sense of achievement as a component of their work?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
32. **What percentage of class sessions or lesson units contain deliberate or identifiable elements that allow all individual students to achieve and to perceive themselves as achievers?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
33. **What percentage of students believe that they have autonomy (options and choices) in academics and in school activities/events?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
34. **What percentage of all employees believe that it is their responsibility to deliberately offer students options and choices in school activities and in instruction?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
35. **What percentage of class sessions or lesson units give students options and choices regarding how they learn and/or demonstrate learning?**
    a. 0% to 20%

b. 21% to 40%
c. 42% to 60%
d. 61% to 80%
e. 81% to 100%

36. **What percentage of students regularly perform tasks which <u>support others, the school, or the community</u> as they participate in school activities and/or instruction?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
37. **What percentage of all employees believe that it is their responsibility to deliberately have students <u>support and/or contribute to others, the school, or the community</u> in the conduct of school activities and in instruction?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
38. **What percentage of class sessions or lesson units include <u>altruistic</u> activities and/or opportunities for students?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
39. **During activities and/or instructional delivery, what percentage of staff members consciously and deliberately act to reduce or minimize confrontation and/or stress?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
40. **During activities and instructional delivery, what percentage of staff members are sometimes observed to act in ways that exacerbate or trigger confrontation and/or stress?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
41. **Which categories of staff members are believed to best interact with students to reduce and minimize confrontation and/or stress? *(you may select more than one option)***

a. Teachers
b. Administrators
c. Counselors
d. Social workers
e. Paraprofessionals
f. Coaches
g. Bus drivers
h. Food service staff
i. Custodians
j. Central office support staff

42. **Which categories of staff members are believed to most often interact with students in ways that exacerbate or trigger confrontation and/or stress? *(you may select more than one option)***
    a. Teachers
    b. Administrators
    c. Counselors
    d. Social workers
    e. Paraprofessionals
    f. Coaches
    g. Bus drivers
    h. Food service staff
    i. Custodians
    j. Central office support staff
43. **During activities and/or instruction, what percentage of staff members are regularly able to recognize early signs of student stress and dysfunction and to effectively diffuse and minimize the negative impact of stress and dysfunction?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
44. **Which categories of staff members are believed to most effectively recognize early signs of student stress and dysfunction and to diffuse and minimize the negative impact of stress and dysfunction? *(you may select more than one option)***
    a. Teachers
    b. Administrators
    c. Counselors
    d. Social workers
    e. Paraprofessionals
    f. Coaches
    g. Bus drivers
    h. Food service staff
    i. Custodians
    j. Central office support staff

45. **Which categories of staff members are believed to be least effective at recognizing early signs of student stress and dysfunction and minimizing the negative impact of stress and dysfunction? *(you may select more than one option)***
    a. Teachers
    b. Administrators
    c. Counselors
    d. Social workers
    e. Paraprofessionals
    f. Coaches
    g. Bus drivers
    h. Food service staff
    i. Custodians
    j. Central office support staff
46. **When disruptive behaviors and situations occur during student activities or in the classroom, what percentage of staff members are able to handle the situation so as to achieve the best possible outcome for the offending student(s) and to minimize the disruptive impact on others?**
    a. 0% to 20%
    b. 21% to 40%
    c. 42% to 60%
    d. 61% to 80%
    e. 81% to 100%
47. **Which categories of staff members are believed to most effectively handle disruptive behaviors and situations so as to achieve the best possible outcome for the offending student(s) and to minimize the disruptive impact on others? *(you may select more than one option)***
    a. Teachers
    b. Administrators
    c. Counselors
    d. Social workers
    e. Paraprofessionals
    f. Coaches
    g. Bus drivers
    h. Food service staff
    i. Custodians
    j. Central office support staff
48. **Which categories of staff members are believed to least effectively handle disruptive behaviors and situations so as to achieve the best possible outcome for the offending student(s) and to minimize the disruptive impact on others? *(you may select more than one option)***
    a. Teachers
    b. Administrators
    c. Counselors
    d. Social workers
    e. Paraprofessionals

f. Coaches
g. Bus drivers
h. Food service staff
i. Custodians
j. Central office support staff

49. **Which best describes the relationships of school personnel with external sources of intervention, treatment, and mental health services that are available to the school's students and families?**
    a. Poor working relationship
    b. Fair working relationship
    c. Unknown
    d. Good working relationship
    e. Excellent working relationship
50. **How knowledgeable and effective are school personnel at recognizing students and families needing internal and/or external intervention, treatment, and mental health services?**
    a. Minimally knowledgeable and effective
    b. Somewhat knowledgeable and effective
    c. Very knowledgeable and effective
51. **How effectively do school personnel communicate with and facilitate referrals of students and families in crisis to internal and external sources of intervention, treatment, and mental health services?**
    a. Minimally effective
    b. Somewhat effective
    c. Very effective
52. **Which categories of school personnel are most effective at identifying and referring students and families needing intervention, treatment, and mental health services?** ***(you may select more than one option)***
    a. Teachers
    b. Administrators
    c. Counselors
    d. Social workers
    e. Paraprofessionals
    f. Coaches
    g. Bus drivers
    h. Food service staff
    i. Custodians
    j. Central office support staff
53. **To what extent are intervention, treatment, and mental health services available to and accessed by disturbed and dysfunctional students, either within or external to the school?**
    a. Seldom or never available and seldom or never accessed
    b. Occasionally available and occasionally accessed
    c. Usually available and usually accessed
    d. Readily available and readily accessed
    e. Don't know

54. **When accessed, how effective are intervention, treatment, and mental health services in meeting the needs of referred students?**
    a. Very ineffective
    b. Somewhat ineffective
    c. Unknown
    d. Somewhat effective
    e. Very effective
55. **Please answer a few demographic questions about the district you represent. What is the total enrollment of your district, K-12?**
    a. Under 1,000
    b. 1,000-3,000
    c. 3,000-5,000
    d. 5,000-10,000
    e. 10,000 or more
56. **What is the average grade level size?**
    a. 0-100
    b. 100-200
    c. 200-300
    d. 400 or more
57. **What is the average percentage of students on Free/Reduced Lunch in your district?**
    a. 0%-10%
    b. 10%-20%
    c. 20%-30%
    d. 40% or higher
58. **What is the average percentage of ENL students in your district?**
    a. 0%-10%
    b. 10%-20%
    c. 20%-30%
    d. 40% or higher
59. **Regarding student ethnicity, what is the average percentage of white students in your district?**
    a. 0%-10%
    b. 10%-20%
    c. 20%-30%
    d. 40% or higher
60. **Regarding student ethnicity, what is the average percentage of black or African American students in your district?**
    a. 0%-10%
    b. 10%-20%
    c. 20%-30%
    d. 40% or higher
61. **Regarding student ethnicity, what is the average percentage of Hispanic or Latino students in your district?**
    a. 0%-10%
    b. 10%-20%

c. 20%-30%
d. 40% or higher

62. **Regarding student ethnicity, what is the average percentage of Asian/Native Hawaiian/Other Pacific Islander students in your district?**
    a. 0%-10%
    b. 10%-20%
    c. 20%-30%
    d. 40% or higher
63. **Lastly, would you be willing to participate in a focus group to further explore and discuss the impact of trauma on student performance and your district's readiness to implement trauma-informed practices?**
    a. Yes
    b. No
    c. If Yes, please indicate name, district, and email address

Appendix B

Focus Group Interview Questions

| **Research Question** | **Interview Questions** |
|---|---|
| What elements of trauma-informed practice do the Guidance Directors in Suffolk County already know, and what elements are currently being practiced? | What steps, training, or professional development has occurred in the school or system relative to trauma?<br><br>What portion of the total school or district staff (all employees, all individuals who interact with students on behalf of the school or district) have received training in trauma issues?<br><br>Was the training or professional development provided appropriate and relative to the work and responsibilities of the personnel that were trained?<br><br>To what extent did the training or professional development already provided to school personnel focus on the types and specifics of trauma incidents and adverse childhood experiences?<br><br>What is the current knowledge of ACEs? |
| What gaps exist between current levels of knowledge and practice need to be met to implement a Trauma-Skills School (TSS) Model? | What categories or groups of school or district staff have received training or professional in trauma issues and what categories or groups have not?<br><br>To what extent did the training or professional development already provided to school personnel focus on the mindsets, perceptions, assumptions, and thought patterns of trauma-impacted students?<br><br>What organizational strategy can be implemented to ensure all students have a trusted adult in the building?<br><br>Are there examples of changes in instructional and classroom practices that can be attributed to the training or professional development on trauma issues?<br><br>Are there procedures in place to provide new staff members with training or professional development in trauma issues in order to ensure that the knowledge levels of all staff members are maintained? |

Appendix C

Trauma-Informed Practice in Suffolk County Survey Results

Q1. Which of the following describes the school's or district's primary reason(s) for understanding the Trauma-Skilled Schools Model? (You may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| State, local, or legal mandate | 40.0% | 6 |
| Need to improve graduation rates | 20.0% | 3 |
| Need to improve student behavior | 46.67% | 7 |
| Awareness of adverse childhood experiences (ACEs) among student population | 53.33% | 8 |
| Need to improve student academic performance | 40.0% | 6 |
| Awareness of the impact of adverse childhood experiences (ACEs) on school performance | 86.67% | 13 |
| | Answered | 15 |
| | Skipped | 0 |

Q2. To what extent are school or system leadership and governance (principals, Superintendent, Board of Education) aware of the presence of trauma-impacted students in the school system?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Not aware | 0.0% | 0 |
| Somewhat aware | 66.67% | 10 |
| Very aware | 26.67% | 4 |
| Don't know | 6.67% | 1 |
| | Answered | 15 |
| | Skipped | 0 |

Q3. To what extent do school or system leadership and governance (principals, Superintendent, Board of Education) understand the relationship of trauma to school success, particularly as it relates to acceptable behavior, learning, and school completion?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Minimal understanding | 0.0% | 0 |
| Moderate degree of understanding | 60.0% | 9 |

| | | |
|---|---|---|
| High level of understanding | 40.0% | 6 |
| Don’t know | 0.0% | 0 |
| | Answered | 15 |
| | Skipped | 0 |

Q4. Who is perceived by school and/or system leadership to be primarily responsible for addressing the needs of trauma-impacted students?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Administrators | 6.67% | 1 |
| Social workers | 53.33% | 8 |
| Classroom teachers | 0.0% | 0 |
| Counselors | 13.33% | 2 |
| Special education teachers | 0.0% | 0 |
| Mental health providers | 26.67% | 4 |
| | Answered | 15 |
| | Skipped | 0 |

Q5. To what extent does the school improvement plan and/or the district strategic plan specifically address services to or support for trauma-impacted students?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Not addressed | 6.67% | 1 |
| Generally or vaguely addressed | 66.67% | 10 |
| Clearly and specifically addressed | 6.67% | 1 |
| Don’t know | 20.0% | 3 |
| | Answered | 15 |
| | Skipped | 0 |

Q6. When the school or district identifies trauma-impacted students, what actions, services, or interventions result from that identification? (You may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Referral to school counselors | 93.33% | 14 |
| Referral to school social workers | 93.33% | 14 |
| Referral to outside agencies | 93.33% | 14 |
| Staff members serving the student are informed | 66.67% | 10 |
| | Answered | 15 |

| | | |
|---|---|---|
| | Skipped | 0 |

Q7. What resources exist within the school or district to serve or to meet the needs of trauma-impacted students? (You may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| School counselors | 93.33% | 14 |
| School social workers | 100.0% | 15 |
| Mental health agencies | 40.0% | 6 |
| | Answered | 15 |
| | Skipped | 0 |

Q8. What resources exist external to the school or district that are regularly accessed and used to serve or to meet the needs of trauma-impacted students? (You may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Community mental health agencies | 100.0% | 13 |
| Faith community supports | 23.08% | 3 |
| Family support agencies | 69.23% | 9 |
| Don’t know | 0.0% | 0 |
| | Answered | 13 |
| | Skipped | 2 |

Q9. What percentage of the school's or district’s student population is believed to be trauma-impacted?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 30.77% | 4 |
| 21% to 40% | 38.46% | 5 |
| 41% to 60% | 30.77% | 4 |
| 61% to 80% | 0.0% | 0 |
| 81% to 100% | 0.0% | 0 |
| | Answered | 13 |
| | Skipped | 2 |

Q10. To what extent does the creation and implementation of school or district policies and rules consider the needs of and/or impact on trauma-impacted students?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Little or no consideration | 38.46% | 5 |
| Some consideration | 46.15% | 6 |
| Always considered | 15.38% | 2 |
| | Answered | 13 |
| | Skipped | 2 |

Q11. What categories of staff have recently received training in trauma issues? (You may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Teachers | 15.38% | 2 |
| Social workers | 61.54% | 8 |
| Food service staff | 0.0% | 0 |
| School board members | 0.0% | 0 |
| Administrators | 46.15% | 6 |
| Paraprofessionals | 0.0% | 0 |
| Custodians | 0.0% | 0 |
| Counselors | 61.54% | 8 |
| Bus drivers | 0.0% | 0 |
| Central office support staff | 0.0% | 0 |
| Don’t know | 53.85% | 7 |
| | Answered | 13 |
| | Skipped | 2 |

Q12. What was the primary theme of trauma training? (You may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Types of trauma | 38.46% | 5 |
| Impact of trauma | 53.85% | 7 |
| Frequency of trauma among students | 38.46% | 5 |
| School climate changes to meet student needs | 30.77% | 4 |
| Referral of trauma-impacted students for mental health services | 30.77% | 4 |
| Instructional changes to meet student needs | 7.69% | 1 |
| Impact of trauma on school behavior | 53.85% | 7 |
| Don’t know | 46.15% | 6 |
| | Answered | 13 |
| | Skipped | 2 |

Q13. What portion of the total school or district staff (all employees, all individuals who interact with students on behalf of the school or district) have received recent training in trauma issues?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 69.23% | 9 |
| 21% to 40% | 23.08% | 3 |
| 41% to 60% | 0.0% | 0 |
| 61% to 80% | 7.69% | 1 |
| 81% to 100% | 0.0% | 0 |
| | Answered | 13 |
| | Skipped | 2 |

Q14. Was the training or professional development provided generic to all categories of employees or was it customized to the work and responsibilities of the personnel that were trained?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Totally generic | 15.38% | 2 |
| Somewhat customized | 30.77% | 4 |
| Totally customized | 7.69% | 1 |
| No training delivered | 0.0% | 0 |
| Don’t know | 46.15% | 6 |
| | Answered | 13 |
| | Skipped | 2 |

Q15. To what extent did the training or professional development provided to school personnel focus on the types and specifics of trauma incidents?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Minimal emphasis on trauma incidents | 16.67% | 2 |
| Moderate emphasis on trauma incidents | 25.0% | 3 |
| Heavy emphasis on trauma incidents | 0.0% | 0 |
| No training delivered | 16.67% | 2 |
| Don’t know | 41.67% | 5 |
| | Answered | 12 |
| | Skipped | 3 |

Q16. To what extend did the training or professional development in trauma provided to school personnel focus on the importance of secondary trauma (perceived, observed, virtual, or second-hand?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Minimal emphasis on trauma incidents | 16.67% | 2 |
| Moderate emphasis on trauma incidents | 8.33% | 1 |
| Heavy emphasis on trauma incidents | 8.33% | 1 |
| No training delivered | 16.67% | 2 |
| Don’t know | 50.0% | 6 |
| | Answered | 12 |
| | Skipped | 3 |

Q17. To what extend was the training or professional development provided to school personnel customized to consider the demographics, contexts, and likely trauma scenarios of the school's or district’s specific population?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Totally generic | 16.67% | 2 |
| Somewhat customized | 8.33% | 1 |
| Totally customized | 8.33% | 1 |
| No training delivered | 16.67% | 2 |
| Don’t know | 50.0% | 6 |
| | Answered | 12 |
| | Skipped | 3 |

Q18. To what extent did the training or professional development provided to school personnel focus on the effects of trauma on student thought processes (mindsets, perceptions, assumptions, and thought patterns)?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Minimal focus | 0.0% | 0 |
| Moderate focus | 25.0% | 3 |
| Significant focus | 8.33% | 1 |
| No training delivered | 16.67% | 2 |
| Don’t know | 50.0% | 6 |
| | Answered | 12 |
| | Skipped | 3 |

Q19. To what extent did the training or professional development provided to school personnel focus on the impact of trauma on the student's school behavior?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Minimal focus on behavior | 0.0% | 0 |
| Moderate focus on behavior | 33.33% | 4 |
| Significant focus on behavior | 0.0% | 0 |
| No training delivered | 16.67% | 2 |
| Don't know | 50.0% | 6 |
| | Answered | 12 |
| | Skipped | 3 |

Q20. To what extent did the training or professional development provided to school personnel focus on the impact of trauma on learning, demonstration of learning, and academic performance?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Minimal focus on learning | 16.67% | 2 |
| Moderate focus on learning | 16.67% | 2 |
| Significant focus on learning | 0.0% | 0 |
| No training delivered | 16.67% | 2 |
| Don't know | 50.0% | 6 |
| | Answered | 12 |
| | Skipped | 3 |

Q21. Did the training or professional development in trauma include, or result in, those trained agreeing on a common language and agreed-on understandings about the impact of trauma on school behaviors and learning?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Minimal inclusion of common language and understandings | 33.33% | 4 |
| Moderate inclusion of common language and understandings | 0.0% | 0 |
| Significant inclusion of common language and understandings | 0.0% | 0 |
| No training delivered | 16.67% | 2 |
| Don't know | 50.0% | 6 |
| | Answered | 12 |
| | Skipped | 3 |

Q22. What portion of staff members trained in trauma issues clearly articulate the influence of trauma on school behavior, on learning, and on long-term school success?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Few can articulate | 18.18% | 2 |
| Some can articulate | 36.36% | 4 |
| Most can articulate | 9.09% | 1 |
| No training delivered | 18.18% | 2 |
| Don’t know | 18.18% | 2 |
| | Answered | 11 |
| | Skipped | 4 |

Q23. To what extent did the training or professional development in trauma include, or result in, discussion about needed changes in school practices and/or in instructional practices?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Very little discussion | 27.27% | 3 |
| Some discussion | 36.36% | 4 |
| Significant amount of discussion | 0.0% | 0 |
| No training delivered | 18.18% | 2 |
| Don’t know | 18.18% | 2 |
| | Answered | 11 |
| | Skipped | 4 |

Q24. What percentage of students do you estimate believe that they have an ongoing positive interpersonal connection with one or more staff members?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 9.09% | 1 |
| 21% to 40% | 0.0% | 0 |
| 41% to 60% | 27.27% | 3 |
| 61% to 80% | 54.55% | 6 |
| 81% to 100% | 9.09% | 1 |
| | Answered | 11 |
| | Skipped | 4 |

Q25. What percentage of all employees believe that it is their responsibility to deliberately develop and cultivate positive interpersonal relationships with students as a component of their work?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 9.09% | 1 |
| 21% to 40% | 18.18% | 2 |
| 41% to 60% | 27.27% | 3 |
| 61% to 80% | 18.18% | 2 |
| 81% to 100% | 27.27% | 3 |
| | Answered | 11 |
| | Skipped | 4 |

Q26. What percentage of class sessions or lesson units contain a deliberate or identifiable component that is intended to foster positive interpersonal relationships among students and/or with staff members?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 45.45% | 5 |
| 21% to 40% | 27.27% | 3 |
| 41% to 60% | 18.18% | 2 |
| 61% to 80% | 0.0% | 0 |
| 81% to 100% | 9.09% | 1 |
| | Answered | 11 |
| | Skipped | 4 |

Q27. What percentage of students believe that they are emotionally, socially, and physically safe and at school and during school activities/events?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 0.0% | 0 |
| 21% to 40% | 0.0% | 0 |
| 41% to 60% | 27.27% | 3 |
| 61% to 80% | 45.45% | 5 |
| 81% to 100% | 27.27% | 3 |
| | Answered | 11 |
| | Skipped | 4 |

Q28. What percentage of all employees believe that it is their responsibility to deliberately develop and cultivate a sense of personal and social security for students as a component of their work?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 9.09% | 1 |
| 21% to 40% | 9.09% | 1 |
| 41% to 60% | 18.18% | 2 |
| 61% to 80% | 27.27% | 3 |
| 81% to 100% | 36.36% | 4 |
| | Answered | 11 |
| | Skipped | 4 |

Q29. What percentage of class sessions or lesson units contain a deliberate or identifiable component that is intended to foster a sense of belonging and inclusion among students?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 18.18% | 2 |
| 21% to 40% | 27.27% | 3 |
| 41% to 60% | 27.27% | 3 |
| 61% to 80% | 18.18% | 2 |
| 81% to 100% | 9.09% | 1 |
| | Answered | 11 |
| | Skipped | 4 |

Q30. What percentage of students believe that they are achievers in academics and in school activities/events?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 0.0% | 0 |
| 21% to 40% | 27.27% | 3 |
| 41% to 60% | 27.27% | 3 |
| 61% to 80% | 27.27% | 3 |
| 81% to 100% | 18.18% | 2 |
| | Answered | 11 |
| | Skipped | 4 |

Q31. What percentage of all employees believe that it is their responsibility to deliberately develop and cultivate a sense of achievement as a component of their work?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 0.0% | 0 |
| 21% to 40% | 18.18% | 2 |
| 41% to 60% | 18.18% | 2 |
| 61% to 80% | 18.18% | 2 |
| 81% to 100% | 45.45% | 5 |
| | Answered | 11 |
| | Skipped | 4 |

Q32. What percentage of class sessions or lesson units contain deliberate or identifiable elements that allow all individual students to achieve and to perceive themselves as achievers?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 0.0% | 0 |
| 21% to 40% | 18.18% | 2 |
| 41% to 60% | 36.36% | 4 |
| 61% to 80% | 18.18% | 2 |
| 81% to 100% | 27.27% | 3 |
| | Answered | 11 |
| | Skipped | 4 |

Q33. What percentage of students believe that they have autonomy (options and choices) in academics and in school activities/events?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 18.18% | 2 |
| 21% to 40% | 18.18% | 2 |
| 41% to 60% | 27.27% | 3 |
| 61% to 80% | 9.09% | 1 |
| 81% to 100% | 27.27% | 3 |
| | Answered | 11 |
| | Skipped | 4 |

Q34. What percentage of all employees believe that it is their responsibility to deliberately offer students options and choices in school activities and in instruction?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 27.27% | 3 |
| 21% to 40% | 18.18% | 2 |
| 41% to 60% | 18.18% | 2 |
| 61% to 80% | 9.09% | 1 |
| 81% to 100% | 27.27% | 3 |
| | Answered | 11 |
| | Skipped | 4 |

Q35. What percentage of class sessions or lesson units give students options and choices regarding how they learn and/or demonstrate learning?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 27.27% | 3 |
| 21% to 40% | 18.18% | 2 |
| 41% to 60% | 36.36% | 4 |
| 61% to 80% | 9.09% | 1 |
| 81% to 100% | 9.09% | 1 |
| | Answered | 11 |
| | Skipped | 4 |

Q36. What percentage of students regularly perform tasks which support others, the school, or the community as they participate in school activities and/or instruction?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 9.09% | 1 |
| 21% to 40% | 27.27% | 3 |
| 41% to 60% | 27.27% | 3 |
| 61% to 80% | 9.09% | 1 |
| 81% to 100% | 27.27% | 3 |
| | Answered | 11 |
| | Skipped | 4 |

Q37. What percentage of all employees believe that it is their responsibility to deliberately have students support and/or contribute to others, the school, or the community in the conduct of school activities and in instruction?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 9.09% | 1 |
| 21% to 40% | 9.09% | 1 |
| 41% to 60% | 45.45% | 5 |
| 61% to 80% | 18.18% | 2 |
| 81% to 100% | 18.18% | 2 |
| | Answered | 11 |
| | Skipped | 4 |

Q38. What percentage of class sessions or lesson units include altruistic activities and/or opportunities for students?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 27.27% | 3 |
| 21% to 40% | 18.18% | 2 |
| 41% to 60% | 45.45% | 5 |
| 61% to 80% | 9.09% | 1 |
| 81% to 100% | 0.0% | 0 |
| | Answered | 11 |
| | Skipped | 4 |

Q39. During activities and/or instructional delivery, what percentage of staff members consciously and deliberately act to reduce or minimize confrontation and/or stress?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 0.0% | 0 |
| 21% to 40% | 30.0% | 3 |
| 41% to 60% | 20.0% | 2 |
| 61% to 80% | 30.0% | 3 |
| 81% to 100% | 20.0% | 2 |
| | Answered | 10 |
| | Skipped | 5 |

Q40. During activities and instructional delivery, what percentage of staff members are sometimes observed to act in ways that exacerbate or trigger confrontation and/or stress?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 54.55% | 6 |
| 21% to 40% | 36.36% | 4 |
| 41% to 60% | 0.0% | 0 |
| 61% to 80% | 9.09% | 1 |
| 81% to 100% | 0.0% | 0 |
| | Answered | 11 |
| | Skipped | 4 |

Q41. Which categories of staff members are believed to best interact with students to reduce and minimize confrontation and/or stress? (you may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Teachers | 72.73% | 8 |
| Administrators | 54.55% | 6 |
| Social workers | 100.0% | 11 |
| Paraprofessionals | 36.36% | 4 |
| Coaches | 100.0% | 11 |
| Bus drivers | 18.18% | 2 |
| Food service staff | 27.27% | 3 |
| Custodians | 18.18% | 2 |
| Central office support staff | 18.18% | 2 |
| | Answered | 11 |
| | Skipped | 4 |

Q42. Which categories of staff members are believed to most often interact with students in ways that exacerbate or trigger confrontation and/or stress? (you may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Teachers | 87.5% | 7 |
| Administrators | 87.5% | 7 |
| Social workers | 0.0% | 0 |
| Paraprofessionals | 37.5% | 3 |
| Coaches | 37.5% | 3 |

| | | |
|---|---|---|
| Bus drivers | 25.0% | 2 |
| Food service staff | 12.5% | 1 |
| Custodians | 0.0% | 0 |
| Central office support staff | 0.0% | 0 |
| | Answered | 8 |
| | Skipped | 7 |

Q43. During activities and/or instruction, what percentage of staff members are regularly able to recognize early signs of student stress and dysfunction and to effectively diffuse and minimize the negative impact of stress and dysfunction?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 10.0% | 1 |
| 21% to 40% | 30.0% | 3 |
| 42% to 60% | 20.0% | 2 |
| 61% to 80% | 20.0% | 2 |
| 81% to 100% | 20.0% | 2 |
| | Answered | 10 |
| | Skipped | 5 |

Q44. Which categories of staff members are believed to most effectively recognize early signs of student stress and dysfunction and to diffuse and minimize the negative impact of stress and dysfunction? (you may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Teachers | 70.0% | 7 |
| Administrators | 50.0% | 5 |
| Social workers | 100.0% | 10 |
| Paraprofessionals | 30.0% | 3 |
| Coaches | 30.0% | 3 |
| Bus drivers | 0.0% | 0 |
| Food service staff | 0.0% | 0 |
| Custodians | 0.0% | 0 |
| Central office support staff | 0.0% | 0 |
| | Answered | 10 |
| | Skipped | 5 |

Q45. Which categories of staff members are believed to be least effective at recognizing early signs of student stress and dysfunction and minimizing the negative impact of stress and dysfunction? (you may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Teachers | 0.0% | 0 |
| Administrators | 25.0% | 2 |
| Social workers | 0.0% | 0 |
| Paraprofessionals | 25.0% | 2 |
| Coaches | 0.0% | 0 |
| Bus drivers | 62.5% | 5 |
| Food service staff | 62.5% | 5 |
| Custodians | 75.0% | 6 |
| Central office support staff | 37.5% | 3 |
| | Answered | 8 |
| | Skipped | 7 |

Q46. When disruptive behaviors and situations occur during student activities or in the classroom, what percentage of staff members are able to handle the situation so as to achieve the best possible outcome for the offending student(s) and to minimize the disruptive impact on others?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0% to 20% | 10.0% | 1 |
| 21% to 40% | 30.0% | 3 |
| 42% to 60% | 30.0% | 3 |
| 61% to 80% | 10.0% | 1 |
| 81% to 100% | 20.0% | 2 |
| | Answered | 10 |
| | Skipped | 5 |

Q47. Which categories of staff members are believed to most effectively handle disruptive behaviors and situations so as to achieve the best possible outcome for the offending student(s) and to minimize the disruptive impact on others? (you may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Teachers | 90.0% | 9 |

| | | |
|---|---|---|
| Administrators | 90.0% | 9 |
| Social workers | 90.0% | 9 |
| Paraprofessionals | 40.0% | 4 |
| Coaches | 40.0% | 4 |
| Bus drivers | 0.0% | 0 |
| Food service staff | 0.0% | 0 |
| Custodians | 0.0% | 0 |
| Central office support staff | 0.0% | 0 |
| | Answered | 10 |
| | Skipped | 5 |

Q48. Which categories of staff members are believed to least effectively handle disruptive behaviors and situations so as to achieve the best possible outcome for the offending student(s) and to minimize the disruptive impact on others? (you may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Teachers | 20.0% | 2 |
| Administrators | 20.0% | 2 |
| Social workers | 10.0% | 1 |
| Paraprofessionals | 30.0% | 3 |
| Coaches | 0.0% | 0 |
| Bus drivers | 70.0% | 7 |
| Food service staff | 80.0% | 8 |
| Custodians | 60.0% | 6 |
| Central office support staff | 40.0% | 4 |
| | Answered | 10 |
| | Skipped | 5 |

Q49. Which best describes the relationships of school personnel with external sources of intervention, treatment, and mental health services that are available to the school's students and families?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Poor working relationship | 0.0% | 0 |
| Fair working relationship | 10.0% | 1 |
| Unknown | 30.0% | 3 |
| Good working relationship | 20.0% | 2 |
| Excellent working relationship | 40.0% | 4 |

| | | |
|---|---|---|
| | Answered | 10 |
| | Skipped | 5 |

Q50. How knowledgeable and effective are school personnel at recognizing students and families needing internal and/or external intervention, treatment, and mental health services?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Minimally knowledgeable and effective | 0.0% | 0 |
| Somewhat knowledgeable and effective | 40.0% | 4 |
| Very knowledgeable and effective | 60.0% | 6 |
| | Answered | 10 |
| | Skipped | 5 |

Q51. How effectively do school personnel communicate with and facilitate referrals of students and families in crisis to internal and external sources of intervention, treatment, and mental health services?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Minimally effective | 0.0% | 0 |
| Somewhat effective | 40.0% | 4 |
| Very effective | 60.0% | 6 |
| | Answered | 10 |
| | Skipped | 5 |

Q52. Which categories of school personnel are most effective at identifying and referring students and families needing intervention, treatment, and mental health services? (you may select more than one option)

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Teachers | 60.0% | 6 |
| Administrators | 60.0% | 6 |
| Social workers | 100.0% | 10 |
| Paraprofessionals | 20.0% | 2 |
| Coaches | 30.0% | 3 |
| Bus drivers | 10.0% | 1 |
| Food service staff | 10.0% | 1 |
| Custodians | 10.0% | 1 |
| Central office support staff | 10.0% | 1 |
| | Answered | 10 |

| | | |
|---|---|---|
| | Skipped | 5 |

Q53. To what extent are intervention, treatment, and mental health services available to and accessed by disturbed and dysfunctional students, either within or external to the school?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Seldom or never available and seldom or never accessed | 0.0% | 0 |
| Occasionally available and occasionally accessed | 20.0% | 2 |
| Usually available and usually accessed | 40.0% | 4 |
| Readily available and readily accessed | 30.0% | 3 |
| Don’t know | 10.0% | 1 |
| | Answered | 10 |
| | Skipped | 5 |

Q54. When accessed, how effective are intervention, treatment, and mental health services in meeting the needs of referred students?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Very ineffective | 0.0% | 0 |
| Somewhat ineffective | 0.0% | 0 |
| Unknown | 10.0% | 1 |
| Somewhat effective | 80.0% | 8 |
| Very effective | 10.0% | 1 |
| | Answered | 10 |
| | Skipped | 5 |

Q55. Please answer a few demographic questions about the district you represent. What is the total enrollment of your district, K-12?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| Under 1,000 | 20.0% | 2 |
| 1,000-3,000 | 20.0% | 2 |
| 3,000-5,000 | 20.0% | 2 |
| 5,000-10,000 | 30.0% | 3 |
| 10,000 or more | 10.0% | 1 |
| | Answered | 10 |
| | Skipped | 5 |

Q56. What is the average grade level size?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0-100 | 20.0% | 2 |
| 100-200 | 10.0% | 1 |
| 200-300 | 10.0% | 1 |
| 400 or more | 60.0% | 6 |
| | Answered | 10 |
| | Skipped | 5 |

Q57. What is the average percentage of students on Free/Reduced Lunch in your district?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0%-10% | 20.0% | 2 |
| 10%-20% | 30.0% | 3 |
| 20%-30% | 30.0% | 3 |
| 40% or higher | 20.0% | 2 |
| | Answered | 10 |
| | Skipped | 5 |

Q58. What is the average percentage of ENL students in your district?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0%-10% | 30.0% | 3 |
| 10%-20% | 40.0% | 4 |
| 20%-30% | 0.0% | 0 |
| 40% or higher | 30.0% | 3 |
| | Answered | 10 |
| | Skipped | 5 |

Q59. Regarding student ethnicity, what is the average percentage of white students in your district?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0%-10% | 10.0% | 1 |
| 10%-20% | 0.0% | 0 |
| 20%-30% | 0.0% | 0 |
| 40% or higher | 90.0% | 9 |
| | Answered | 10 |
| | Skipped | 5 |

Q60. Regarding student ethnicity, what is the average percentage of black or African American students in your district?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0%-10% | 70.0% | 7 |
| 10%-20% | 10.0% | 1 |
| 20%-30% | 20.0% | 2 |
| 40% or higher | 0.0% | 0 |
| | Answered | 10 |
| | Skipped | 5 |

Q61. Regarding student ethnicity, what is the average percentage of Hispanic or Latino students in your district?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0%-10% | 30.0% | 3 |
| 10%-20% | 20.0% | 2 |
| 20%-30% | 20.0% | 2 |
| 40% or higher | 30.0% | 3 |
| | Answered | 10 |
| | Skipped | 5 |

Q62. Regarding student ethnicity, what is the average percentage of Asian/Native Hawaiian/Other Pacific Islander students in your district?

| Answer Choices | Response Percent | Responses |
|---|---|---|
| 0%-10% | 80.0% | 8 |
| 10%-20% | 20.0% | 2 |
| 20%-30% | 0.0% | 0 |
| 40% or higher | 0.0% | 0 |
| | Answered | 10 |
| | Skipped | 5 |

Q63. Lastly, would you be willing to participate in a focus group to further explore and discuss the impact of trauma on student performance and your district's readiness to implement trauma-informed practices?

| Answer Choices | Response Percent | Responses |
|---|---|---|

| | | |
|---|---|---|
| Yes | 60.0% | 6 |
| No | 40.0% | 4 |
| If Yes, please indicate name, district, and email address | | 6 |
| | Answered | 10 |
| | Skipped | 5 |

Appendix D

Consent for Participation


**Consent Form**

You have been invited to take part in a research study to learn more about trauma-informed practice and the effects of trauma on student performance. This study will be conducted by Mark Palios, Principal Investigator (PI), in the School of Education, St. John's University, as part of his doctoral dissertation. His faculty sponsor is Dr. Anthony Annunziato, SJU School of Education. If you agree to be in this study, you will be asked to do complete a survey that asks questions on the role that trauma play on student performance and you/your district's readiness to implement trauma-informed practices and systems. At the end of the survey, you will be asked if you are willing to participate in a focus group interview on the same topic. The focus group interview will be conducted through Zoom Virtual Meeting will be recorded and audio-taped. You may review these tapes and request that all or any portion of the tapes be destroyed that includes your participation. Participation in this study will involve approximately 2 hours of your time: 20 minutes if you complete only the survey, and 1.5 hours if selected to be a participant in the focus group.

There are no known risks associated with your participation in this research beyond those of everyday life. Although you will receive no direct benefits, this research may help the investigator understand trauma-impacted students better. Confidentiality of the research records will be strictly maintained by keeping all records secure and separated from other work. Your responses will be kept confidential with the following exception: the researcher is required by law to report to the appropriate authorities, suspicion of harm to yourself, to children, or to others. Your responses will be kept confidential by the researcher, but the researcher cannot guarantee that others in the group will do the same. Participation in this study is voluntary. You may refuse to participate or withdraw at any time without penalty. For interviews, questionnaires or surveys, you have the right to skip or not answer any questions you prefer not to answer.

If there is anything about the study or your participation that is unclear or that you do not understand, if you have questions or wish to report a research-related problem, you may contact Mark Palios at 631-379-8223, mark.palios15@my.stjohns.edu or the faculty sponsor, Dr. Anthony Annunziato at 718-990-7781, annunzia@stjohns.edu, Dept. of Admin. & Instructional Leadership, Long Island Graduate Center, St. John's University. For questions about your rights as a research participant, you may contact the University's Institutional Review Board, St. John's University, Dr. Raymond DiGiuseppe, Chair digiuser@stjohns.edu 718-990-1955 or Marie Nitopi, IRB Coordinator, nitopim@stjohns.edu 718-990-1440. You will receive a copy of this consent to keep.

___ Yes, I give the investigator permission to use my name when quoting material from our interview in his dissertation.

___ No, I would prefer that my name not be used.

**Agreement to Participate**

_____ _____

Subject Signature Date

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