TST in Schools: An Adaptation of Trauma Systems Therapy in a Public School Setting

Lisa Baron, Ed.D.
Program Director, Connecting With Care
Alliance for Inclusion and Prevention, Boston, MA

Adam Brown, Psy.D.
Clinical Assistant Professor in Child and Adolescent Psychiatry
NYU Child Study Center, NYC

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Learning the Language: Promoting Effective Ways for Interdisciplinary Collaboration
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Objectives

1) Understand the Connecting With Care Model
   • Adaptation of Trauma Systems Therapy (TST) in Schools

2) Understand TST “Basics”
   • Cross-systems Collaboration to Develop Shared Language

3) Use “TST Language”
   • Identify “Survival-in-the-Moment” states to inform planning of effective interventions for students
Connecting With Care
A School-Community Collaboration to Promote Children’s Mental Health

Connecting With Care (CWC) Program Overview:

• Developed in collaboration with key community stakeholders
• Model maximizes health insurance reimbursements
• Expanded over 9 years to K-8 school in Boston neighborhoods with low SES, high immigrant populations, high violence/trauma
CWC is about Partnerships

CURRENT AND FOUNDING PROGRAM PARTNERS, FUNDERS, AND SCHOOLS

Brighton-Allston Mental Health Association
Family Service of Greater Boston
Home for Little Wanderers
MSPCC
North Suffolk Mental Health Association
Boston Children’s Hospital
New York University Child Study Center
Massachusetts General Hospital
Robert Wood Johnson Foundation
Amelia Peabody Foundation
Bennett Family Foundation
Blue Cross Blue Shield of MA Foundation
Boston Foundation
Hestia Fund
Adams Elementary
BTU Pilot K-8
Frederick Pilot Middle
Gardner Pilot Academy
Mather Elementary
Mattahunt Elementary
McKay K-8
Harvard/Kent Elementary
Holland Elementary
Holmes Elementary
Irving Middle
Mildred Avenue K-8
Orchard Gardens K-8
Quincy Elementary
Taylor Elementary
Timilty Middle
Umana Academy
Young Achievers Pilot
Cummings Foundation
Cabot Family Charitable Trust
MA Attorney General’s Office
CWC Goals

1) Better access to children’s mental health services
2) Full-time mental health clinicians in schools
3) Improve the quality of service delivery in schools
   • Partnership brokering: Schools and agencies
   • Coordination: Making the service work for the school/finances work for the agencies
   • Data collection: Finance, utilization, and clinical outcomes
   • EBPs, including the first school-based adaptation of TST
To sustain the full-time model, a coordinator functions as the “translator” among stakeholders:

- CWC must understand the mission and source of pain for each partner to build a working alliance
  - Schools: Treatment must be in service of academic success
  - **Goal:** Teach clinicians how to work collaboratively with teachers
  - Agencies: Full-time model must be financially sustainable
  - **Goal:** Teach schools about the importance of building a caseload in a timely manner
Why Do Trauma Work in Schools?

In schools, traumatized children may be seen as:

- Disruptive and unmotivated to learn
- Angry and over-reactive

Need for specialization in treating children exposed to high rates of violence and trauma in ways that enhance teaching and learning
TST offers the specific and actionable information you need to help a traumatized child: no matter how complex and severe her/his problems.
Basic Concepts
The Tragedy of Trauma

• 50% to 70% of the general population has been exposed to major trauma.

• 15% to 40% of traumatized children develop significant adverse psychiatric and psychological reactions to trauma, broadly called child traumatic stress.

• Child traumatic stress is associated with substance abuse, violence, suicide, heart disease, homelessness, chronic mental illness, school failure, and unemployment.

• Traumatic stress is a disorder related to how individuals process signals of threat.

• Traumatic stress influences brain development and has a cascading impact on people over the course of their lives.
Trauma in vulnerable populations

- 75% of children from a study of 30,000 children in the New York City foster care system in 2000 had exposure to traumatic experiences.

- Research shows that between 75% and 93% of youth entering the juvenile justice system annually in this country are estimated to have experienced some degree of trauma (compared to 34% of the general population of children in the U.S.).
A systems approach to trauma

• A traumatized child who is unable to regulate survival states.

• A social-environment/system of care that cannot help contain this dysregulation.
Is it a disorder?

The child who does not want to go to sleep because he or she is afraid of being abused in the night hours,

The child who lives in a neighborhood where there is a gang war and who spends a lot of time scanning the environment for sources of threat,

The child who avoids going to school because someone has threatened to kill her,

The adolescent who is aggressive with his mother’s boyfriend to protect her from getting beaten up,
The Specific, and Actionable, Information You Need...
To Help a child named Samantha
Samantha

A 14 year old girl with a trauma history and who also has a history of assaultive behavior. She is in a regular school and has been restrained numerous times by security in the school for out of control behavior. In one instance she has broken the arm of the school nurse. You are a consultant to the school and are asked to see her because she knocked a teacher to the ground today, in math class.

Where do we start?
What more information do we need to know how to help Samantha?
What information do we need, to know how to help her?

How much will knowing her diagnosis help?

How much will knowing her trauma history help?

How much will knowing her family and social history help?

How much will knowing her psychiatric and medical history help?
We need to go from
speculating about what it might be...
To knowing what it is.
4 ideas for knowing what it is (so that we may know how to help)

Idea #1:
It’s all about moments.
Count the Moments

Problematic Moments = Very Small
All Moments
Samantha’s Moment

Samantha was in the classroom learning math. She remembers feeling agitated and nauseous. She remembers her foot shaking. She asked her teacher if she could leave the class as she was not feeling well. The teacher declined her request saying ‘you always want to get out of the tough work’. The teacher stood between Samantha and the door. Samantha ran to the door and knocked the teacher to the ground on her way out.
What do we know, now?
4 ideas for knowing what it is (so that we may know how to help)

Idea #2:

It’s all about survival-in-the-moments.
“The amygdala leads a hostile takeover of consciousness by emotion (Joseph LeDoux, The Emotional Brain)”
Survival-in-the-Moment & Moment-by-Moment Assessment

Usual State

Regulating

Reconstituting
Revving
Reexperiencing

Survival-in-the-moment States
Playing Rats

Where is the cat hair?

Survival-in-the-Moment & Moment-by-Moment Assessment

Usual State

Regulating

Reconstituting

Revving

Reexperiencing

Survival-in-the-moment States

Cat Hair
Where is the cat hair?

- Where is Samantha’s cat hair?
What do we know, now?
4 ideas for knowing what it is (so that we may know how to help)

Idea #3:
It’s all about patterns of survival-in-the-moment.
What problems does TST seek to address?

All clinical problems addressed in TST are defined in *only* one way:

**TST Priority Problems**

*Patterns of links between a traumatized child’s experience of threat in the present environment, and the child’s transition to a Survival-in-the-Moment state.*
Samantha’s Moments

- **Event #1**: When the math teacher didn’t believe Samantha about feeling ill and needing to leave the class, Samantha knocked her down while leaving the class.

- **Event #2**: When the school nurse said Samantha was ‘faking’ her stomach ache, Samantha assaulted her and broke her arm.
Examples of TST Priority Problems: Samantha

When **Samantha** is exposed to feelings of illness, Description of threat signals (cat hair)

She/he responds by Feeling need to escape (leg shaking), then rage, then assault.

Description of Survival-in-the-Moment state (3A’s in Re-experiencing)

This pattern can be understood through her past experience(s) of: Sexual abuse from stepfather and mothers disbelief (including somatic symptoms)

Information about Environment-Past that informs understanding of Survival-in-the-Moment response in present
Without this knowledge, how can we help?

What do we know, now?
4 ideas for knowing what it is (so that we may know how to help)

Idea #4: It’s all about using the information about patterns of survival-in-the-moment, to help.
It’s About a Trauma System

A traumatized child who experiences *Survival-in-the-Moment States* in specific definable moments

A social environment and/or system of care that is not able to help the child regulate these *Survival-in-the-Moment States*
Primary Aim of Treatment

*Traumatized child’s tendency to have dramatic shifts in emotional/survival state when confronted by a stressor or traumatic reminder.*

- Psychotherapy enhances a child’s capacity to stay regulated when confronted by a stressor/reminder
- Psychopharmacology supports this capacity
- Social interventions enhance the capacity of members of the child’s social environment to protect child from reminders and support child’s regulation
What did we do for Samantha??
Examples of TST Priority Problems: Samantha

When ______________________ is exposed to ____________________________,
Child’s name

She/he responds by _______________________________________________________

She/he responds by Feeling need to escape (leg shaking), then rage, then assault.

This pattern can be understood through her past experience(s) of:

--Sexual abuse from stepfather and mother’s disbelief (including somatic symptoms)

Information about Environment-Past that informs understanding of Survival-in-the-Moment response in present

Interventions

• Classroom plan: Leg shaking, teacher, guidance counsellor
• More flexible classroom rules to address Samantha’s needs and build more empathic attitude towards Samantha.
• More proactive about Samantha’s physical symptoms and communication about them. Scheduled meetings with (new) school nurse.
• Integrate foster family and case worker in plans.
• Guidance for security officers.
• Build emotional regulation skills re feelings of not being believed.
• Psychopharmacology to help while skills are built.
How does TST address those problems?

By offering an array of interventions/services, all designed to address the tightly defined problems in specific and integrated ways:

- Skill based Psychotherapy
- Home/Community/Milieu based intervention
- Psychopharmacology
- Legal Advocacy

By offering this array of interventions/services in a phase based manner, depending on the needs of the child within their social environment:

- Safety-focused Treatment
- Regulation-focused Treatment
- Beyond Trauma Treatment
All TST interventions/services dedicated to three main goals:

1. Protect the child from environmental signals experienced as threat (‘cat hair’), until child is able is able to manage them. Protect child from actual threats (‘cat’): Safety-focused Treatment.

2. Build the child’s ability to manage environmental signals experienced as threat (‘cat hair’), when the environment is safe and stable enough: Regulation-focused Treatment.

3. Prepare the child to grow into the future in a way that is not consumed by the past: Beyond Trauma Treatment.
The TST Sequence

Assessment

• Gathering the information you need, to consider what to do.

Treatment Planning

• Using the information for decision-making, to know what to do.

Treatment Engagement (Ready-set-go)

• Collaborating with the child and family in this decision-making process (based on what is most important to them).

Treatment Implementation

• Doing it!
  • Safety Focused
  • Regulation Focused
  • Beyond Trauma
## The Phase of Treatment

<table>
<thead>
<tr>
<th>The Child’s Survival States</th>
<th>TST Treatment Planning Grid</th>
<th>The Environment’s Level of Help and Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Survival States</td>
<td>Beyond trauma</td>
<td>Helpful and Protective</td>
</tr>
<tr>
<td>Survival States</td>
<td>Regulation-focused</td>
<td>Insufficiently Helpful and Protective</td>
</tr>
<tr>
<td>Dangerous Survival States</td>
<td>Regulation-focused</td>
<td>Harmful</td>
</tr>
</tbody>
</table>

- **Helpful and Protective**
- **Insufficiently Helpful and Protective**
- **Harmful**
TST Innovation Community

TST is currently being implemented in agencies in 14 States, including programs that provide:

• Outpatient therapy
• Residential treatment
• Foster Care
• Refugee services
• Substance-abuse/MH services
• Community based prevention
• School-based mental health
Why is TST a good fit for schools?

• TST addresses the need for safety in the social environment
• Directly addresses teachers’ “source of pain:” Disruptions to teaching and learning (disruptive behaviors and quiet dissociative types)
• Daily contact with teachers and staff helps them understand the behaviors they see and respond in more helpful ways
• Demonstrated effectiveness in Boston (2005) with children and families
• Integrates work within the service system of the Children’s Behavioral Health Initiative in Massachusetts (CBHI)
Middle School Student, “Henry”

- Henry has experienced multiple moves and chronic homelessness living with his abusive, alcoholic father.
- Henry and his family recently moved from New Mexico to Massachusetts where his mom lives, but he doesn’t see her often.
- As a younger child, Henry was often awakened by his drunk father and beaten up “for no reason.”
- Now, Henry often has to retrieve his father, the primary caregiver, from the bars late at night.
- Henry can “black out” and behave violently when he perceives he is being treated unfairly.
- Henry is only 12.
Working with Teachers

- Train teachers and staff in TST-informed interventions to provide an infrastructure of support for students

- Clinician observes Henry’s behavior (class, lunchroom, etc.) and gets the teacher’s perspective on what gets Henry upset, when, and where

- In consultation with Henry’s teachers, the clinician works through the TST analytical process:
  - Theme of environmental threat (perceived injustice)
  - Theme of Henry’s response (yelling, throwing things, leaving the classroom)
Help them understand that Henry is reacting to perceived injustices, based on his traumatic experiences.

- Help them choose alternative responses to problem behaviors
  - Maintain clear and consistent expectations
  - Empathize with Henry’s experience of “injustice”
  - Establish “time out” space
  - Establish signal to allow Henry to go to an alternative space when triggered
  - Lunch together one day/week to build trust and rapport
Working with the Family and Larger System

- Engage in-home therapy supports to address the family’s “sources of pain”
  - Find housing closer to Boston
  - Help dad find support for his alcohol addiction
  - Parenting skills to improve the parent/child relationship

- Maintain treatment alliance with providers
  - Regular communication
  - Ensure everyone is following TST treatment plan
  - Address any barriers to family’s treatment engagement
  - Attend TST team meetings whenever possible
  - Inform providers of important school meetings
Working with the Student

• Teach Henry how to understand and begin to regulate his emotions (build coping skills, access “safe space”)
• Gradually challenge Henry’s distorted thoughts that disrupt relationships with teachers and peers
• Work with teachers around finding opportunities for Henry to experience success and build his own “buy-in” to school
  • Assisting teachers with tasks
  • After-school enrichment
  • Positive phone calls home
**Challenges and Solutions for TST Implementation in Schools**

**Challenge:** Staff turnover in Schools and Agencies

**Solution:** Provide regular TST-informed training for teachers, staff, and agency providers

**Challenge:** Clinicians must be in place when school starts

**Solution:** Hire during the summer for a September start date

**Challenge:** TST team meetings impact productivity

**Solution:** Weekly meetings occur after school hours

**Challenge:** Family engagement

**Solution:** Clinicians are coached in how to approach parents
# TST Outcomes 2009-14

**Trauma Systems Therapy (TST):**
CWC collects data on Fidelity and Outcomes on TST. For the 99 children at the 7 schools in the sample (2009-14):

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Decrease in Child’s Level of Emotional Dysregulation</td>
<td>36.03%*</td>
</tr>
<tr>
<td>Decrease in Child’s Level of Dangerous Behaviors</td>
<td>38.13%*</td>
</tr>
<tr>
<td>Decrease in Repeat Exposure to Trauma or “Triggers”</td>
<td>36.30%*</td>
</tr>
<tr>
<td>Improvement in Caregiver Ability to “Help and Protect” Child</td>
<td>34.81%*</td>
</tr>
<tr>
<td>Improved Service System Ability to “Help and Protect” Child</td>
<td>37.09%*</td>
</tr>
</tbody>
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*Statistically significant T-test results across all 5 scales at the 99% confidence level
Conclusions

- CWC is a school-based mental health model that deeply integrates school and mental health partnerships by “Learning the Language” of its partners.

- TST practices and principles demonstrate the importance of developing shared goals and language to understand and prioritize problems while watching for potential barriers across systems that can interfere with treatment.

- CWC data demonstrates that TST is an effective model for the treatment of trauma in schools.
Contact Information

Lisa Baron:
   lbaron@aipinc.org

Adam Brown:
   adam.brown2@nyumc.org
Resources

- Robert Wood Johnson Foundation: Connecting With Care
- Center for Disease Control: AHRQ Profile of Connecting With Care
- www.aipinc.org
- Traumasystemsthrapy.com