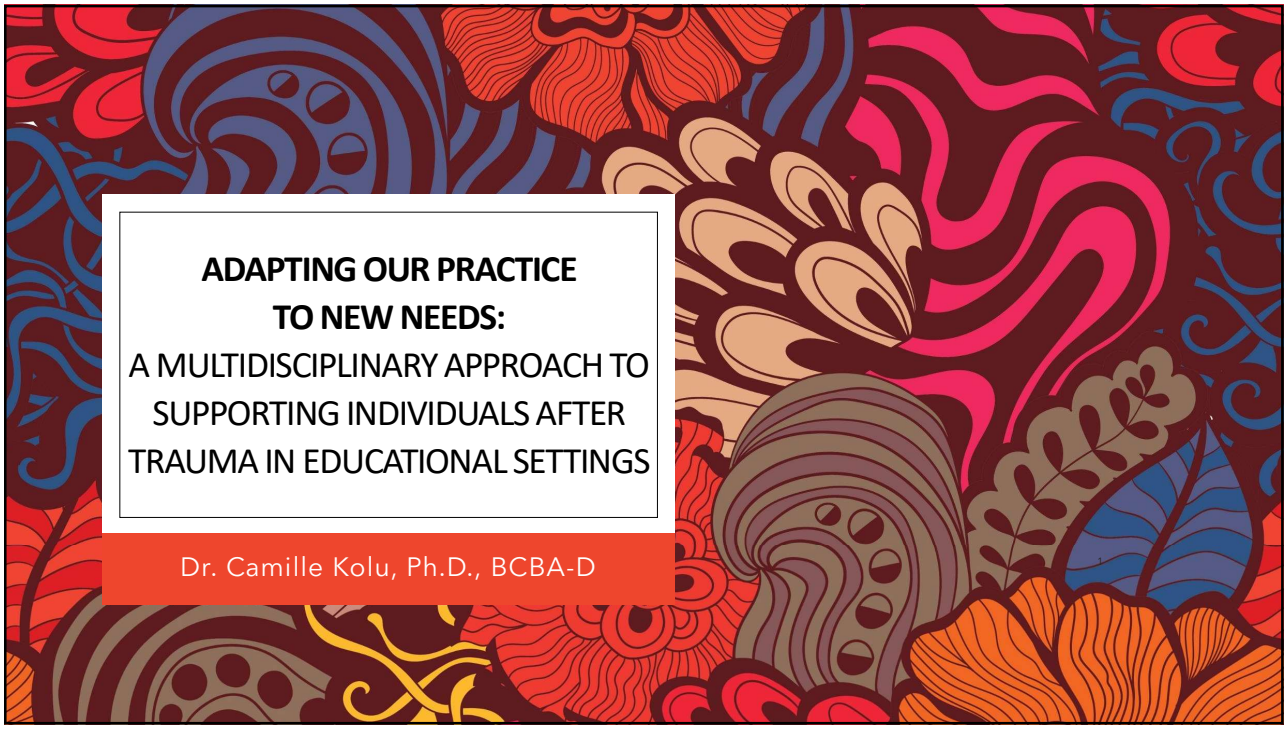
ADAPTING OUR PRACTICE
TO NEW NEEDS:
A MULTIDISCIPLINARY APPROACH TO SUPPORTING INDIVIDUALS AFTER TRAUMA IN EDUCATIONAL SETTINGS
Dr. Camille Kolu, Ph.D., BCBA-D
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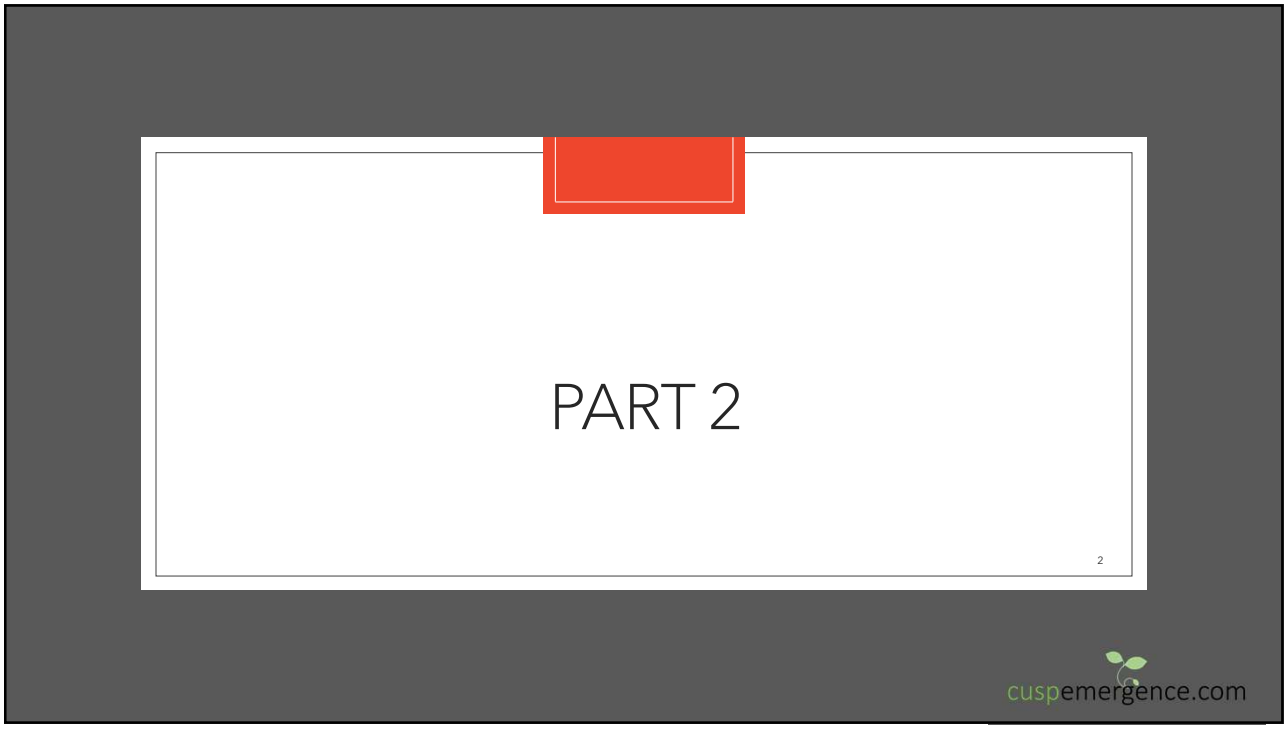
PART 2
2
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ABSTRACT
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Abstract

Despite the cultural movement to extend the inclusive principles of trauma informed services to behavior supports and education, many of us lack the training or support to apply this idea, and have not yet acquired meaningful experience teaming with the many essential disciplines that make up a supportive environment after a student has been through trauma. At the same time, some of the practices we think of as “best” for other students, may be contraindicated for someone with a significant history of adverse childhood (or educational) experiences. This series aims to empower educators from all disciplines to understand some of the links between what students need after trauma, and how we can help, in a context rich with collaboration, risk mitigation practices, and an understanding of how past experiences can shape and inform current needs. Participants will be equipped with useful tools that may support our students with both significant and minor histories of trauma—and those in between, for whom a trauma history may be suspected but cannot be documented.

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LEARNING OBJECTIVES

6

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1

1. Participants will select procedures that may be contraindicated for some clients with trauma backgrounds

7

LEARNING OBJECTIVES

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2

2. Participants will select examples of using tools to enhance behavior support practices with people affected by trauma

8

LEARNING OBJECTIVES

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3

3. Participants will select features of multidisciplinary case studies in which behavior analytic procedures are supportive components of student support after trauma

9

LEARNING OBJECTIVES

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3

- Administrative (and systems) support is present
- Each person participates regularly, not reactively
- Expertise, and also clinical oversight, is valued
- Input is requested and shared regularly
  - This helps risks to be shared, documented and discussed preventively
- Tools are used to facilitate collaboration and cohesion (pulling all the information about the client's background into the forefront, if and when appropriate, to be integrated in FBAs, then plans, and then in support plans)

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Features of interdisciplinary cases in which behavior analytic procedures are supportive components of support after trauma

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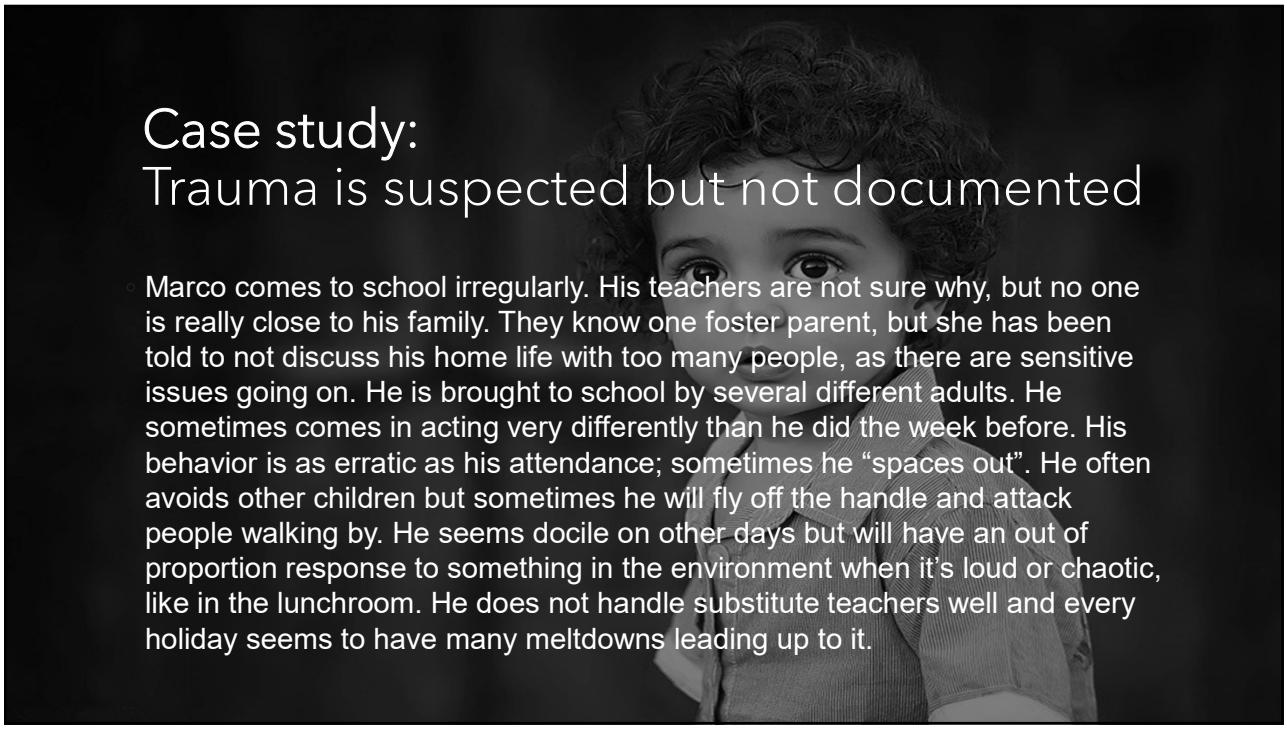
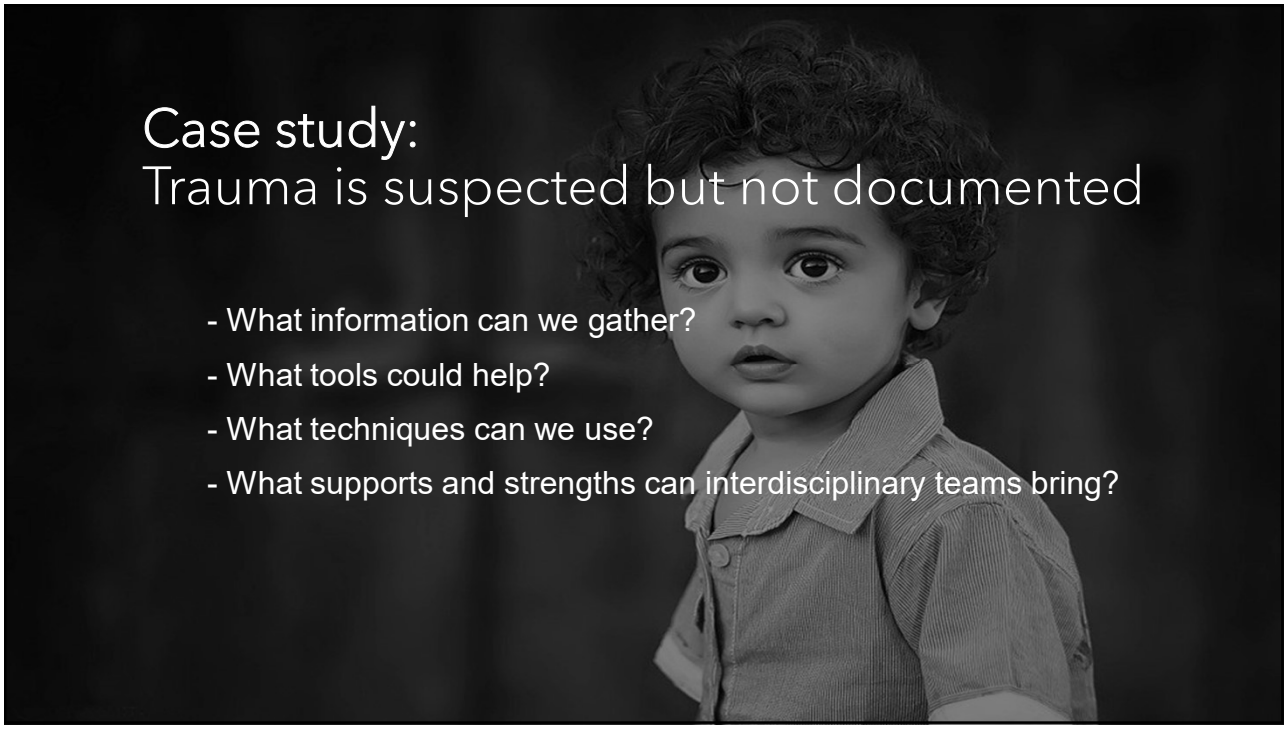


Case study:
Trauma is suspected but not documented

- Marco comes to school irregularly. His teachers are not sure why, but no one is really close to his family. They know one foster parent, but she has been told to not discuss his home life with too many people, as there are sensitive issues going on. He is brought to school by several different adults. He sometimes comes in acting very differently than he did the week before. His behavior is as erratic as his attendance; sometimes he “spaces out”. He often avoids other children but sometimes he will fly off the handle and attack people walking by. He seems docile on other days but will have an out of proportion response to something in the environment when it’s loud or chaotic, like in the lunchroom. He does not handle substitute teachers well and every holiday seems to have many meltdowns leading up to it.



Case study:
Trauma is suspected but not documented

- What information can we gather?
- What tools could help?
- What techniques can we use?
- What supports and strengths can interdisciplinary teams bring?

HELPFUL INFORMATION TO GATHER

- What does the student avoid or find difficult? (consider IPASS for sensory stimuli; attention preference survey for attention)
- Which times of day/week/year/month are difficult?
- Information about behavior (lots of potentially trauma related behavior? Consider screening tool)
- Information about what is not working (some cues might be: parenting/caregiving techniques not working; praise causing adverse reaction; prompting results in emotional responding
- Information about the response itself (signs of conditioned responses to stimuli, non-operant behavior)
- Clues about situations without knowing the details (e.g., we know a child went through several foster placements, or was adopted and given back, or has a parent with multiple challenges)

Which tools might help?

- **IPASS and Adult Attention Preference Survey** (discussed and shown in Part 1)
- **SAFE-T Screening** (excerpt shown today, distributed with slides)
- **SAFE-T Assessment*** to learn more (a LOT more- 200 items)
- **Buffers Score**
- **Risks versus benefit (RVB)** and risk mitigation plan templates (see examples in this presentation)
- **TIBA BIP** (see graphic in this presentation)
- **TIBA FBA** (see graphic in this presentation)

*SAFE-T Assessment is the only tool not available free (due to the extensive training required- comes only with 4.5 CEUs and a booklet of resources)

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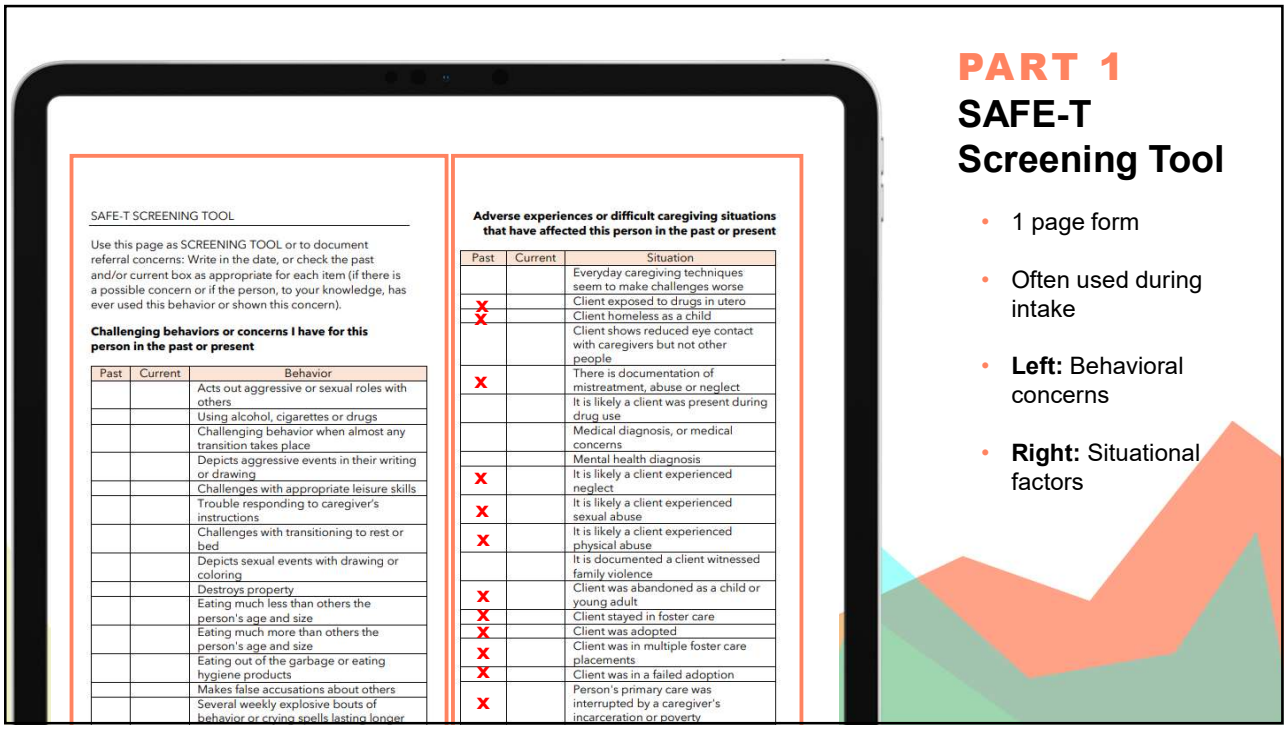
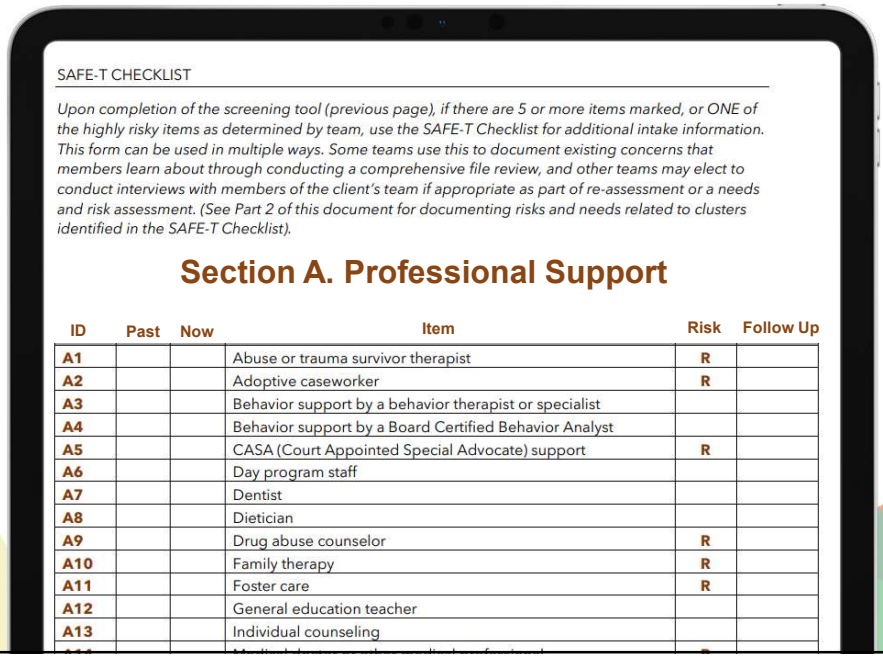


PART 1
SAFE-T Screening Tool

- 1 page form
- Often used during intake
- **Left:** Behavioral concerns
- **Right:** Situational factors



SAFE-T CHECKLIST

Upon completion of the screening tool (previous page), if there are 5 or more items marked, or ONE of the highly risky items as determined by team, use the SAFE-T Checklist for additional intake information. This form can be used in multiple ways. Some teams use this to document existing concerns that members learn about through conducting a comprehensive file review, and other teams may elect to conduct interviews with members of the client's team if appropriate as part of re-assessment or a needs and risk assessment. (See Part 2 of this document for documenting risks and needs related to clusters identified in the SAFE-T Checklist).

Section A. Professional Support

ID	Past	Now	Item	Risk	Follow Up
A1			Abuse or trauma survivor therapist	R	
A2			Adoptive caseworker	R	
A3			Behavior support by a behavior therapist or specialist		
A4			Behavior support by a Board Certified Behavior Analyst		
A5			CASA (Court Appointed Special Advocate) support	R	
A6			Day program staff		
A7			Dentist		
A8			Dietician		
A9			Drug abuse counselor	R	
A10			Family therapy	R	
A11			Foster care	R	
A12			General education teacher		
A13			Individual counseling		

PART 1
SAFE-T Checklist with ACES

- Complete if needed
- 200 items
- 6 Domains

ENTER CODE HERE FOR CEU:

Code for Continuing Education Units

18

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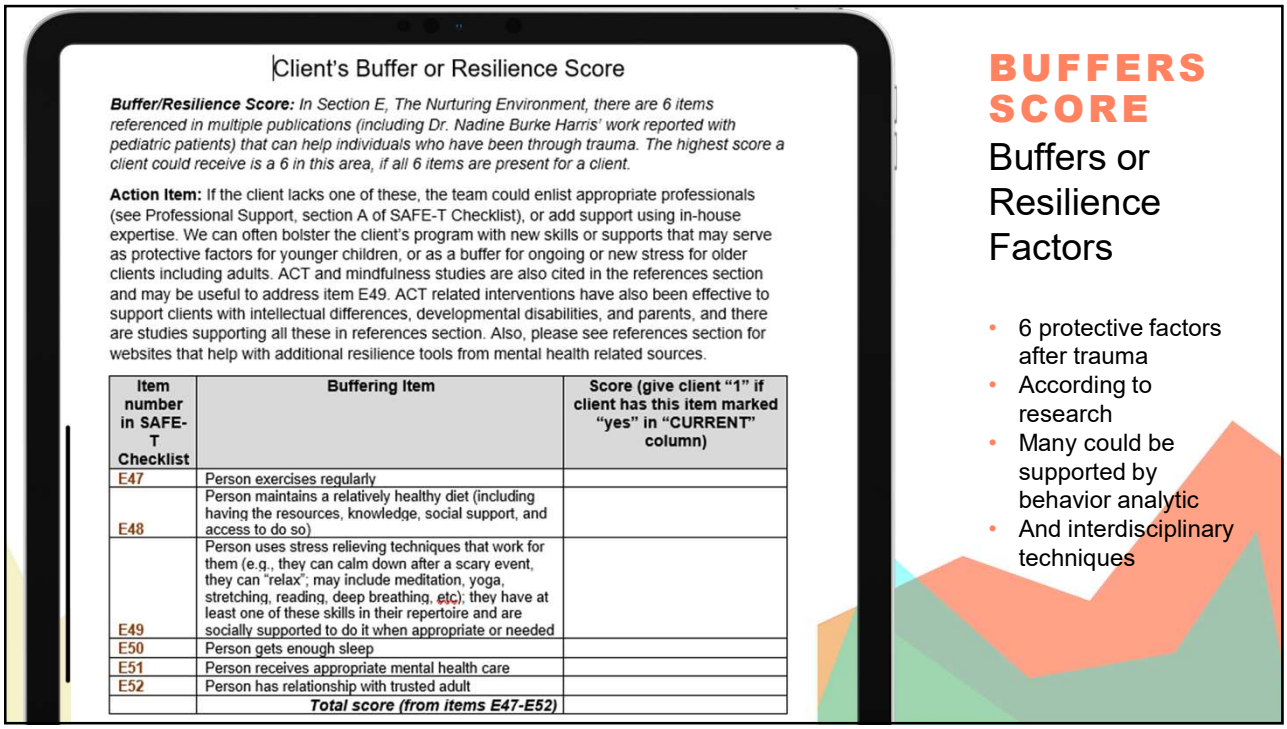


Client's Buffer or Resilience Score

Buffer/Resilience Score: *In Section E, The Nurturing Environment, there are 6 items referenced in multiple publications (including Dr. Nadine Burke Harris' work reported with pediatric patients) that can help individuals who have been through trauma. The highest score a client could receive is a 6 in this area, if all 6 items are present for a client.*

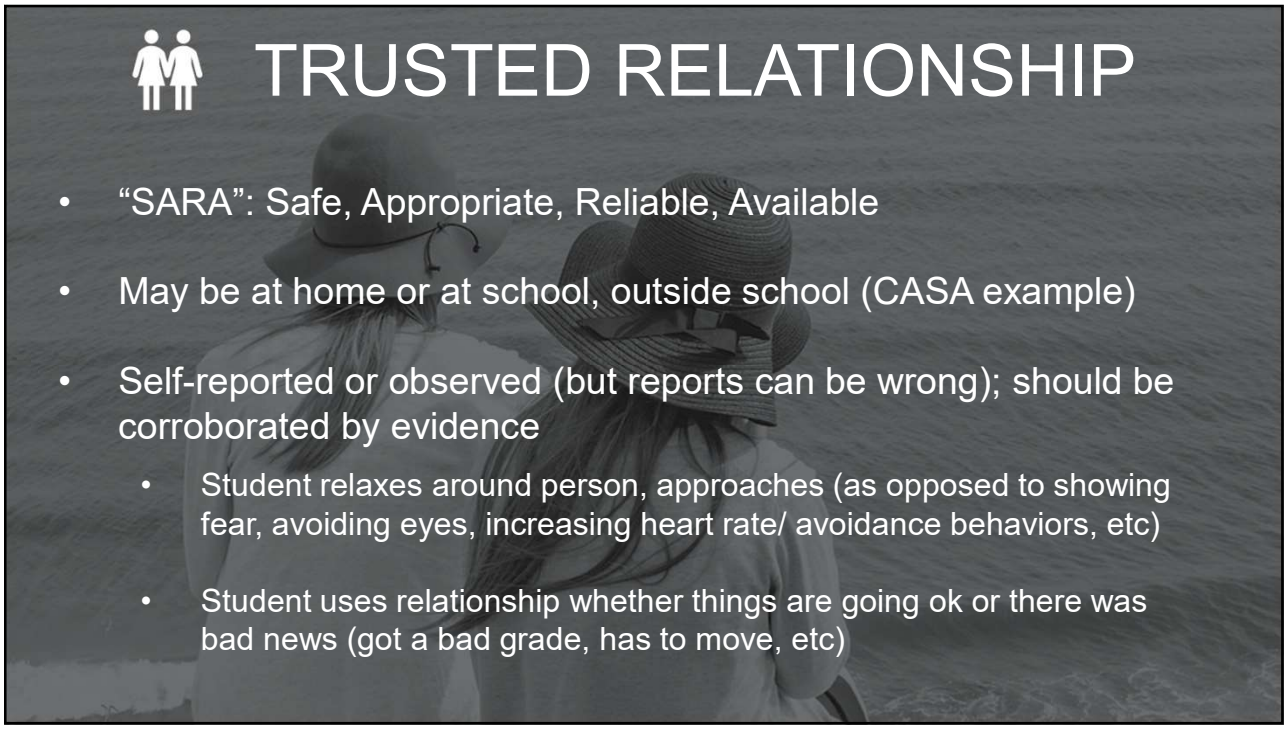
Action Item: If the client lacks one of these, the team could enlist appropriate professionals (see Professional Support, section A of SAFE-T Checklist), or add support using in-house expertise. We can often bolster the client's program with new skills or supports that may serve as protective factors for younger children, or as a buffer for ongoing or new stress for older clients including adults. ACT and mindfulness studies are also cited in the references section and may be useful to address item E49. ACT related interventions have also been effective to support clients with intellectual differences, developmental disabilities, and parents, and there are studies supporting all these in references section. Also, please see references section for websites that help with additional resilience tools from mental health related sources.

Item number in SAFE-T Checklist	Buffering Item	Score (give client "1" if client has this item marked "yes" in "CURRENT" column)
E47	Person exercises regularly	
E48	Person maintains a relatively healthy diet (including having the resources, knowledge, social support, and access to do so)	
E49	Person uses stress relieving techniques that work for them (e.g., they can calm down after a scary event, they can "relax"; may include meditation, yoga, stretching, reading, deep breathing, etc); they have at least one of these skills in their repertoire and are socially supported to do it when appropriate or needed	
E50	Person gets enough sleep	
E51	Person receives appropriate mental health care	
E52	Person has relationship with trusted adult	
	Total score (from items E47-E52)	

BUFFERS SCORE

Buffers or Resilience Factors

- 6 protective factors after trauma
- According to research
- Many could be supported by behavior analytic
- And interdisciplinary techniques



COMMUNICATING ABOUT RISKS

10-Step RVB

(Sample Items in Risk Versus Benefit Analysis Template)

Introduction

1. Overview of the document
2. Primary question the team is asking
3. List of options being considered or potentially available, or list of risks and concerns being addressed, and options you have in addressing them

Option analysis

4. Describe Option A
5. List all potential risks given Option A (long-term risks, short-term risks; include section for each RISK TARGET
6. List of potential benefits given Option A
7. Summary statement of risks for Option A

(Repeat option analysis (Steps 4-7) for options B, C, D, etc)

Conclusions

9. Additional concerns or notes
10. Overall recommendations for Risk Versus Benefit Analysis (e.g., if person(s) preparing the analysis recommends one path over another)
11. Team input and signatures

Basic Risk Mitigation Report Template

Info

- Client:
- Team members:
- Problem this plan is addressing:
- Date the RVB was reviewed with team:
- Option the team selected:

Plan

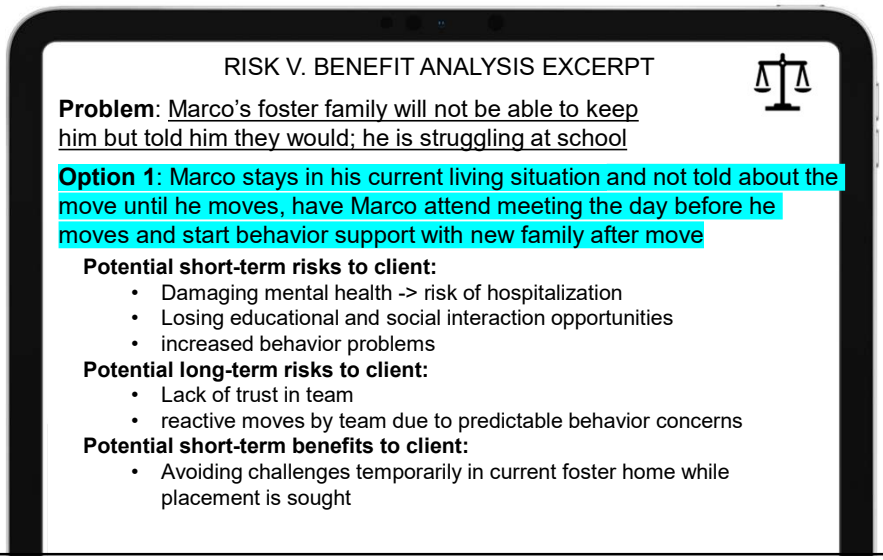
- Risk(s) addressed by this option:
- Actions required to mitigate this risk:
- Person(s) responsible for actions:
- Additional resources required:
- Date to be completed:

Team communication

- Team initials for Risk Mitigation Plan (includes statement of agreement or nonagreement with plan, and place for each member to add input)

COMMUNICATING ABOUT RISKS

Option 2: Marco is given a meeting preventively; behavior supports start now; new providers are educated on what to say/ not say; educators all trained on preventive supports, predicting increases in unsafe behaviors, safe responses to them



What supports and strengths can interdisciplinary teams bring?

- Information about goals we need to target, but could miss because of our lack of expertise/ experience
- Supports from a systems perspective
- Listening and valuing all perspectives / a different perspective
- Naysayers often bring a very important group of risks to consider in the risk versus benefit analysis, but these may be dismissed as "worries or concerns that don't apply to us" if we don't
  - Make a time to ask for them
  - Show we value them
  - Hear from everyone
  - Document them
  - And act on them

What supports and strengths can interdisciplinary teams bring? A few examples from my practice:

- **OT**: sensory differences; ways to design supportive sensory environments, assess sensory needs and challenges, look at pain threshold
- **Mental health and social workers**: safe place to hold the trauma- practice safe routines when it's not a challenging time; teach all team members how to support client in a crisis without re-presenting triggers; help differentiate whether a difficulty with mental health is part of a learning difference; help us learn about the client's past
- **SLP**: teach us to design communication and speech/ language goals related to self advocacy needs the student may have after trauma- honor the person's communication attempts, meet them where they are- bring in technology to help minimize the effort a student has to exert during a difficult situation – buttons, sentence strips, visuals, etc

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For behavioral team members: You can help us understand WHY this behavior now? We need this input in order to program for NEW behavior or strengthen the OLD

-"believing" the student and their body, looking at all aspects of (for example) avoidance, not just operant (the "they are getting something out of this interpretation"), but also…

-"this is painful for them",

-or "this is something that was modeled for them",

-or "this was once helpful; a survival skill for them",

-or "this may be a conditioned response for them"

-or "this skill is too difficult for them",

-or "there is not enough payoff for them considering this was once punished by their environment",

-or "this is something that pays off for most people but at home the student's behavior is not reinforced because their parent is not available, or is not intact, or is not able, or does not have the resources, to do that" etc

Special thoughts for administrative team members:

- **Support the team**! Back up team members who need to insure our ethics are followed and team's needs are met:
- **Protect time and space** (and pay team members) for meetings
- **Follow guidelines** set to protect the client (e.g., if there's a program that asks that attention not be provided after certain events, or insure that attention IS provided regularly, try to be a part of it, be the change you want to see, not the one disruptive team member)
- **Follow guidance or team leadership** that gives pointers on how to speak to and about a client, or a parent/guardian, in their presence; know what behaviors to bring up (mention) in their presence, and topics to avoid (if the team doesn't igve you guidelines on this, ask- and team members, ask a leading member to MAKE guidelines to distribute)

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Special thoughts for administrative team members: *More on following clinical guidance*

- **Honoring** everyone's need to provide input
- **Making medical recommendations** even when those are not followed
- **Establishing and honoring boundaries:** Sometimes we need to draw a line in the sand (pause a certain treatment or something that is not safe to continue without knowing more, or getting someone training, or getting someone resources)
- **Connecting** us to other resources: If you can't facilitate training, but team desperately needs it to treat this new unsafe behavior or to understand this student, please honor expertise that is requesting that, and connect us to someone else who can help
- **Working with the community:** Grow and work relationships (you won't always have everything in house, but you may be able to facilitate a connection)

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Some Features of a Trauma-Informed FBA

Examples of supportive timing for delivering key stimuli on preventive schedules (NCR, FT schedules)

Behavioral descriptions of adverse conditioning experiences and trauma related stimuli

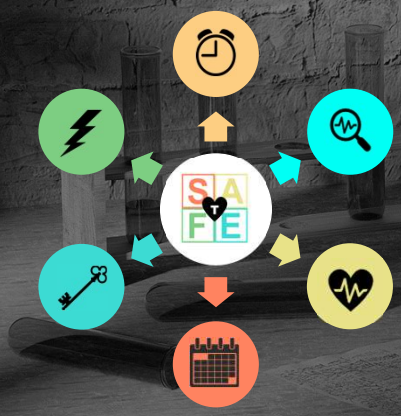
Past and historical functions of the person's challenging behaviors

List examples of triggering environmental events and how person responds

Document medical or physiological contributions to trauma-related events

Describe important past or present schedules and how person was affected
(e.g., what time of year a tragedy occurred, or what holidays or times of day, month or year are most difficult and why)

Some Features of a Trauma-Informed FBA



Possible Appendices

Referral documentation; description of social network of client and team; letters to police, administrators or medical staff describing important preventive interactions (NCR, FT schedules)

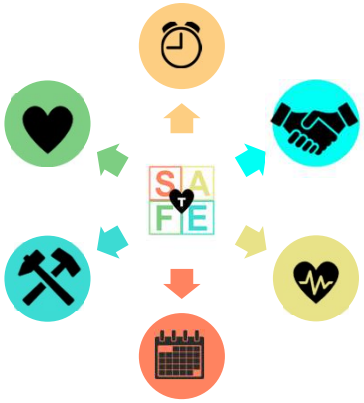
Risk versus benefit analysis for options being considered; risk mitigation plan addressing option(s)

Possible Features of a Trauma-Informed Behavior Plan

Time-In is scheduled as an antecedent strategy with preferred people. High-level attention is not contingent on acting out but regularly scheduled. Preventive check-ins are used and scheduled based on data.

There is a **designated safe person** who will start and regularly practice check ins at a safe place. Descriptions are in plan, to help safe person continue to foster the relationship.

Procedures and activity schedules are included that **target appropriate repertoire development**. May include AIM, PEERS, TAPS, ACT skills, behavioral activation, IISCA, etc; add **buffering items*** to plan if not already present

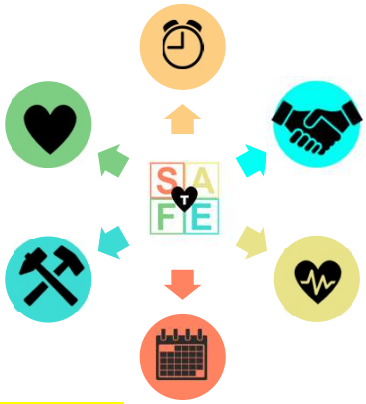


Relationship building procedures present for regular people in student's life. Primary caregivers/educators receive training (strengthen approach, neutralize aversive interactions, address needs). Adult attention preferences are assessed/ described.

If **medical factors** were part of FBA results, provide behavior plan recommendations in 3 areas: Communication, behavior, and training.

Preventive procedures for times of day, month, year, etc that team will be addressing historically difficult times. Team practices these in advance. If there is going to be a substitute, there are clear visual aids and videos or brief trainings.

Possible Features of a Trauma-Informed Behavior Plan



**Buffering items are the 6 components that Nadine Burke Harris (2017) and others suggest can protect AFTER trauma; include adequate exercise, sleep, nutrition; good relationship; stress relieving skills; and mental health support*

Notes on procedures that target appropriate repertoire development:

- Assess all procedures for risks/benefits, reducing contraindicated procedures.
- Select research based techniques.
- Consider missing skills (e.g., flexibility, defusion, social emotional skills, self advocacy, problem solving, correspondence between verbal behavior and actual events (e.g., "telling the truth" and "self-awareness"; see Dymond and Barnes (1997); tolerating appropriate demands. Some compatible and behavioral approaches or programs may include the following:
  - ❑ DNA-V (includes free resources on the developmental model acceptance and commitment therapy) https://thrivingadolescent.com/dna-v-free-resources/
  - ❑ TAPS/ (talk aloud problem solving; work by Joanne Robbins): https://talkaloudproblemsolving.com/
  - ❑ AIM/ work by Mark Dixon: https://www.acceptidentifymove.com/about
  - ❑ IISCA/ work by Greg Hanley: https://practicalfunctionalassessment.com/
  - ❑ Flexible and Focused (book by Adel Najdowski targeting executive functioning skills)

- We looked at a case study and then discussed several more tools to help us understand relationships between challenging behaviors and trauma related events
- We saw some examples of how interdisciplinary team members could support a complex trauma related case
- We can use the tools (all free except SAFE-T Assessment) in our own cases to guide development of more trauma informed FBAs, behavior plans, and support programs for students after trauma

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BRIEF REVIEW

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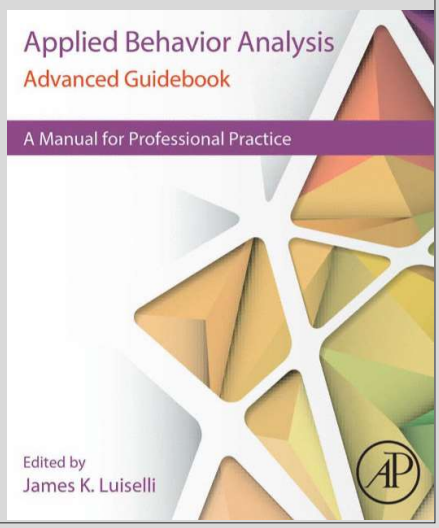
Some selected references and further reading (see next pages for articles)

Books mentioned:

- The Boy Who Was Raised As a Dog (Dr. Bruce Perry, psychiatrist)
- The Deepest Well (Dr. Nadine Burke Harris, pediatrician)
- ABA Advanced Guidebook (Ed. Luiselli, see ch. 5 on Behavioral Risk Assessment)
  - Includes a behavioral screening tool
    - Not trauma-informed, but a good place to start when developing your own process if you don't have access to a tool that is **both trauma-informed and behavioral**
  - Discusses risk mitigation and cases in which outside specialties must be considered



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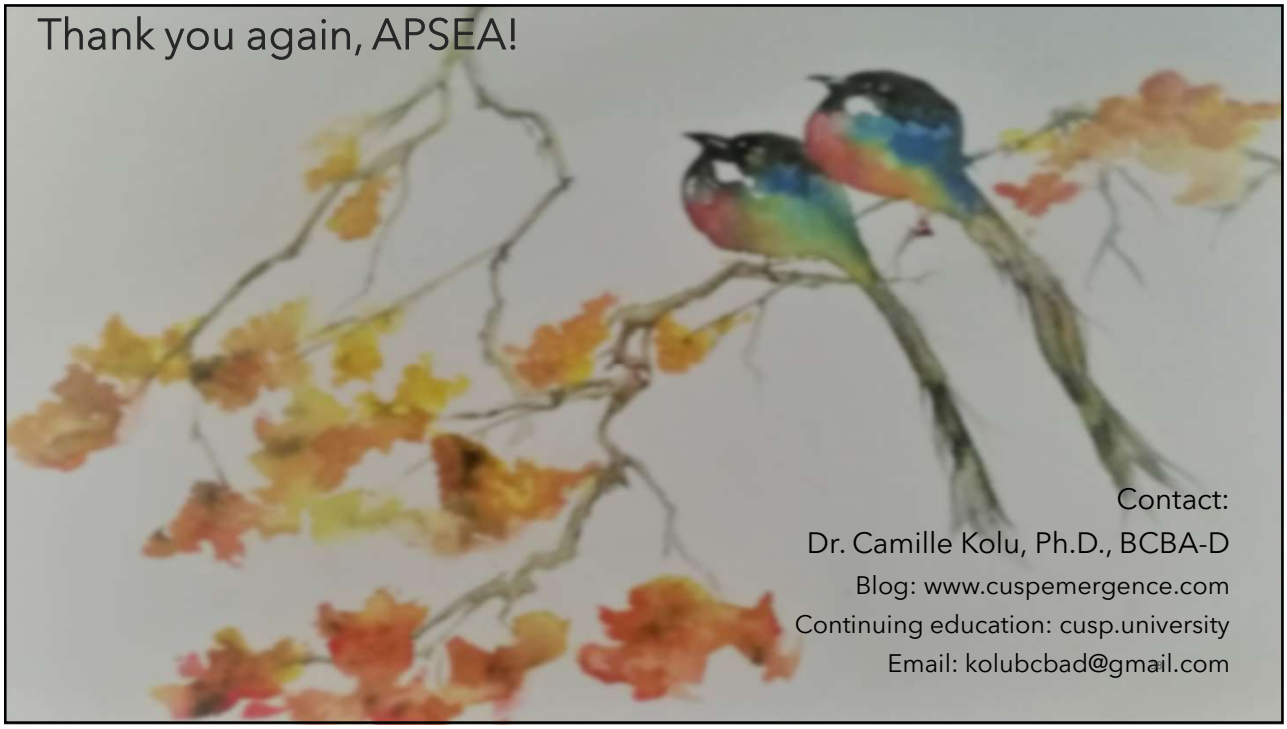
Thank you again, APSEA!



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