BRIEFING

Centre for Mental Health

54: Trauma, challenging behaviour and restrictive interventions in schools

Executive summary

There has been a lot of debate over the last year about the links between mental health and behavioural issues in schools. This has included concerns being raised about the use of restrictive interventions on children with learning disabilities and political debate about the best ways to improve behaviour in schools and reduce the use of exclusion.

This policy briefing summarises the available evidence for associations between trauma, challenging behaviour and restrictive interventions in educational settings and considers alternative approaches for policymakers and school leaders.

Exposure to trauma is relatively common among young people. Without appropriate support, traumatic experiences can have severe and long-lasting effects.

Challenging behaviour and trauma are associated. Young people who show challenging behaviour are more likely than average to have been exposed to trauma. In some cases, challenging behaviour is a symptom of trauma.

Thousands of young people are subject to some form of restrictive intervention in schools in England every year for challenging behaviour. There is reason to believe that these interventions have a negative impact on mental health, irrespective of previous trauma exposure.

Young people who have experienced trauma in the past are especially at risk of experiencing psychological harm from restrictive interventions. For example, exclusion and seclusion can echo relational trauma and systemic trauma; while physical restraint can echo physical and sexual abuse. As a result, these interventions may cause harm and potentially drive even more challenging behaviour.

Positive behavioural support (PBS) may reduce the use of restrictive interventions. However, it fails to address the wider system. It supports the young person to manage their behaviour but does not necessarily do anything about external circumstances that may be causing the behaviour.

Trauma-informed schools, in contrast, seek to minimise the trauma-causing potential of the school environment. One aspect of this is using less emotionally harmful alternatives to restrictive interventions. A trauma-informed school also seeks to maximise the healing potential of the school environment. One way of doing this is through teaching young people about mental wellbeing. Another way is by creating a positive ethos, providing young people with a direct experience of reliable attachment figures and a safe and caring environment.

Trauma

What is trauma?

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines a traumatic experience as one in which there is "actual or threatened death, serious injury, or sexual violence" (APA, 2013). The Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the US Department of Health and Human Services, adopts a broader definition of a traumatic experience as:

> *an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
>
> (SAMHSA, 2014)

This definition would include systemic trauma. Systemic trauma refers to the harm caused to people by contextual features of environments and institutions through, for example, poverty, racism and other forms of discrimination and oppression (Goldsmith, Martin & Smith, 2014).

Young people's trauma is often discussed with reference to Adverse Childhood Experiences (ACEs – see Box 1) and, more recently, to concepts such as Adverse Community Environments (McEwen & Gregerson, 2019). The former focuses predominantly on three categories of experience: neglect, abuse and household dysfunction. The latter is concerned with the role of systemic factors in causing and compounding trauma (Ellils & Dietz, 2017). Efforts to address trauma must be concerned with both.

Prevalence of trauma

Childhood and adolescence are key developmental windows when environmental and emotional experiences have their greatest impact, and the effects of trauma on young people can be particularly severe and long-lasting (e.g. Kearney, Wechsler, Kaur & Lemos-Miller, 2009; Brent & Silverstein, 2013; Hostinar & Gunnar, 2013; Straussner & Calnan, 2014). Approximately one third of young people in England and Wales have been exposed to traumatic experiences by the time they are eighteen years old and approximately one quarter of these young people will develop post-traumatic stress disorder (PTSD) as assessed by DSM-5 criteria (Lewis *et al.*, 2019).

Research has shown that trauma exposure is higher than average among young people with a range of developmental difficulties and disabilities:

- **Conduct disorder:** Young people who have been exposed to trauma are twice as likely to have a conduct disorder as those who have not been exposed to trauma (Lewis *et al.*, 2019).
- **Attention-deficit hyperactivity disorder (ADHD):** They are also twice as likely to have ADHD (Lewis *et al.*, 2019).
- **Autism spectrum disorder (ASD):** Young people with ASD are more likely to have been exposed to Adverse Childhood Experiences than those who do not have ASD (Berg *et al.*, 2016; Rigles, 2016; Kerns *et al.*, 2017).
- **Intellectual disability:** Young people with intellectual disability are more likely to have experienced trauma than those without (Hatton & Emerson, 2004; Mevissen *et al.*, 2014; Byrne, 2018).

Systemic trauma, by definition, affects the young people who face the greatest oppression and discrimination. At risk groups include:

- Young people from black and minority ethnic (BAME) communities;
- Those from poor and socially disadvantaged backgrounds;
- Those who identify as LGBT+;
- Those who are migrants, refugees or seeking asylum;
- Those with disabilities;
- Those from minority religious groups.

Few studies have explored systemic trauma among young people in the UK. However, research reporting the prevalence of bullying – an experience that can take the form of oppression and discrimination, as well as emotional and physical abuse – indicates that many young people face, for example, racism and homophobia at school and in their community. For example:

- Stonewall (2017) found that 45% of LGBT young people across Britain had been bullied at school because of their sexual orientation.
- The Guardian (2018) has reported record numbers of UK children excluded for racist bullying in recent years.
- Ditch the Label (2019), in their annual survey, has highlighted the role that prejudice continues to play in bullying.

Summary

Exposure to trauma is relatively common among young people; and, without appropriate support, these experiences can have severe and long-lasting effects.

Box 1: Adverse Childhood Experiences (ACEs)

ACEs research is interested in the long-term effects of adversity experienced in childhood. Much of the research is based on the ten-item ACEs checklist, which covers experiences such as emotional and physical abuse, and neglect. The higher a young person's score on the checklist, the greater risk they will have problems with their physical and mental health later in life.

While ACEs researchers are not the first to have made this connection, the concept of ACEs has proved to be particularly accessible and engaging. It has been credited with raising public awareness of the challenges faced by many young people and the often enduring effects of these difficult experiences. Advocates of 'ACE-awareness' argue that anything that brings these issues to a wider audience should be welcomed.

Others, however, have expressed reservations about the 'ACE-aware' movement. Their concerns include the potential narrowing of the debate around trauma. The ACEs checklist does not cover all the traumatic events a young person might experience, nor are the events it does cover necessarily traumatic in all cases. Moreover, it has been argued that the focus on becoming 'ACE-aware' can be a distraction from the more important tasks of prevention and support: How do we stop children from experiencing trauma? How can we help those who have been traumatised? And, bearing in mind that many of those who have experienced trauma might not be willing or able to put their experiences into words, are there things we can do to help without needing to identify who they are?

Challenging behaviour

In everyday usage, the term 'challenging behaviour' covers examples of externalising behaviours such as anger, aggression, disobedience, cheating and stealing, which may or may not be associated with personal or social risks. A 'technical' definition covers more extreme instances:

> *Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion.*
>
> (RCPsych/BPS/RCSLT, 2007)

Challenging behaviour, like trauma, is strongly associated with certain developmental difficulties and disabilities.

Trauma and challenging behaviour

Young people who have been exposed to trauma are more likely to have psychological and behavioural problems, and there is evidence that greater trauma exposure is associated with more severe and diverse behaviour problems (Lansford *et al.*, 2012; Greeson *et al.*, 2014). In addition, young people with behavioural issues and mental health conditions may be at higher risk of abuse and neglect than children without these conditions (Jaudes & Mackey-Bilaver, 2008). These findings taken together suggest the possibility of a feedback cycle in which young people who have experienced trauma and who have mental health conditions and behavioural issues are at the highest risk of further trauma, mental health conditions and behavioural issues (Jaudes *et al.*, 2008).

Trauma and challenging behaviour are connected by several pathways, any or all of which may apply to different extents to different individuals:

1. Trauma causes challenging behaviour

There is evidence that trauma exposure leads to poor regulation of the stress response system and this, in turn, can lead to impulsivity and poor emotional control (Tarullo & Gunnar, 2006; Bright & Thompson, 2018). As a result, young people with trauma histories are more likely to respond to subsequent stressful experiences with internalising or externalising behavioural problems (Milot, Éthier, St-Laurent & Provost, 2010; Grasso, Ford & Briggs-Gowan, 2012). For example, children's perceived experiences of ethnic-racial discrimination at age seven predict behaviour problems one year later, even after controlling for relevant factors such as existing behavioural issues (Marcelo & Yates, 2018).

2. Challenging behaviour causes trauma

Challenging behaviour may result in young people being exposed to dangerous situations and it may result in defensive or aggressive reactions from others. For example, young people with a diagnosis of conduct disorder are more likely to be involved in criminal and antisocial activities, which are, in turn, associated with a higher risk of trauma (Bernhard *et al.*, 2018).

3. Challenging behaviour and trauma are independently caused by a common factor

Certain environments, experiences and diagnoses are known to be linked to a range of more negative outcomes. For example, intellectual disability is associated with a higher risk of experiencing trauma (Hatton & Emerson, 2004; Mevissen *et al.*, 2014; Byrne, 2018) and, for reasons other than trauma exposure, with a higher likelihood of showing challenging behaviour (Lowe *et al.*, 2007; Poppes, Van Der Putten, Post & Vlaskamp, 2016).

Summary

Challenging behaviour and trauma are associated. Young people who show challenging behaviour are more likely than average to have been exposed to trauma. Furthermore, there is evidence that, in some cases, challenging behaviour is a symptom of trauma.

Restrictive interventions

In the research literature 'restrictive intervention' generally refers to physical restraint, seclusion, mechanical restraint, blanket restrictions and chemical restraint (CBF/PABSS, 2019). For this briefing we are also exploring other restrictions on a young person's freedom such as suspension and exclusion.

Suspension and exclusion

Persistent disruptive behaviour is the most common reason for exclusion from school, accounting for approximately one third of all permanent and fixed-term exclusions (DfE, 2019a). The rate of permanent exclusions remained relatively stable over the previous decade at around 10 pupils per 10,000, but the rate of fixed-term exclusions has increased in recent years from 4.76% 2016/17 to 5.08% 2017/18, which is equivalent to around 508 pupils per 10,000 (DfE, 2019a).

According to the Timpson Review of School Exclusion, the rate of both temporary and permanent exclusion is highest among Black Caribbean and Gypsy/Roma and Traveller pupils, and

> *78% of permanent exclusions issued during secondary school were to pupils who either had special educational needs, were classified as in need or were eligible for free school meals. 11% of permanent exclusions were to pupils who had all three characteristics.*
>
> (DfE, 2019b)

While few studies have quantified the prevalence of trauma among young people who belong to these groups, there is evidence that social, educational and intellectual disadvantage, and belonging to a racial or ethnic minority are risk factors for trauma (Brewin, Andrews & Valentine, 2000; Hatch & Dohrenwend, 2007).

There is a two-way relationship between psychological distress and exclusion: young people who have poor mental health are more likely to be excluded, and exclusion is associated with worsening mental health (Ford *et al.*, 2018). Young people with conduct disorder and ADHD are more likely to be excluded than young people with other types of disorder (Parker *et al.*, 2018).

There is also evidence that suspension and exclusion have a negative impact on the emotional wellbeing of the young person's immediate family. These interventions can leave the family feeling judged, powerless and unsupported, and the practical difficulties of having a child out of school can add strain to relationships that may already have been troubled (McDonald & Thomas, 2003; Parker, Paget, Ford & Gwernan-Jones, 2016).

Restraint and seclusion

According to general guidance, restraint and seclusion should only be used as a last resort when there is real possibility of harm to the child, staff or others, and then it should only be for the shortest time possible using the least restrictive means possible (e.g. DH, 2014; NHS England, 2015; NCCMH, 2015; NICE, 2015a; NICE, 2015b; Ofsted, 2018, HM Government, 2019).

While the Department for Education collects and annually publishes national data on exclusions, there is no equivalent data set for restraint and seclusion. Currently, schools are not formally required to record details of their use of these interventions.

The Challenging Behaviour Foundation (CBF) conducted an online survey on restrictive interventions in educational and respite settings. It was completed by 204 families of young people with challenging behaviour (CBF/PABSS, 2019). Findings relating to frequency included:

- 88% of families reported that their child had experienced physical restraint (35% said this happened on a regular basis)
- 71% reported incidents of seclusion (21% on a daily basis)

- 64% reported blanket restrictions, e.g. lack of access to outdoor space (30% on a regular basis)
- 50% reported chemical restraint
- 20% reported mechanical restraint (35% on a daily basis).

Other findings included:

- A majority of the restrictive interventions took place in schools (68%).
- A majority of families said that the interventions were not planned in advance, not in their child's best interests and not carried out with parental input.
- A majority of incidents were not followed up with plans of how to avoid use of restrictive interventions in the future.
- A majority (58%) of young people who had been subject to physical restraint had been physically injured as a result.
- Almost all families (91%) whose children had been subject to physical restraint reported that the intervention had had an emotional impact on their child.
- Children aged 5-10 years old were especially likely to be subject to restrictive interventions.

And, again, as with suspension and exclusion, there is evidence that restraint and seclusion have a negative impact on the emotional wellbeing of the young person's immediate family.

The report concluded that:

> *The evidence families have presented to us suggests that restrictive interventions are being used too readily and are happening at a frequency that reflects a lack of planning or a focus on children's rights.*
>
> (CBF/PABSS, 2019, p. 24)

There has also been media and political interest in the use of physical restraint and seclusion in schools. For example:

- Restraint in special schools (5 Live, 2017)
- Police probe 'inappropriate pupil restraint' (BBC, 2019)
- Pupil brings legal action against school's isolation policy (Guardian 2018b)
- Mother sues over daughter's suicide attempt in school isolation booth (Guardian, 2019)
- Disabled children 'constantly' physically restrained and left with bruises and trauma, parents say (Independent, 2019).

Summary

Thousands of young people are subject to some form of restrictive intervention in England every year for challenging behaviour. There is reason to believe that these interventions have a negative impact on mental health, irrespective of previous trauma exposure.

Previous trauma and restrictive interventions

Young people who have had adverse experiences are especially sensitive to situations that resemble their previous trauma in some way. Similarities between their current situation and past trauma trigger a stress response, readying them to take protective action. While this can help keep them safe if the situation does become dangerous, it also takes a significant emotional toll. As a result, an objectively similar experience may cause more negative mental health consequences for a young person with a history of trauma than for a young person without such a history. Three illustrations are given below, in the context of restrictive interventions.

Relational trauma – exclusion and seclusion

Relationships (or their absence) can be a source of psychological harm. Young people who have been neglected by or separated from their caregiver, for example, have been exposed to trauma in the context of being cut off from people. As a result, punishments such as exclusion and seclusion may be disproportionately distressing to them, especially if, as a result of these punishments, they spend more time in the home where they are being neglected.

Systemic trauma – exclusion and seclusion

Some groups of young people regularly experience discrimination and oppression. Exclusion and seclusion can feel like – or, at worst, are – another form of discrimination. For example, the rates of both permanent and fixed-term exclusions are disproportionately high among Black Caribbean pupils (Demie, 2019; DfE, 2019b). In accounting for this, research has identified lack of cultural understanding, lack of awareness of racism and discrimination, and institutional racism as factors (Gillies & Robinson, 2012; British Youth Council, 2016; Demie, 2019).

Physical and sexual abuse – physical restraint

Young people who have suffered physical and sexual abuse are vulnerable to being retraumatised by physical restraint. For them, forcible physical contact – which, as discussed above, is psychologically harmful in its own right – will be associated with intensely distressing experiences. See, for example, research conducted with adult survivors of abuse who had been subject to restraint in psychiatric inpatient settings (Cusack et al., 2018).

Summary

Young people who have experienced trauma in the past are especially at risk of experiencing psychological harm from restrictive interventions. For example: exclusion and seclusion can echo relational trauma and systemic trauma; physical restraint can echo physical and sexual abuse. As a result, these interventions may cause retraumatisation which, in turn, may drive even more challenging behaviour.[1]

[1] This argument is based on established theory, not empirical evidence. The psychological and behavioural impact of restrictive interventions on young people who have experienced trauma is an area in need of research.

Reducing the use of restrictive interventions

If, as the evidence indicates, restrictive interventions are a problem for the emotional wellbeing of young people, especially those who have been exposed to trauma, then it is crucial to find alternatives. The most widely used approach that has proven to be successful in reducing the use of restrictive interventions is positive behavioural support (PBS).

What is PBS?

PBS "provides a framework that seeks to understand the context and meaning of behaviour in order to inform the development of supportive environments and skills that can enhance a person's quality of life" (DH, 2014, p. 20). It is currently the best evidenced approach for people with learning disabilities or autism whose behaviours challenge (CBF/PABSS, 2019), and it is recommended by government guidance (HM Government, 2019).

PBS is characterised by a planning process (see Box 2) that is data-driven, subject to ongoing revision in light of new evidence, and shaped by the following values and principles:

- Person-centred;
- Involves all stakeholders, including the individual;
- Carried out for the benefit of the individual;
- Does not use punishment;
- Transparent and honest (BILD, 2016).

Because support plans are designed around an individual's needs, the interventions recommended by PBS will look different for different pupils. It is also worth noting that, in theory, support plans could recommend restrictive interventions as a key strategy, if they were seen to be compatible with the values listed above. However, in practice, introducing PBS works to drive down the use of restrictive interventions: PBS requires the person drawing up the plan to make wellbeing a priority and to attend to data; as a result, if restrictive interventions are not good for the student and are not associated with a reduction in challenging behaviour (and evidence indicates that in most cases they are not), an alternative must be found.

Does PBS reduce restrictive interventions?

A majority of the studies in this area have been carried out in mainstream schools and have looked at suspension and exclusion. Evidence for the reduction of physical restraint and seclusion tends to come from non-educational settings (e.g. psychiatric wards) or take the form of individual case studies. Although the evidence isn't equally strong in both cases, the introduction of PBS tends to be associated with a reduction in the use of both types of restrictive interventions.

- Bradshaw, Mitchell and Leaf (2009) conducted a randomised controlled trial (RCT) of the effectiveness of PBS over the course of 5 years across 37 elementary schools in the US. They found significant reductions in student suspensions and office discipline referrals.
- Reynolds *et al.* (2019) studied a modified version of PBS in a youth psychiatric setting. In a sample of 442 admissions, they found meaningful reductions in the use of seclusion and restraint.
- Caldarella *et al.* (2015) investigated the effects of school-wide PBS on middle school climate and student outcomes. Data consisted of more than 300 teacher responses and 10,000 student responses from two middle schools in the western United States. Compared to the control, the schools with PBS had improved ratings of school climate and fewer office discipline referrals.
- Gage *et al.* (2018) matched 593 schools in Florida that had introduced PBS with 593 that had not. The schools with PBS had significantly fewer suspensions of students with disabilities and black students.
- Pas, Ryoo, Musci and Bradshaw (2019) found a significant reduction in suspensions in 859 elementary, middle and high schools in the US that undertook PBS training.

- Lenehan (2017) provides anecdotal evidence for the success of PBS. One respondent to the call for evidence noted that a PBS-informed strategy had coincided with an almost 90% reduction in the use of physical restraints; and one local authority estimated that PBS had saved them £1.8m over 4 years.

The limitations of PBS

One criticism of PBS is that it doesn't adequately address the wider system. While PBS can recognise that challenging behaviour may be a reaction to the wider environment, it puts the onus on the young person to develop better coping strategies. For example, if a pupil's challenging behaviour is triggered by a teacher who frequently raises their voice, the solution might be for the young person to do breathing exercises to help manage their stress level; it won't be for the teacher to do less shouting. Trauma-informed approaches, on the other hand, do address the whole system.

Summary

There is evidence that PBS reduces the use of restrictive interventions. However, one criticism of PBS is that it fails to address the wider system; it supports the young person to manage their behaviour but does not necessarily do anything about the external circumstances that may be causing the behaviour.

Box 2: How does PBS work?

Stage 1

Collection and analysis of data relating to the behaviour concerned. This includes an examination of what happens before, during and after the behaviour, how intense it is, how often it happens and how long it lasts.

Stage 2

When you feel that you have a detailed understanding of the behaviour and why it is happening, design and put in place a number of strategies to reduce the person's unwanted behaviours and enhance their lifestyle opportunities and wellbeing. The strategies are grouped as:

Primary strategies: Everything that is put in place that reduces the likelihood of the behaviour happening; for example, managing situations that you know will trigger a behaviour, changing environments, and providing opportunities for new experiences and acquiring new skills.

Secondary strategies: These are plans for what to do if the primary strategies do not work and behaviour starts to escalate. These might include using calming approaches, changing the environment, and diverting the person's attention to an activity they enjoy.

Reactive strategies: These are planned, robust strategies that are put in place to be used as a response to an incident of challenging behaviour. They aim to take control of a situation and minimise the risk to the person and others.

Stage 3

Regularly review and revise the support provided to make sure that it reflects their current needs, interests, health and wellbeing, and risks.

Adapted from BILD, 2016

Trauma-informed schools

Trauma-informed schools actively seek to minimise the risk that they will add to their students' traumatic experiences. One aspect of this might be trying to eliminate the use of restrictive interventions (which, as discussed above, can be emotionally harmful) by introducing school-wide PBS. But they also go beyond this, actively seeking to help students to heal from past traumatic experiences and to support the wellbeing of everyone in the school community. This might be done by direct instruction, explicitly teaching students about coping strategies and psychological wellbeing (in the literature this is often referred to as social and emotional learning). It might also be done by trying to create an ethos and a culture that makes attending the school a positive experience for students and staff (in the literature this is often referred to as school climate).

Social and emotional learning

Social and emotional learning (SEL) refers to interventions that actively set out to provide young people with the knowledge and skills they need to build positive relationships and to look after their mental health. A range of interventions has been developed, with variations in content and teaching approach. However, there is enough common ground between these variations to allow research to draw general conclusions.

There is evidence that the effects of PBS and SEL have the most positive impact on mental health and externalising behaviours when the approaches are combined, as opposed to one being adopted without the other (Cook *et al.*, 2015). A large-scale review of the international evidence for SEL found:

- Positive and small-to-medium effects on mental, emotional and social health and wellbeing in general;
- Positive and moderate-to-strong effects on social and emotional skills; and
- Positive and moderate effects on self-esteem and self-confidence (Weare & Nind, 2011).

A more recent review of the effects of SEL at follow-up concluded that young people who had received SEL, compared to those who hadn't, fared significantly better in social-emotional skills, attitudes, and indicators of wellbeing over the longer-term (Taylor, Oberle, Durlak and Weissberg, 2017). However, a systematic review of exclusively UK-based school interventions to promote mental and emotional wellbeing only found neutral-to-small effects (Mackenzie & Williams, 2018). Whether this reflects something culturally specific, or has more to do with methodology, it is not possible to conclude without further research.

School climate

Less research has been conducted in this area, perhaps because changes in culture and ethos are more difficult to standardise and quantify than more structured interventions. However, small-scale studies have demonstrated a relationship between a supportive school environment and emotional and behavioural adjustment, especially in more vulnerable students (Ward, Martin, Theron & Distiller, 2007; Wang, Brinkworth & Eccles, 2013; Liu, Li, Chen & Qu, 2015; Walker & Graham, 2019). And a large-scale review of the international evidence found that efforts to influence and change school climate "were positive and very promising for future research" (Weare & Nind, 2011).

In addition to empirical evidence, there are strong theoretical grounds for believing that school climate could have benefits for the mental health of young people (Jamal *et al.*, 2013). The best way to improve emotional wellbeing is not, for example, simply being given a lesson on positive thinking, but directly experiencing something positive. In terms of school climate, this means a young person's strong relationship with a warm, caring and reliable teacher could, to some extent, mitigate the harm from a relationship with a neglectful or abusive parent; it could be a benevolent childhood experience (BCE) to set against an adverse childhood experience (ACE).

Benevolent childhood experiences

Benevolent childhood experiences (BCEs) are not just the opposite of adverse experiences, they are experiences that have been shown to buffer the harmful effects of ACEs (Crandall *et al.*, 2019). They are characterised by their positive effect on perceived relational and internal safety, positive and predictable quality of life, and interpersonal support. Box 3 lists the ten questions on the BCE Scale, several of which relate to experiences of school. Research has demonstrated that these ten items generally contribute to resilient functioning, which is defined as manifestations of sustained or restored positive functioning despite, or in the aftermath of, adversity (Narayan *et al.*, 2018).

The concept of BCEs ties in with attachment research. It is now widely recognised that young people's mental wellbeing depends to a large extent on the availability of a reliable and caring attachment figure. Such a figure functions as a secure base from which the child can explore the surrounding environment and as a haven to which the child can return for safety in case of fear or threat. Lacking such a figure exposes young people to a higher risk of trauma, as well as being traumatic in its own right. While there is general agreement that, for example, schools can function as safe havens and teachers as positive attachment figures, the extent to which this can mitigate the harm of adverse experiences is an area in need of further research (Hamre & Pianta, 2003; Bergin & Bergin, 2009; Schuengel, 2012; Verschueren & Koomen, 2012).

Summary

Trauma-informed schools seek to minimise the trauma-causing potential of the school environment. One aspect of this is using less emotionally harmful alternatives to restrictive interventions. A trauma-informed school also seeks to maximise the healing potential of the school environment. One way of doing this is through education, teaching young people about mental wellbeing. Another way is by creating a positive ethos, providing young people with a direct experience of reliable attachment figures and a safe and caring environment.

Box 3: Items on the Benevolent Childhood Experiences Scale

1. Did you have at least one caregiver with whom you felt safe?
2. Did you have at least one good friend?
3. Did you have beliefs that gave you comfort?
4. Did you like school?
5. Did you have at least one teacher who cared about you?
6. Did you have good neighbours?
7. Was there an adult (not a parent/caregiver or the person from #1) who could provide you with support or advice?
8. Did you have opportunities to have a good time?
9. Did you like yourself or feel comfortable with yourself?
10. Did you have a predictable home routine, like regular meals and a regular bedtime?

Narayan *et al.*, 2018

Trauma-informed schools: Guidance

Below are four broad strategies recommended for trauma-informed schools:

1. Increase the capacity of school personnel to recognise and respond to students who may have been affected by trauma.
2. Implement policies and practices shown to create school climates where all students and adults feel safe, valued, and supported.
3. Help students develop skills to overcome challenges, such as managing emotions and behaviour, coping with stress and anxiety in healthy ways, forming positive relationships, and making responsible decisions.
4. Establish protocols to connect students with supports.

(Saxton, 2019)

The Washington State Compassionate Schools initiative has also produced an overview of its approach (Hertel & Johnson, 2015), and other organisations have published evidence-based guidance that, although not explicitly labelled as trauma-informed, is in line with trauma-informed principles. For example:

- Weare (2015) provides a framework for promoting positive social and emotional wellbeing in schools, focusing on engaging the whole school community.
- Abdinasir (2019) discusses the impact of educational settings on young people's mental health and the role they can play in creating the conditions for success. The report highlights, for instance, the importance of providing school staff with supervision for reflective practice.
- Harris and Whittle (2019) summarises what teachers can do to help young black men to thrive (see Box 4).

A whole-school approach

Trauma-informed care requires a whole-school approach. It requires schools, families, communities and other organisations to work together (DH/NHS England, 2012; PHE, 2015; Weare, 2015; DfE, 2019). Previous publications have set out steps for implementing whole-school approaches to wellbeing and behaviour. For example, Public Health England's eight principles for promoting health and wellbeing in schools and colleges (PHE, 2015) and Education Endowment Fund's guidance for improving behaviour in schools (EEF, 2019). Many of these steps could be adapted for implementing school-wide trauma-informed care.

Box 4: This is me: A handy guide for schools to help young black men thrive (Harris & Whittle, 2019)

Centre for Mental Health has produced a guide for schools to help promote young black men's wellbeing and maximise their chances of a positive future. The guide sets out the context in which young black men are growing up and highlights the ways teachers and the school system can help them to thrive. It covers the need for changes to the school culture, building relationships and providing greater opportunities outside school.

Discussion

The potential for schools to influence young people's wellbeing for better or worse is widely recognised. Students in OECD countries are expected to receive a total of 7,751 hours of instruction on average during their primary and lower secondary education, and the bulk of these hours are compulsory (OECD, 2014). This time is spread across some of the most important developmental stages – stages when young people are laying the foundations for beliefs and behaviours that will shape the rest of their lives. Therefore, school is a crucial formative environment.

That schools have an impact on mental health is supported by research. At their worst, schools can add to young people's feelings of being unsafe, anxious and stressed (Hilarski, 2004; Hong & Eamon, 2012; Place2Be, 2017; YoungMinds, 2017). At their best, they can play a positive role, protecting and promoting emotional wellbeing (Weare & Nind, 2011; Weare, 2015; YoungMinds, 2017; Abdinasir, 2019).

Schools not only have the potential to protect pupils from harm and to promote their wellbeing, they have a duty to do so (HM Government, 2004). The National Institute for Health and Care Excellence (NICE) advises that primary schools and secondary schools should be supported to adopt a comprehensive, whole school approach to promoting the social and emotional wellbeing of children and young people (NICE, 2008 & 2009).

Last year, the House of Commons debated the use of restrictive interventions. Sir Norman Lamb initiated the debate by:

> *call[ing] on the Department for Education to urgently issue guidance on reducing the use of restrictive intervention of children and young people; and further call[ing] on Ofsted to change its guidance to inspectors to recognise the importance of seeking to avoid the use of those interventions with children and young people.*
>
> (House of Commons, 2019)

Responding, education minister Nadhim Zahawi MP stated:

> *Restrictive intervention can have long-term consequences for the health and wellbeing of children and young people... It can also have a negative impact on the staff who carry out such interventions. It is never something to turn to unless there are very good reasons to do so... The law and our guidance are clear that there are situations where using reasonable force is necessary in a school environment, to make schools safe places for pupils and staff. For example, force can be used to prevent pupils from hurting themselves or others, from damaging property or from causing disorder. However, the law is absolutely clear that force can never be used as a punishment.*
>
> (Ibid)

In this context, it is especially important to understand the connections between trauma, challenging behaviour and restrictive interventions, in order to ensure schools are doing everything in their power to promote wellbeing and to eliminate the use of force as anything but a method of last resort.

Conclusion

Evidence indicates that:

- A disproportionately high number of young people who show challenging behaviour have been exposed to trauma.
- Young people who show challenging behaviour are also at the highest risk of being subject to a restrictive intervention such as suspension, exclusion, seclusion and restraint.
- Restrictive interventions can cause psychological harm, especially in young people who have experienced trauma.
- The psychological harm may manifest in further challenging behaviour, leading to a higher risk of being subject to restrictive interventions (see Figure 1).

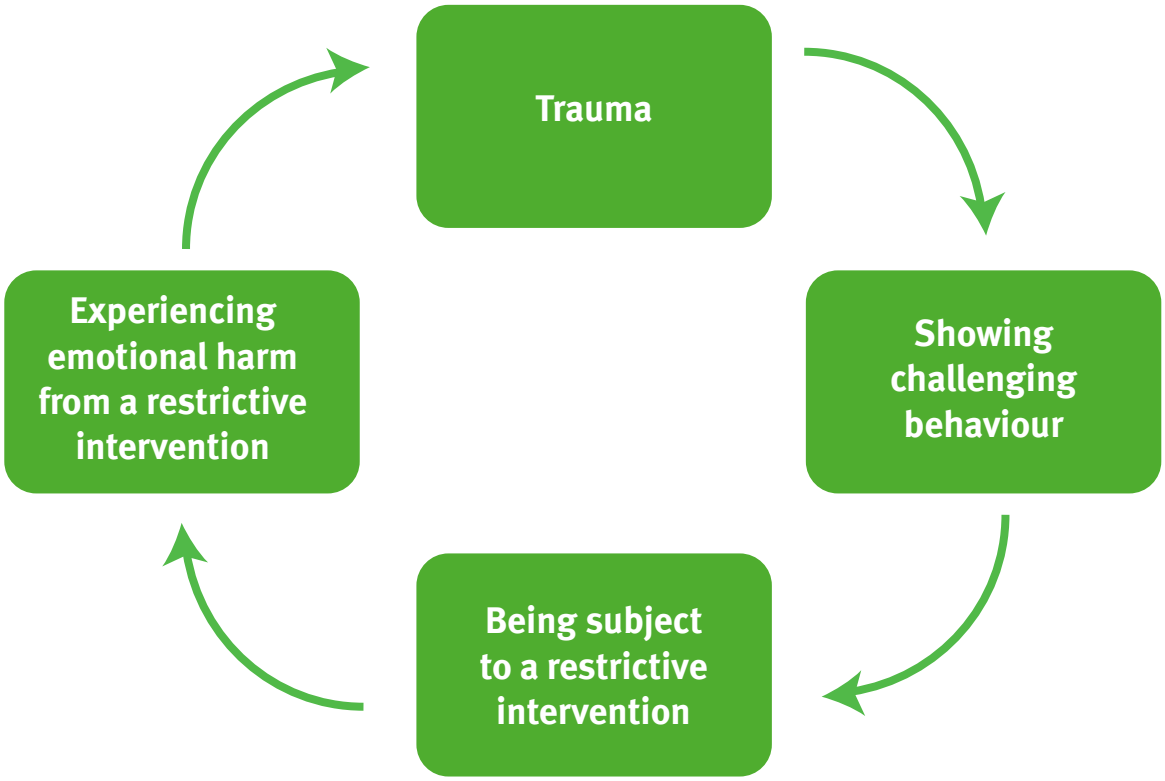
Taken together, these findings support the conclusion that restrictive interventions are problematic on at least two counts. First, in terms of behaviour management: removing the young person from the classroom (or, in the case of physical restraint, forcibly preventing the young person from carrying out the behaviour) is not the same as removing the challenging behaviour, let alone the thoughts and feelings that give rise to it. In fact, there is reason to believe that restrictive interventions may add to these thoughts and feelings. Second, restrictive interventions do not promote the wellbeing of the young people who are subject to them; and whether they promote the wellbeing of other young people in the school is open to debate.

A less problematic alternative is positive behavioural support. Research has shown it to be an effective framework for behaviour management that reduces the use of restrictive interventions. However, PBS also has limitations. Its focus is on what the young person can do to cope with difficult feelings; it does not address the problems that may be giving rise to the difficult feelings.

Trauma-informed care, on the other hand, is a whole-system approach in which managing challenging behaviour is only one aspect of a wider goal to minimise harm and promote wellbeing. This is likely to involve a combination of teaching young people about mental wellbeing (social and emotional learning) and creating a positive school climate, providing young people with a direct experience of reliable attachment figures and a safe, caring environment. It addresses not only challenging behaviour but some of the factors that are likely to be causing this behaviour.

Currently, the evidence base for trauma-informed schools is small – partly because, in the UK at least, there are few trauma-informed schools to evaluate. However, the concept receives strong support both from the well-established field of attachment studies and more recent work on benevolent childhood experiences. Therefore, there are compelling theoretical grounds to think that trauma-informed schools could make a positive difference to young people's behaviour and, more importantly, to their mental wellbeing, attainment and future life chances.

Figure 1: The relationship between trauma, challenging behaviour and restrictive interventions



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Briefing 54: Trauma, challenging behaviour and restrictive interventions in schools

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BRIEFING

Centre for Mental Health

54: Trauma, challenging behaviour and restrictive interventions in schools

Executive summary

There has been a lot of debate over the last year about the links between mental health and behavioural issues in schools. This has included concerns being raised about the use of restrictive interventions on children with learning disabilities and political debate about the best ways to improve behaviour in schools and reduce the use of exclusion.

This policy briefing summarises the available evidence for associations between trauma, challenging behaviour and restrictive interventions in educational settings and considers alternative approaches for policymakers and school leaders.

Exposure to trauma is relatively common among young people. Without appropriate support, traumatic experiences can have severe and long-lasting effects.

Challenging behaviour and trauma are associated. Young people who show challenging behaviour are more likely than average to have been exposed to trauma. In some cases, challenging behaviour is a symptom of trauma.

Thousands of young people are subject to some form of restrictive intervention in schools in England every year for challenging behaviour. There is reason to believe that these interventions have a negative impact on mental health, irrespective of previous trauma exposure.

Young people who have experienced trauma in the past are especially at risk of experiencing psychological harm from restrictive interventions. For example, exclusion and seclusion can echo relational trauma and systemic trauma; while physical restraint can echo physical and sexual abuse. As a result, these interventions may cause harm and potentially drive even more challenging behaviour.

Positive behavioural support (PBS) may reduce the use of restrictive interventions. However, it fails to address the wider system. It supports the young person to manage their behaviour but does not necessarily do anything about external circumstances that may be causing the behaviour.

Trauma-informed schools, in contrast, seek to minimise the trauma-causing potential of the school environment. One aspect of this is using less emotionally harmful alternatives to restrictive interventions. A trauma-informed school also seeks to maximise the healing potential of the school environment. One way of doing this is through teaching young people about mental wellbeing. Another way is by creating a positive ethos, providing young people with a direct experience of reliable attachment figures and a safe and caring environment.

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