Integrating Trauma-Informed Care Post-ACE Screening in School Settings

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Doctor of Nursing Practice Project Executive Summary

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July 11, 2025

Executive Summary

Main Points

- Over 60% of students have experienced some form of childhood trauma, impacting their health and academic performance.
- The project aimed to train school staff in Adverse Childhood Experiences (ACEs) screening and trauma-informed care.
- Informal feedback showed increased awareness and interest in trauma-informed care among staff.
- Time constraints, lack of training infrastructure, and insufficient support were significant implementation challenges.
- Future success depends on flexible training and strong leadership support.

Background

Childhood trauma, such as abuse, neglect, and other adverse experiences, is widespread and can significantly affect a child's mental health, behavior, and academic success. This concern aligns with the Healthy People 2030 goals of improving mental health, increasing access to school-based support services, and promoting safe and supportive learning environments (Office of Disease Prevention and Health Promotion [ODPHP], 2020). Still, schools often lack the systems, training, and resources needed to identify and support these students effectively. This quality improvement project was developed to help address that gap by equipping school staff in a high-need school with trauma-informed practices. The primary audience consists of school administrators, educators, and healthcare providers working in school-based settings. While the original plan included involving parents, this strategy was revised due to low participation. The

project pivoted to focus on training existing school staff who interact most frequently with students to better recognize signs of trauma and respond appropriately.

Purpose

The purpose of this project was to determine whether school-based support staff could be trained to administer the Adverse Childhood Experiences (ACEs) screening tool and respond to students with trauma histories in a supportive, trauma-informed manner. The goal was to help students feel supported and to connect them with services if needed.

Methodology

This school-based quality improvement initiative was guided by the RE-AIM framework, an implementation science model that stands for Reach, Effectiveness, Adoption, Implementation, and Maintenance (McMahon et al., 2023). RE-AIM is widely used to evaluate the real-world impact of evidence-based interventions by examining not only outcomes but also the processes and systems that affect program delivery and sustainability. This type of framework played a crucial role in shaping both the design and evaluation of the project. It provided a comprehensive lens for evaluating not only whether the intervention was effective, but also why and how it succeeded or failed in the school setting. It helped identify multiple implementation barriers such as time, staff capacity, and logistics training. It also helped identify key areas for future improvement, including stakeholder engagement, scheduling strategies, and integration into school policies. The project took place at a Title I elementary school and a reformative school that combined middle school and high school-aged children in the Piedmont region of North Carolina.

Project Setting and Participants

Thirteen school support staff members were eligible to participate, and two were selected based on their availability and expressed interest. The intervention included structured, interactive training sessions designed to emphasize practical application in school settings.

Training Components

The training covered the following core areas:

- The purpose and appropriate use of the ACEs screening tool
- Trauma-informed communication and response strategies
- Identification of student behaviors commonly associated with ACEs
- Documentation procedures and referral protocols

Evaluation Tools

Four tools were developed to assess the effectiveness of training:

1. **ACEs Screening Tool Knowledge Assessment Survey** – Combined multiple-choice and open-ended questions to evaluate understanding of ACEs, trauma-related outcomes, screening procedures, and trauma-informed responses. It also assessed participants' confidence and perceived usefulness of the training.
2. **Self-Assessment ACEs Screening Tool** – Asked participants to rate their confidence (on a 1–5 scale) in understanding the ACEs framework, identifying ACE-related behaviors, responding empathetically, and documenting encounters.
3. **ACEs Screening Usage Log** – Intended to capture staff-student interactions, whether the ACEs tool was used, and outcomes or next steps taken.

4. **Referral Tracking Spreadsheet** – Designed to track student referrals following ACEs screening, including reasons for referral, type of support needed, follow-up actions, and outcomes.

Results

Although no staff members completed the training survey and no students were formally screened, the project yielded valuable insights into the feasibility and barriers of implementing trauma-informed care in school settings. Of the 13 staff members eligible, only two were selected to participate due to availability and interest. However, competing job responsibilities prevented them from completing the full training curriculum. Consequently, no quantitative data were collected, and referral logs remained unused. Despite these limitations, the project resulted in several practical outcomes:

- **Increased Awareness:** Informal conversations and reflective feedback revealed that staff gained a greater understanding of trauma-informed care principles and recognized the value of ACE screening in student support.
- **Systemic Barriers Identified:** Major obstacles included limited time, lack of built-in professional development infrastructure, and competing priorities, which hindered full participation and training completion.

These early findings suggest that, although implementation did not progress as planned, a clear foundation of readiness and interest has been established. The model has potential for broader adoption with stronger planning, administrative support, and integration into existing staff development systems.

Table 1: Training Participation Rates

Stage	Number of Staff (n)	Percentage of Staff

Eligible for Training	13	100.0%
Selected for Training	2	15.4%
Completed Training	0	0%

This table highlights the difficulty of implementing new initiatives in high-demand educational environments without dedicated time and administrative structure for professional development.

Strengths and Limitations

This project demonstrated several strengths, including leadership support and the effective use of an implementation framework. The RE-AIM model provides a structured foundation to guide planning and evaluation (McMahon et al., 2023). Additionally, the project addressed an urgent and well-documented need to integrate trauma-informed practices within schools to better support students exposed to adverse childhood experiences (ACEs) (Gentry & Paterson, 2022). Several potential biases may have influenced the project. First, the selection of only two participants, based on availability and interest, introduces a potential selection bias that could limit the applicability of the findings. Second, the reliance on informal feedback and reflective discussions instead of validated measurement tools may lead to response bias, as participants may have reported socially desirable opinions rather than critical assessments. Third, the absence of student screening data restricts the ability to evaluate intervention outcomes objectively. These limitations and biases should be considered when interpreting the findings, and future studies should employ more rigorous methods and involve broader staff engagement to enhance validity and applicability.

Implications

To move this project forward and achieve successful implementation in the future, several critical areas must be addressed. Trauma-informed care initiatives must be backed by school leadership to ensure the integration of training into the professional development calendar and alignment with schoolwide priorities. Embedding these into regular staff meetings or development days can help overcome time constraints. Provide access to trauma-informed care champions (trained peer mentors), checklists, and quick-reference guides to encourage practice during student interactions. Start with a smaller group, for example, one staff member per grade level. To better gauge staff readiness when survey participation is low, consider using short verbal check-ins or interviews with staff.

Conclusions

The findings from this pilot show that schools urgently need better systems to support students' emotional and psychological needs after trauma. School support staff can serve as frontline responders in recognizing and assisting students affected by trauma, but they require targeted training, sufficient time, and supportive infrastructure to do this effectively (Marsicek et al., 2019). Furthermore, strong administrative commitment and supportive policies are essential for successfully implementing trauma-informed care across school systems.

References

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