

Guidelines for Conducting VTRA's With Neurodivergent Students: A Whole Person Assessment (WPA)



FIRST EDITION - FEBRUARY 2025

ADHD

ID

FASD

TBI

ASD

LD

ETC.

NOS



**These guidelines are for Violence Threat Risk
Assessment (VTRA) professionals trained and active
in the application of the model**

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Disclaimer

These guidelines are for Violence Threat Risk Assessment (VTRA) professionals trained and active in the application of the model. Due to publishing time constraints, this document will not revisit the concepts, variables, and dynamics of the VTRA model. We encourage our colleagues to refresh their VTRA knowledge. For those who have received these guidelines but are not yet VTRA-trained, please contact your local Certified VTRA Trainers or reach out to the [Center for Trauma Informed Practices \(CTIP\)](#) directly to arrange your Level One VTRA training. As well, in the 6th Edition of the Level One VTRA Training Guide we introduced the updated name for the practical application of VTRA, when working on cases with children and youth, called "Assessment of Risk to Others" (ARTO). As many have not yet recertified in this newest iteration, we will use the acronym VTRA for the majority of this document and then introduce VTRA/ARTO in the latter stages of these guidelines.



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About the Title

The title of this guide, Guidelines for Conducting VTRA's with Neurodivergent Students, refers to individuals whose neurological development and functioning differ from what is considered typical or "neurotypical." "Divergent" highlights the unique and valuable differences in individuals. When assessing violence in this population, it's crucial to use robust data collection strategies and multiple, reliable sources, ensuring a thorough and compassionate approach to both assessment and intervention. The social model of disability values and respects all individuals by recognizing their unique abilities and contributions to society. In line with this model, we acknowledge the preference of some individuals to identify as neurodivergent. By using this term, we aim to honor and support their choice, embracing the diverse ways in which people understand and express their neurodevelopmental differences (Chapman, 2019, pp. 371–389).

About the Case Studies

Due to the broad distribution of these guidelines, all case studies are appropriately veiled, and some are an integration of cases into thematic representations of our clinical work. All were **complex VTRA cases** involving neurodivergent students where there were at least **two or more risk enhancers present that required at least two or more different agencies, beyond the school, to lower the level of risk and achieve lasting gains**. To further protect the many students and their families we work with, the examples are not meant to be comprehensive complex case studies; they are meant to teach concepts, variables, and dynamics related to each section of these guidelines.

Acronyms Used in This Document

VTRA	Violence Threat Risk Assessment
IOC	Individual of Concern
SCS	Severity of Concern Scale
PBA's	Plausibility, Baseline, and Attack-Related Behaviours
NRN	Not Right Now
ARTO	Assessment of Risk To Others

SECTION ONE



CTIP
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INFORMED PRACTICES

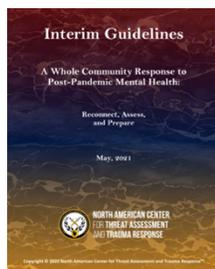
Guidelines for Conducting VTRA's with Neurodivergent Students

Introduction

Many schools, both publicly and privately funded education systems, across Canada have seen an increase in suspensions and expulsions in the first five months of the 2024-25 academic year. Colleges and Universities are also maneuvering through intensified symptom development with some students. Many systems' leaders have reported numbers higher than pre-VTRA days (20 plus years ago) when suspension and expulsion was often used as a primary intervention for "acting out" students. The nature of these current expulsions is frequently due to extreme violence, sexualized behaviour and other distressing behavioural combinations that, according to established Policies and practices, warrant formal discipline.

The frequency and intensity of violent acting out has often been directed towards school staff resulting, at times, in injury and harm that may be one of the factors that is contributing to a general shortage of teachers and significant shortage of Education Assistants (EAs)/Teacher Assistants (TAs) due to an increase in the amount of time lost. Some have outright left their positions due to an increase of possible injury or safety concerns in the workplace. There is also growing distress among many school staff about the escalating "potential" for violence from students who have engaged in threat-making or threat-related behaviours or **perceived** threat-related behaviours.

In the CTIP guidelines ***"Interim Guidelines: A Whole Community Response to Post-Pandemic Mental Health; Reconnect, Assess and Prepare"*** we addressed the predictable delayed response to the worldwide pandemic that we are now witnessing from children, youth, and many adults. This includes parent and caregiver stress and anxiety that has also been acted out against some school staff. Many underlying individual and family stressors were exposed or exacerbated during pandemic quarantine and are only now beginning to become evident in case work. As such, CTIP also published a paper ***"One Year Later: The Effects of Quarantine on Post-Pandemic Mental Health"*** that is instructive for making sense of some of the current symptom development.



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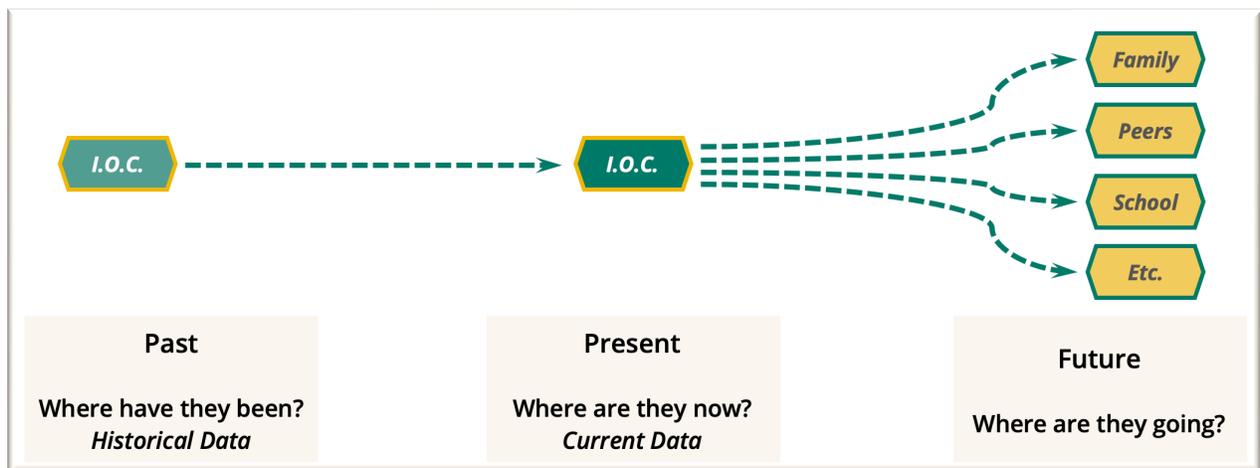
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Reason for the Guidelines

The vast majority of neurodivergent students do not pose a risk of violence towards others. While there has been an increase in the numbers of discipline interventions, suspensions and expulsions across all student groups it is our neurodivergent students who have shown the greatest escalation in actual or **perceived** violence potential in school. Although the VTRA process is adequate for assessing neurotypical and neurodivergent students, the difficulty lies in the range of knowledge and skill of professionals conducting the assessments and the degree of collaboration among the adults who have a vested interest in students. Notably, many suspensions and expulsions involving neurodivergent students, necessitate a nuanced, trauma informed, and research-driven VTRA approach. The primary reason for these specialized guidelines is to assist VTRA teams to enhance their understanding of the

subtleties of threat-risk assessment with neurodivergent students and make reasonable decisions based on the level of risk for serious violence and the capacity of each school to manage and intervene to lower the risk.

A common challenge in working with neurodivergent students is that it can be difficult, without an effective adult multidisciplinary collaboration, to develop a clear understanding of their baseline and identify if they are on an evolutionary pathway to violence. This can easily result in underreaction and overreaction to worrisome behaviour and critical situations. Underreaction can happen when school staff overlook significant changes in behaviour due to their familiarity with high baselines, while overreaction may occur when typical behaviours are misinterpreted as elevated risk without thorough investigation. Multidisciplinary collaboration for data collection that allows for weighing past behaviours and communications of the “Individual of Concern” (IOC) with the current presentation (i.e. why the VTRA is occurring now), is an integral component for establishing a student’s baseline and potential for violence (See Figure 1).



(Figure 1)

A primary risk enhancer is when neurodivergent students engage in serious violence, and are **underreacted** to because parents, professionals, and others argue that the concerning behavior is just a manifestation of the student’s diagnosis and therefore must be accommodated by the school. In fact, some of these students demonstrated clear pre-incident signs and indicators that they were moving on a pathway to serious violence, prior to the act occurring. Yet, in other cases, professionals, students, and others **overreacted** because a student’s neurodivergent thoughts, behaviours, or communications were erroneously viewed as a precursor to violence from an individual who they believed were experiencing ‘active mental health symptoms’. The general standard in VTRA has always been, ‘we will not activate the VTRA protocol if a neurodivergent students’ thoughts, behaviours, or communication are consistent with their diagnosis and how it its known to manifest within them.

VTRA was developed because it is extremely difficult, and sometimes impossible, to assess risk through a one-time or unidimensional interview with the IOC. It is also difficult for school professionals to make a determination of risk if they only consult the parent(s) or caregiver(s). VTRA is a data-driven process designed to assist teams in determining if an IOC is moving on a pathway to violence and then plan strategies (interventions) based on the data to lower the level of risk and achieve lasting gains. This is only possible when multidisciplinary teams use multiple data-points across time to determine if the current behaviour of concern is:

- a) Typical baseline.
- b) An isolated incident.
- c) Significant shift towards violence.

What follows is an introduction to the standard view of neurodivergence among professionals followed by the CTIP perspective as relates to the intersectionality with threat assessment and risk assessment. This includes how to

distinguish threat-related behavior, through a VTRA lens, within the complexities of a neurodiversity. This will be followed by our recommended trauma-informed assessment process and data-driven interventions. Case studies will also be used throughout the guidelines to help ground VTRA teams in consistent and collaborative interventions, thereby mitigating potential violence in school communities.

Standard View of Neurodivergence

In today's interconnected world, understanding neurodivergence is essential, especially when assessing potential risks for violence and extreme behaviour. This guide will draw on perspectives from the neurodivergence paradigm, the International Classification of Functioning, Disability, and Health (ICF) framework (International Classification of Functioning, Disability and Health, 2024), and formal forensic risk assessment to provide organizations, leaders, and interveners with valuable knowledge about assessing risks to others. These frameworks serve as foundational perspectives that shape our approach, setting the stage for a thorough and nuanced assessment process. Our goal is to offer a comprehensive and balanced approach to understanding and addressing serious violence potential, equipping multi-disciplinary teams with the knowledge to make informed decisions to better support and serve students, staff, and families.

The VTRA Model:

This guide centers on the VTRA model, which is designed to ascertain traditional and non-traditional risk enhancers using its staged and multi-disciplinary protocols. It involves multi-disciplinary teams conducting comprehensive risk evaluations based on collected data. The objective is not to label individuals, but to determine whether they pose a danger to themselves or others. This model emphasizes collaborative, multi-sectoral engagement and early intervention, involving educators, mental health, health, children's services, law enforcement, families and others. A diagnosis of autism, ADHD, a specific learning disorder, or another neurodivergent condition does not mean a person is a risk to others. The key question for teams, if the IOC engages in threat-making, threat-related, or violent behaviours is, **"if they do pose a risk, how much, if at all, does the diagnosis contribute to the risk?"**

Neurodiversity:

Neurodiversity refers to the natural variation in human neurodevelopment (or human brain function, cognition, and processing styles). Individuals whose neurodevelopment falls within the typical range are termed neurotypical, while those whose neurodevelopment diverges from this range are known as neurodivergent. This includes a variety of conditions such as, ADHD, specific learning disorders, autism and more. The term neurodiverse also describes groups that include a mix of neurodevelopmental types, such as both autistic and non-autistic people (Pellicano & den Houting, 2021).

The Neurodivergence Paradigm:

The neurodivergence paradigm emphasizes the importance of social responses in supporting neurodivergent individuals and, considering VTRA, mitigating risks. Unlike the medical model, it views challenges through the social model of disability, suggesting that 'disability' arises from environments that do not accommodate individual differences. Our physical and social environments are typically designed for neurotypical individuals, which often creates challenges for neurodivergent people (Pellicano & den Houting, 2021). For example, traditional school settings can cause sensory discomfort and distress due to their large, noisy, and chaotic nature. When the needs of neurodivergent individuals are not addressed, frustration and distress can escalate, potentially increasing the risk for context-specific reactionary violence. Recognizing and accommodating these needs is vital for reducing risks and enhancing safety.

The ICF Framework:

The International Classification of Functioning, Disability, and Health (ICF) framework offers a thorough approach to understanding individual differences by integrating biological, psychological, and social factors (International Classification of Functioning, Disability and Health, 2024). This framework provides a holistic view of disability and functioning, which complements the VTRA model's extensive assessment process by ensuring that all relevant factors are considered when evaluating potential risks.

For example, consider an individual with FASD or autism who struggles with sensory overload in a noisy classroom, with multiple teachers, and continuous change. The ICF framework encourages us to assess the environment and the individual's needs to identify potential stressors and address them. This proactive approach is a form of early intervention, which is a key principle of the VTRA model. Importantly, having a diagnosis like autism does not inherently mean an IOC poses a risk. By conducting thorough assessments early, we can determine if stressors from various environments, such as home or school, might escalate into potential violence. This naturally depends on collaboration among various sectors—education, mental health, law enforcement, and families—to create supportive environments that mitigate these risks.

Recognizing and addressing environmental factors is essential for supporting neurodivergent individuals. The ICF framework promotes a pluralistic view of neurodivergence, which is crucial for understanding the most effective ways to support neurodivergent individuals (Bölte et al., 2021). Importantly, it enables us to consider more than just the diagnosis when evaluating potential threats of violence. By assessing the evolving needs of both the IOC and their environment, we can determine whether these factors contribute to an increased risk or have no impact at all. This comprehensive understanding is vital when applying the VTRA protocol, when ensuring that assessments are detailed, evolving, and well-rounded, taking into account and incorporating the full context of the individual's life and environment.

Forensic Research and Practice Perspectives:

When forensic psychologists are available, the forensic perspective offers a formal and structured approach to evaluating potential threats of violence to others (Fritzon et al., 2020). While standardized forensic risk assessments are useful for individuals charged with violent offenses, they are less effective for those who have not yet engaged in violence, as these individuals are often deemed low risk. For example, non-traditional individuals of concern (IOC) may not be accurately identified through standard forensic assessments. Therefore, when incorporating forensic assessment data into VTRA, it is crucial to integrate trauma-informed knowledge and, when necessary, an understanding of neurodivergence to minimize critical omissions and ensure a thorough evaluation.

By integrating these perspectives, this guide aims to provide a well-rounded approach to VTRA, particularly with neurodiverse individuals. Our goal is to equip multi-disciplinary teams with the knowledge and tools needed to effectively address these complexities, ultimately enhancing community safety. While we do not dive deeply into the ICF framework or the forensic perspective, they serve as valuable lenses to confirm and explain our approach, ensuring that Violence Threat Risk Assessments are detailed and precise.

Neurodivergent Diagnoses Related to VTRA:

There are many past and current diagnostic or clinical terms used in education as school professionals try to make sense of atypical behaviour or changes in baseline functioning. Even in psychiatry and other helping professions, our understanding of neurodivergence is evolving and shifting (Reed et al., 2019). These guidelines draw on international research consistent with the diverse backgrounds of students in the Canadian educational system. Some countries focus more on some diagnoses than others and therefore a global perspective of neurodivergence applied to VTRA is more useful.

Distinguishing between individuals with life-course-persistent versus adolescence-limited antisocial pathways (Moffitt & Caspi, 2001) was a dichotomy utilized in the early iterations of the VTRA model. The focus has shifted away from psychopathology, yet its principles still apply to neurodivergence. Some students' baseline behaviours may have been somewhat concerning when they were younger though not severe enough to warrant formal psychological assessment. Consequently, when these students transition and progress through the education system from elementary to middle / junior high school 'with a clean bill of health' their symptoms may seem to be adolescent onset behavioural disorders when, in reality, they may have been neurodivergent all along.

It is not uncommon for students to be diagnosed with ADHD, FASD, ASD, learning disabilities, etc. as late as high school or young adulthood. This suggests that prodromal signs and symptoms were either normalized or missed entirely.

The first order range of neurodivergence addressed in these guidelines will include those most frequently identified in psychological and psychiatric assessments currently presented to the educational system for accommodation:

Fetal Alcohol Spectrum Disorder	(FASD)
Attention Deficit Hyperactivity Disorder	(ADHD)
Autism Spectrum Disorder	(ASD)
Intellectual Disability	(ID)
Traumatic Brain Injury	(TBI)
Learning Disability	(LD)
Subthreshold <i>Not Otherwise Specified</i> Diagnoses	(NOS)

VTRA teams need to be open to a range of possibilities when conducting assessments including the potential for undiagnosed neurodivergence that has been ignored or mislabeled. Some students may have either mild or subthreshold symptoms, leading professionals to mistakenly assume that the student is more capable of understanding and self-correcting than they actually are. In one study, researchers found that most of the youth involved in the criminal justice system had mild learning difficulties and were therefore "less likely to have had their learning needs identified in mainstream schools" (Chitsabesan et al., 2007). The assumption by Chitsabesan is that a significant risk reducer for an individual on a pathway to violence could be proper and early diagnosis of neurodivergence, aligned to appropriate school accommodations.

Thus, even if there is a potential for violence, students who are diagnosed early and receive appropriate accommodations, can have risk significantly reduced.

Autism and the Broader Landscape of Neurodiversity:

When school and helping professionals think of neurodiversity, they often think of autism, as it is more widely publicized, both positively and negatively, through media portrayals, advocacy efforts, and, in some cases, associations with school shootings. Autism also tends to receive more funding, support, and general understanding compared to other neurodivergent diagnoses, such as specific learning disorders, ADHD, FASD, and other lesser-known disorders, some of which may go undiagnosed.

From a Violence Threat Risk Assessment (VTRA) perspective, a lack of comprehensive understanding of neurodivergence, coupled with disparities in resource allocation, can be particularly detrimental. Misinterpretation of behaviours may lead to inaccurate risk assessments, where actions are mistakenly attributed to a single diagnosis rather than considering the full spectrum of neurodivergent factors, including undiagnosed or misdiagnosed conditions. This gap in awareness and understanding exacerbated by limited resources for certain neurodivergent

conditions, complicates the planning and implementation of effective interventions, as professionals may lack access to necessary tools and supports tailored to these diagnoses. Consequently, interventions may be misaligned, ineffective, or even escalatory. Without a sound understanding of the diverse ways neurodivergence may present in each Individual of Concern (IOC), professionals risk overlooking critical baseline shifts, failing to identify valid risk-enhancing variables, and implementing strategies that do not adequately address the IOC's specific needs. This increases the likelihood of escalation, further reinforcing cycles of misunderstanding, mismanagement, and heightened risk. Part of the solution is found in ensuring that specialists, in each primary diagnosis, be utilized for consultation in complex VTRA cases.

Initial Assessment of the Neurodivergent IOC

Multidisciplinary VTRA, applied at its highest level, always gives special consideration to students with exceptional needs, including those who are neurodivergent. One external risk enhancer contributing to the escalation we are seeing with some individuals is the 'drift' " that has occurred between professionals since the pandemic. This drift has moved us from effective multiagency collaboration to the current situation, where many schools are trying to manage complex cases in isolation and on their own. Having multidisciplinary teams and agencies return to the VTRA table will provide tremendous support for neurodivergent students, their parents (caregivers), and the schools trying to support them. Without effective collaboration, schools cannot possibly have all the data to determine if the current presentation of the IOC is typical or a sign of escalation.

Beyond the details of what brought the IOC to our attention, the first step in assessing a neurodivergent student is to ask of ourselves:

- Is the current circumstance that brought the IOC to our attention typical baseline behaviour, or is there a significant increase in baseline?
- Is it an understandable presentation from a neurodivergent student, whose thoughts, behaviours, or communications are consistent with their diagnosis and how it is known to manifest in them?

Once we understand the baseline of the IOC we need to ask:

- What has changed?
- What are the internal or external factors?
- Have the protective factors or interventions failed, or have new risk factors emerged?
- Is their baseline too high, or their level of dangerousness too extreme for the regular school setting to manage at this time?

To better understand baseline with neurodivergent students, we developed a simplistic pathway called "Triple C"

Cameron & Turner, 2024

“Triple C” (Cute-Concerning-Critical):

Cute: Young children, for a variety of reasons, are sometimes allowed to get away with certain problematic behaviours because they are considered ‘cute’, such as a three-year-old throwing a temper tantrum or a five-year-old using an inappropriate sexual term. If the adults closest to them find it funny, they both reinforce the behaviour and add to the justification for why children will continue to repeat it. Even in early elementary school, staff may underreact if they likewise find certain problematic behaviour to be cute. This dynamic is especially heightened if the student is likeable or considered good looking.

Concerning: This same behaviour was considered cute when the child was younger. However, it is now ‘concerning’ to some adults as they approach the pre-teen and early teen years (10 years or older).

Critical: This behaviour, once deemed cute, now appears very different as the student has become a teenager and is physically larger. Throwing a temper tantrum in the classroom now feels more concerning than it did when they were five years old. A new school staff member who has just inherited this student may perceive them as ‘very dangerous’. However, if they scream, hit the wall, and storm out of class the same way they did as a young child, from a VTRA perspective, they are not moving on a pathway to violence. Instead, the case would be assessed as ‘static risk’, with recommendations to introduce appropriate behaviour modification and self-regulation supports if schools, in the past, had only been accommodating the behaviours.

Case Study One:



Sometimes a Triple C case may appear static but, by considering the subtleties of frequency and intensity of the behaviours, the individual may be escalating. For instance, in elementary school an IOC’s temper tantrums typically occurred once every two weeks, and the individual always tearfully apologized to the teacher within the hour. Now, in middle school, the IOC’s tantrums were happening several times a week, and when the student returned to class, rather than apologize, they would glare at their teacher. This would denote a shift in their baseline behaviour. An increase in frequency and intensity, that emerged later in the developmental period, signalled failing or failed intervention strategies, new stressors, and failed/failing coping mechanisms. *No professional should make conclusions about this case, or others like it, until context, intent and other variables are considered.

Case Study Two:



In other cases, it may be pure version Triple C, but the level of dangerousness has increased. Consider the IOC who attended a single-story elementary school with no stairs. When they were in the ‘cute’ phase, they would push their EA/TA in the back of the legs, trying to knock them over. Because they did not have the strength to topple the EA/TA, no serious efforts were made to eliminate the behaviour. Then, in their first year at a two-story middle school, the IOC - older and physically stronger – pushed their EA/TA who fell down the stairs the third week of school. *No professional should make conclusions about this case, or others like it, until context, intent and other variables are considered.

Triple C can be present in both urban and rural school settings; however, it is sometimes smaller schools and communities where there is a higher level of tolerance, leading to a delayed response for assessments or interventions that should have occurred much earlier. Often, family or other relational connections between school

staff and parents/caregivers, in smaller communities, or more intimate school programs (e.g. private schools), has resulted in underreaction, with the reasoning being, 'That's just the way he/she/they (IOC) are'. When family, school, and other professionals realize, 'I think we missed something with the neurodivergent student,' corrective action can be taken quickly.

The problem arises when school recognizes Triple C is present, but more dangerous, because the threat-related behaviour is coming from a bigger body, while the parents/caregivers do not. Educating parents/caregivers in Triple C can help keep the student out of the middle of adult conflict about risk. Only clear policy, practice, and professional (VTRA) collaboration can resolve this concern by addressing that even if the IOC's behaviour is their typical baseline there can be 'too high of a baseline' for the current school to manage on their own.

It should be noted that there are some government education directives, school board/district/division policies, and senior leadership procedures in our school board/district/divisions that need to be reviewed. These have led school principals to assume they must educate all neurodivergent students in the regular school setting, regardless of the severity of their risk to others. This is not correct and will be addressed at various points throughout these guidelines.

Review Earlier Assessments and Diagnoses:

In some cases, students new to a school or board/district/division come with reported diagnoses from parents/caregivers, only to discover during the VTRA that they have never been officially diagnosed. In other cases, students who have been in the same school district/division for several years receive support based on notes from a counsellor or other employee indicating a diagnosis of neurodivergence or another DSM-5-TR diagnosis, which everyone assumed was confirmed but was not. When a VTRA is warranted, teams should always confirm diagnoses and, if confirmed, consider whether re-evaluation is necessary. The following are a series of prompts for the clinical member of the VTRA team to consider:

- a) What is the current diagnosis?
- b) Was it a verifiable diagnosis?
- c) Who was the evaluator?
- d) What were the test conditions?
- e) What was the age and stage when the IOC diagnosed?
- f) Could it be a misdiagnosis?
- g) Does there need to be a re-evaluation?
- h) Are there or could there be other diagnoses?
- i) What is being viewed as the "primary diagnosis" and is it possible that the "secondary diagnosis" is the actual primary risk enhancer that is not being treated (e.g. ASD is the primary diagnosis, but untreated ADHD is the actual primary risk enhancer)?
- j) What developmental milestones are influencing current diagnosis or previous evaluation? Transition from middle to high school (social anxiety, depression, alienation)

Whenever possible, a re-evaluation is recommended. Evaluations are frequently moment specific. Diagnoses are typically contingent on the instruments used, experience of the evaluator, interpretation of the data, mindset of the IOC, and other factors.

Dr. Tony Beliz

Aetiology of Neurodevelopmental Disorders (2023)

In addition to other factors..., adverse experiences during the developmental period have been demonstrated to have long-term impacts on a range of outcomes for those affected. Neglect and abuse in childhood can result in features that resemble those of other neurodevelopment disorders (e.g. attachment disorder vs ASD) and can contribute to latter onset mental disorders such as personality disorders.

Dr. Jana de Villiers

Assessment of Context

Serious violence is evolutionary, but it is also contextual. In other words, someone could have a sustained level of risk that is both consistent with their diagnosis and how it is known to operate within them. So, when a neurodivergent student has a significant shift in baseline behaviour the VTRA team needs to hypothesize whether a contextual factor is contributing to risk including an acute traumatic experience, peer dynamics or a puppet master (usually another student) in the background encouraging the violent, threat-making, or threat-related behaviour.

PBA's:

The standard in VTRA screening or Stage One VTRA that determines how serious to take a threat or violent acting out are PBA's: Plausibility, Baseline, Attack-Related Behaviours.

Plausibility is the single most important variable in determining whether the verbal/written/physical gesture threat should be taken seriously enough to screen the case for a possible VTRA.

If the IOC is not known to the team or is new to the program, workplace, or community, then establishing baseline may be more difficult at the time of the screening phase. Thus, plausibility alone will justify the activation of the VTRA protocol.

Baseline Behavior is the single most important variable in the VTRA process to determine if the IOC is on a pathway to act out violently. "Serious violence is an evolutionary process and any significant increase or shift in baseline denotes evolution" (J. Kevin Cameron, 2001).

Caution: Even with training in VTRA™ some professionals may continue to underreact to cases because they say "That's just JD. He is always that way!" or "That's Jaz. She always says stuff like that!" VTRA teams must thoroughly consider the elements of Baseline Behavior which include History of Human Target Selection, History of Site Selection, Frequency of Past Violence, Intensity of Past Violence and Recency of Past Violence etc.

Attack-Related Behaviors are the single most important series of questions in the VTRA process (i.e. Is there any evidence the IOC has engaged in behaviors consistent with their threat) that denote they are moving from thought to action.

Remember: "If the Site-Specific VTRA team is struggling with whether to activate the protocol, you already answered your question! Better safe than sorry, do it!"

(J. Kevin Cameron, 2001)

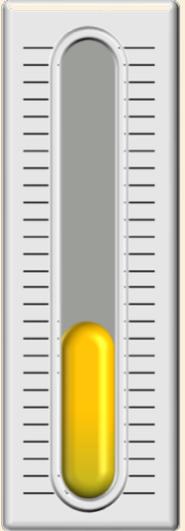
Severity of Concern Scale (SCS):

The following Severity of Concern Scale (SCS) is a non-quantitative construct for categorizing possible levels of concern. It is partially adapted from the work of Marshal, L.L (1992) whose original scale was developed for evaluating and assessing risk for Intimate Partner Violence (IPV).

Traditionally, the threshold for assessing the severity of a situation was often based on whether an IOC had engaged in criminal behavior. However, professionals trained in VTRA do not focus on whether a pre-incident sign or indicator of violence is chargeable, especially since VTRA is used to support many children under the age of 12. The evaluation of serious risk to others is not contingent upon whether an IOC has violated criminal codes; rather, it focuses on assessing their evolution along an individualized pathway of concerning behaviour. Furthermore, it is essential to consider whether an elementary-aged student, especially one in early elementary, has the capacity to pose a genuine risk of serious harm. This consideration underscores the importance of developmental, contextual, and situational factors in conducting comprehensive risk assessments for neurodivergent students.

The **Severity of Concern Scale** was developed by CTIP to determine the necessary comprehensiveness of a VTRA (i.e. Screening, Stage One VTRA, Stage Two VTRA) based on the degree of harm posed - or potentially posed - by an IOC at the time of assessment. A student whose shift in baseline includes shaking their fist at a peer or kicking the garbage can in anger while leaving the classroom, would generally be assessed as low risk on the SCS. A student who keys a staff member's car after being corrected for inappropriate behaviour in the classroom would be assessed as moderate on the SCS, if they never engaged in that type of behaviour before. Alternatively, a student who attempts to stab a peer or staff member with a knife brought from home would be assessed as high on the SCS.

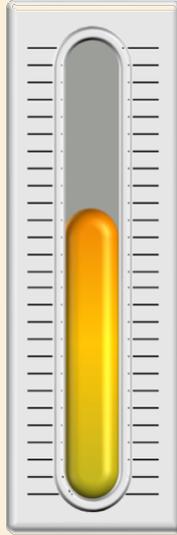
Moderate-severity threats would warrant "Screening" at the school level, but high-severity threats, acts of violence, or threat-related behaviour would automatically warrant a Stage One VTRA. The VTRA Team must then determine whether it is reasonable for the IOC to remain in the school setting at this time or if immediate threat management strategies are necessary.

Low Severity of Concern (SCS)		
<ul style="list-style-type: none"> ▪ Presenting baseline is consistent with the diagnosis. ▪ Contextual variables have been stable and unchanged (e.g. classroom setting, staff members, family, etc.). ▪ Psycho-emotional baselines are consistent with diagnosis, such as: <ul style="list-style-type: none"> ○ ADHD - Time on task is consistent (no rapid cycling beyond the baseline) ○ FASD - Adapts to social cues consistent with baseline and diagnosis ○ ASD - Appropriately regulates ▪ IOC demonstrates appropriate adaptations to proximal cues, such as shifting classrooms, transitions in school, and other environmental changes. 	<p>Severity</p> 	<p>Assess these behaviours in the context of the student's individual diagnosis and baseline functioning:</p> <ul style="list-style-type: none"> • Made threatening gestures or faces • Shook a finger • Shook a fist • Threatened to destroy property • Hit or kicked a wall, door, or furniture • Threw, smashed, or broke an object • Threw an object • Threatened to hurt the target • Threatened to kill themselves • Threatened to kill the target • Pushed or shoved the target once and ran away • Pulled the target's hair • Twisted the target's arm

Moderate Severity of Concern (SCS)

- Presenting baseline is less consistent with the diagnosis, and there is acute and/or intermittent escalations.
- Contextual variables *seem* stable and unchanged at school (i.e. classroom setting, staff members, etc.).
- Psycho-emotional baselines are less consistent with diagnosis, such as:
 - ADHD - Time on task is acutely or intermittently inconsistent (increased cycling beyond the baseline)
 - FASD - Adapts to social cues acutely or intermittently inconsistent with baseline and diagnosis
 - ASD - Fixation is acutely or inconsistently shifting in frequency, intensity or both.
- IOC demonstrates compromised adaptations to proximal cues, such as shifting classrooms, transitions in school, and other environmental changes.

Severity



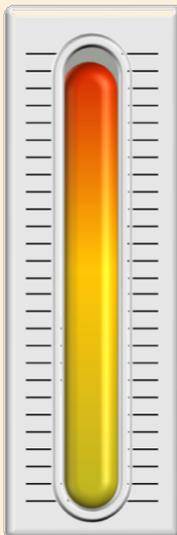
Assess these behaviours in the context of the student's individual diagnosis and baseline functioning:

- Threatened to harm or damage things the target cares about
- Threatened someone the target cares about
- Destroyed something belonging to the target
- Scratched the target
- Grabbed the target suddenly or forcefully
- Bit the target
- Punched the target
- Kicked the target
- Slapped with the palm of their hand
- Slapped with the back of their hand
- Slapped around face and head

High Severity of Concern (SCS)

- PBA's are present.
- IOC's baseline is significantly shifted in Frequency and Intensity.
- IOC is rapidly cycling between cognitive domains and affective domains resulting in a intensification of behavior (e.g. shifting from angry threat making to sobbing within minutes).
- IOC is activated intensely by any proximal cues (transitions)
- Strategies that usually regulate the IOC have shifted to action; threat to kill someone and observed following the target around the school.
- Screen data indicates contextual variables are unstable.
- IOC is locked into behavioural domain with a sustained level of risk (e.g. found to have had a knife on them for the past three days and telling more peers each day that they are going to "shank" the target.

Severity



Assess these behaviours in the context of the student's individual diagnosis and baseline functioning:

- Threatened with a replica knife or gun
- Threatened with a weapon
- Threatened with a club-like object
- Threatened with a knife
- Threatened with a gun
- Attempted to attack with a weapon
- Attempted to attack with a club-like object
- Attempted to attack with a knife
- Attempted to attack with a gun
- Held target down, pinning in place
- Stomped on target
- Burned target with something
- Attacked with fists or feet
- Attacked with a weapon (knife, club, desk, gun, etc.)
- Choked target

Foundational to all VTRAs with neurodivergent students is evaluating their level of acute or chronic dangerousness. It is crucial to differentiate between plausible threats that require VTRA and those that do not. For example, a student posting something hurtful online about another student and threatening to airdrop an embarrassing picture of them at school is not the same as having a knife in their locker at school, consistent with their online threat to stab a staff member or student. Although both plausible, the threat to airdrop would not activate a VTRA protocol but the knife incident would.

Severity of Concern Scale (SCS) Case Examples:

Case Study Three:



Low Risk: A student with ASD, whose baseline behavior includes difficulty managing sensory overload, becomes overwhelmed in a noisy hallway. They clench their fists and glare at a peer who accidentally bumps into them. However, consistent with their baseline, they use learned coping strategies, take deep breaths, and walk away without further incident.

Case Study Four:



Moderate Risk: A student with ADHD, whose baseline includes struggles with impulsivity and frustration tolerance, reacts to an unexpected change in routine by shoving a teacher who redirects them, then running out of the classroom. While they have previously expressed frustration verbally, their escalation to physical contact and a subsequent online post about “getting back” at school staff indicates a shift from their typical baseline behavior.

Case Study Five:



High Risk: A student with an undiagnosed neurodevelopmental condition, whose baseline includes difficulty with impulse control and emotional regulation, repeatedly expresses violent ideation. Unlike previous expressions of frustration, they are now found carrying a hammer in their backpack after making direct threats to attack a peer, signaling a significant shift from their established patterns of behavior.

Additional Considerations for VTRA Teams:

- a) Is there a peer relationship dynamic contributing to risk?
- b) Is there another student acting as a ‘puppet master’ in the background?
- c) Is there a current crisis or loss in the school or community that has elevated overall school anxiety?
- d) Is there a social media dynamic contributing to risk?
- e) Is there an AI relationship or is there online exposure (e.g., exposed to images on the dark web or gaming) that has triggered an acute response?

Intent as an Important Consideration:

When assessing the potential for violence in neurodivergent students using the Severity of Concern Scale (SCS), it is critical to consider not just the severity of the behavior, but also the intent behind it. While the scale helps determine the necessary comprehensiveness of a Violence Threat Risk Assessment (VTRA), it is equally important to recognize that for some students, especially those who are more profoundly neurodivergent, violent or aggressive behavior may not stem from an intentional desire to harm others. Rather, these actions can be a reaction, often referred to as 'reactive violence', triggered by a perceived threat to their own safety, space, or well-being.

For instance, a student might react violently if a teacher raises their voice, makes sudden movements, or grabs the student's arm. To the student, these actions may be interpreted as threatening, even though that may not be the teacher's intention. In these situations, the student's behavior is a defensive reaction, not an act of aggression with premeditated intent to harm. When these types of behaviors occur, they may present as a heightened response to stress or a perceived violation of personal space or boundaries.

This context is important when assessing risk because not all violent behaviors are equal in intent. A student shaking their fist at a peer, or kicking a garbage can in frustration, while concerning, may be indicative of heightened emotions but not an immediate or premeditated threat. On the other hand, a student who resorts to more severe actions, such as attempting to stab a peer or staff member, may indeed be expressing a more dangerous escalation. By distinguishing the intent, the VTRA team can help differentiate between behaviors that are reactive and those that are intentional, allowing to tailor their interventions more effectively.

Understanding intent is crucial for providing and adapting appropriate interventions. If a student's violent behavior is reactionary, then the intervention may need to focus on helping the student develop better coping skills and a greater sense of safety within the school environment, rather than simply focusing on discipline or controlling the behavior. Reactionary violence is often rooted in an overwhelming sense of fear, confusion, or frustration. In these cases, increasing the student's sense of predictability, safety, and emotional regulation can be key to reducing the likelihood of future violent episodes.

In addition to reactive violence, it is also important to recognize that some neurodivergent students may be vulnerable to manipulation by peers or external influences. As noted earlier, there may be a "puppet master" dynamic where certain individuals may exploit a neurodivergent student's need for social acceptance, pressuring them into making threats or engaging in harmful behaviors that they do not fully understand and is atypical for their normal behaviour patterns. Students that fit this profile may act out not because they intend harm, but because they believe compliance will earn them friendship, validation, acceptance, or a sense of belonging. In these cases, the student's behavior is less about personal intent and more about external influence, reinforcing the need for a thorough VTRA process that examines all contextual factors surrounding an incident.

Recognizing that violence may be a reaction to perceived threats or the result of manipulation, plays a key role in accurately assessing and addressing risk. It also underscores the importance of providing not just behavioral management strategies but also incorporating trauma-informed care and proactive safety measures that help neurodivergent students feel secure and supported in their school environment.

Case Study Six:

A 14-year-old student diagnosed with ASD was persuaded by peers to send a threatening message to another student, stating, “You better watch your back tomorrow.” The IOC complied, wanting to ‘fit-in’ and be accepted by the group, despite having no personal issues with the other student. Typically, the IOC’s baseline is non-aggressive, with a tendency to avoid confrontations, focusing more on academic interests. They also have a strong desire to make friendships, though often struggle with social interactions. Recognizing the student’s eagerness to belong, peers exploited this vulnerability by convincing the IOC that sending the threatening message would demonstrate loyalty and ensure their friendship. The IOC, lacking understanding of the severity of the action, agreed in hopes of being accepted and belong to the peer group. When interviewed, the student expressed confusion over the resulting concern, stating they “liked the peer who they threatened” and “had no intention of hurting them”. Their primary motivation was a desire to belong, not to intimidate or cause harm.

This case underscores the susceptibility of students with ASD, during developmental milestones, to peer manipulation, leading to actions that conflict with their typical behavior and intentions. It highlights the importance of monitoring social dynamics and providing guidance to prevent exploitation of vulnerable individuals.

Case Study Seven:

A grade seven student diagnosed with FASD and ADHD had a high but sustained baseline in elementary school that involved her kicking and throwing objects in the classroom, yelling at the female teacher, and using sexualized threats towards her peers. The transition from grade six to seven involved moving to the new junior high school. Her individual program plan was re-evaluated and modified based on her age, current functioning, available resources, and the newness of the setting. From September to December, her baseline decreased in both frequency and intensity.

During the first week back to school in January, she was staring at her female teacher in a way that felt “very unusual” to the teacher, who decided to walk up to the students’ desk and quietly ask if she was okay. When the teacher approached the student, she reached into her backpack, pulled out a wooden spoon, and started hitting the teacher in her head and torso. Several students intervened and physically stopped the assault from continuing. This new behaviour (assault with a weapon) represented a profound increase in the student’s baseline, and was highly traumatic for the teacher, EATA, and other students present.

Throughout the VTRA process, the multidisciplinary team found that, during December Break, the IOC’s mother caught her looking at pornography. For the first time ever, the IOC assaulted her mother with a large wooden spoon – a spoon her mother always threatened to use on her daughter but never did. Both mother and daughter kept the secret, but the daughter was internally traumatized by her own act of violence towards her mother. The unresolved conflict (assault) between mother and daughter led to her mother noticeably pulling away (distancing herself) from her child. During the VTRA interview, the student said in her defense that the teacher “was ignoring me and it f...ing pissed me off”. The police member of the team interviewed mom and asked her “if she felt safe at home?” Mom broke down in tears and admitted to the earlier assault by her daughter. Family support and re-evaluation of the IOC by mental health and psychiatry occurred including the additional diagnosis of PTSD for an undisclosed sexual assault two years earlier.

As a trauma-informed threat assessment model, we are seeing more students who are bearing the weight of being traumatized by their own acts of violence (at home or in the community) and then acting it out at school, in what is referred to in human systems theory as a parallel process. To those outside the school system, a case may appear to be “school violence” that the school is solely responsible for addressing. However, in many cases, the behavior stems from family or community related dynamics manifesting at school. Effective intervention requires strong multiagency VTRA collaboration to accurately assess and respond to such cases.

Adult Incongruence as a Risk Enhancer:

Theoretical orientation is a framework that successful helping professionals have developed through their academic studies and practicum placements to guide their assessment and interventions for specific presenting issues. The more experienced and skilled a helper, the more likely they have modified their perspective over time with more clinical (or classroom) experience and an ongoing critical review of the best current research and proven or promising practices available. VTRA is a data driven, systems-oriented model that likewise follows this framework of research and practice and continues to thrive by constantly considering the neurodivergent IOC as a whole person (Cole, 2023; Kazda et al., 2021 and wondering about how the following may be contributing to risk:

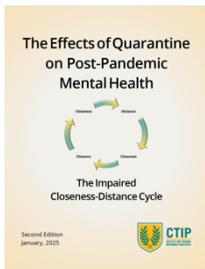
- A) Individual Functioning (personality traits and characteristics)**
- B) Mental Health Diagnoses (DSM-5-TR, ICD-11, etc.)**
- C) Contextual Factors (current setting where escalation has occurred)**
- D) Historical Factors (past undiagnosed or untreated trauma, losses, etc.)**
- E) Current Dynamics (family, peer, online/social media, etc.)**
- F) Other**

The limitations/barriers in some of the emerging VTRA cases is that some professionals' theoretical orientation is derived from their own personal experience and that of early mentors or linked to one or two early research articles that they feel 'prove' their position is correct. This can be intensified if the professional or para-professional has a family member diagnosed with a neurodevelopmental disorder and they assume that:

- a)** they are experts on all cases, and
- b)** every student (client, patient, etc.) functions like their own family member.

This adult dynamic is a frequent risk enhancer because some of these helpers only see the diagnosis and assume everything the child does is because of the diagnosis. This is simply not correct in most of the high-risk VTRA cases.

Ten neurodivergent students can engage in serious violence, threat-making, or threat-related behaviour for ten different reasons. In one case, their diagnosis may be the primary contributor to current risk; in another, it may be a secondary contributor. It is also reasonable to consider that their current risk may be unrelated to their diagnosis and instead linked to some other contributor, like being a witness to violence in the home and other adverse childhood experiences (ACEs). Below is a link to an *updated version* of a paper originally published by the lead author during the pandemic examining the effects of quarantine on family functioning; effects that are now emerging in many VTRA cases.



[Click Image to Access Document](#)

Without multi-disciplinary data-driven assessments and congruence amongst the adults most influential in a student's life (e.g. parents/caregivers, psychiatry, psychology, education, mental health, child protection, EA/TAs, etc.), we are often seeing the neurodivergent student subject to the unresolved conflicts between the adults. Conflicts that are usually about etiology, rather than open and collaborative discussions that place the student at the centre of a circle of care.

In these cases, the adults are locked in open (and sometimes unspoken) disagreements with each other about **cause** which has become the primary reason why some students become the symptom bearers of the adult conflicts. What follows in this section are some additional dynamics evolving in our national VTRA case work, followed by recommended solutions.

School:

Consider the student who hears their own parents/caregivers fighting about the legitimacy of the IOC's diagnosis and what they are 'capable of' and then place the same child in their school the next day. A school where a skilled helper sees the student holistically and identifies areas for growth behaviourally, interpersonally, etc., but finds themselves in constant conflict with a long-standing colleague or supervisor who views the student only in light of the diagnosis (IOC as ADHD, FASD, or ASD, etc.). Conflicts also occur over ***behaviour management versus behaviour modification strategies**. Neurodivergent students can sense the tension between important adults in their lives and bear the conscious or unconscious weight of feeling like they (the IOC) are the cause of all the problems. Some neurodivergent students' extreme escalations have been a result of being caught in the middle of this adult conflict, and often their target selection becomes the staff member trying to encourage growth. Several of these assaults have occurred immediately after two staff members were arguing within earshot of the student about 'realistic expectations'.

*To clarify, behaviour management focuses on fostering prosocial habits and minimizing inappropriate behaviours through consistent strategies. It relies on positive reinforcement to encourage desirable behaviors, modeling to provide students with examples to emulate, and developmentally appropriate consequences such as thoughtfully designed time-outs for undesired behaviours. By creating a structured environment, this approach aims to enhance students' sense of security and belonging, aiding in the development of self-control and emotional regulation.

Behaviour modification is a more intensive method intended to address specific behaviours. It involves operant conditioning to systematically increase or decrease behaviours and to guide students toward desired behaviours. While effective in addressing certain behavioural challenges, behaviour modification must be based on thorough assessment to prevent negative impacts on a student's self-perception and sense of belonging, ultimately resulting in a more stabilized baseline.

When applied effectively and respectfully, both approaches often influence the wellbeing of neurodivergent students. Behaviour management cultivates a supportive environment that enhances the development of critical life skills, contributing to overall wellbeing. Conversely, behaviour modification, when applied sensitively, can improve academic and social outcomes. However, if applied without care, it might feel punitive, affecting the student's self-view and school experience (Scott et al., 2023).

An often-complicated adult dynamic is a teacher and EA/TA conflict that goes unresolved, that can create two different standards for behaviour and discipline in the class for students in general, and the neurodivergent student in particular. As noted, many neurodiverse students are acutely aware of, and influenced by, the stress and anxiety of important adults around them. They may visually appear unaffected, but once their tension surpasses a personal threshold, those with the potential for violence may act out against the staff member they perceive as being in the wrong or as the cause of the tension in the classroom at that time.

Board/District/Division/Ministry/Department:

Coming out of the pandemic, CTIP has seen up to a 400% increase in complex case consultations with well over half of the VTRA cases centered on neurodivergent students who engaged in extreme acts of violence, attempted violence or concerning behaviours. Complicating the situation is that school resources have become increasingly stretched as teachers, and especially EA/TAs, are away from the workplace due to work related injuries or stress as related to threats of violence from students, leaving them feeling unsafe in the workplace. With an overreliance on the same and increasingly limited resources, system, school, staff and student anxiety has increased, contributing to the steady development of symptoms in some of our neurodivergent students. Adding to the stress on systems and schools, the pressure on school board/district/division leadership, as a result of provincial legislation or policy, are compelled to try to keep neurodivergent students in schools, and often times mainstream classrooms, even when there is a high level of concern for safety and dangerousness. Some education ministries/departments have provided little counsel or tangible support when an IOC poses a significant risk of bodily harm, offering only the advice to 'make it work; they need to be in school'.

External to School Professionals:

The complexities in student behaviour have led to significant lack of alignment, coherence, among professionals at various levels - within education ministries/departments, school boards/districts/divisions, and schools - when it comes to threat assessment and risk management for neurodivergent students.

This misalignment extends beyond education to external professionals as well, including medical practitioners including but not limited to, psychiatrists, psychologists, and pediatricians, who often have considerable influence over parents and caregivers.

When a parent/caregiver says that the doctor said, "my child is not a risk" or "they diagnosed my child with ADHD and you are required to accommodate them", many school systems and schools have felt compelled to comply even though the school system and school could clearly see and demonstrate the increasing risk culminating in an eventual extreme behaviour or event. In too many of these cases, external professionals have been non-responsive, incorporative, or at least disinterested, in the professional insights from the education system. This is evidenced by how often decisions about violent risk of neurodivergent students have been made outside of the school, without including school system or school personnel and without school data about the IOC. As noted, VTRA is a data-driven model; yet there are many cases where external professionals make commentary and decisions about school safety based solely on what parents/caregivers, and sometimes the IOC, communicate to them.

The standard in VTRA is simple: if an external professional (no matter what their credentials) assesses risk without receiving the school system (schools') input and data regarding the details of the incident and overall risk-related data, then the external evaluation should not be viewed by the school system and/or school as a data-driven assessment, as relates to the case at hand. To be fair, many external professionals have given a 'clean bill of health' to the IOC's because the parent/caregiver never told them about verified violent incidents. For example, they do not tell the external professional that the VTRA team found the knife consistent with the student's threat, or what was described as an 'accidental bumping' of another student involved premeditated pushing the target down the stairs with two hands.

Parents/Caregivers:

When positive collaboration between school professionals and external professionals does not exist, it is often that the parents/caregivers and the neurodivergent student who are caught between conflicting recommendations, planned, and agendas. They are left to decide 'who to listen to' or 'agree with' in VTRA-related cases. Invariably, agreement will rest with the psychiatrist, psychologist, pediatrician, etc., who, in many regions, is not VTRA trained.

When this happens, it may leave the school system and school excluded from the assessment of risk, yet responsible for implementing external professionals' interventions that may not align with the IOC's diagnosis, the environmental dynamics, or current risk. This misalignment is also due to professionals' limited time to communicate and effectively collaborate, which ultimately becomes the primary reason for failed interventions. In other words, the lack of communication, collaboration and data-driven assessments resulting in non-data-driven interventions is a primary risk enhancer in many of our moderate to high-risk cases.

When school system and school VTRA team members have access to all relevant data from parents/caregivers and external professionals, and these professionals likewise have access to the school data, they can conduct assessments with relative ease and efficiency. This allows them to identify why the IOC's baseline (SCS) escalated so high and how to intervene without suspension or expulsion in most cases. In some cases, data-driven assessments may identify that the neurodivergent IOC may be safer outside of the school setting as part of a **'Not Right Now' (NRN)** approach for school attendance if significant risk of harm to others or self is present. If the VTRA indicates that the level of risk is contextually too high and NRN is the best immediate risk reducer, then a return to school should not be considered until there is evidence that other identified interventions are working before re-entry. However, most VTRA-related NRNs are usually very brief (one week or less) when all the adults understand that the intervention is meant to be helpful, not hurtful. Again, it is usually unresolved discord between the adults and failure to 'buy-in' to data-driven assessments and data-driven interventions that results in most protracted separations from school for the neurodivergent student.

Parent (Caregiver) Roles (First Contact in VTRA):

Parent(s) or caregiver(s) are central to the assessment process, and essential when the Individual of Concern (IOC) is neurodivergent. They are the necessary sources of insight and data regarding the “bedroom dynamic”, an increase or shift in baseline, and other contextual factors. Collaboration between the VTRA Team and the home provides a deeper and comprehensive assessment and stronger interventions. The caregiver’s knowledge of their child’s neurodevelopmental disorder(s), combined with their knowledge of the individual themselves, will support a more comprehensive assessment. Neurodivergent individuals may be hypo or hypersensitive. Considering this, parent or caregiver notification has the potential to both intensify the IOC’s reactions to contextual factors making them risk-enhancing, or can be supportive during the interviewing phase, acting as a calming presence and having a risk-reducing impact.

Clear, regular, and ongoing communication with identified parents (caregivers), often weekly, especially if the student exhibits impulsive or defiant behaviors. Over time, a push-pull dynamic can emerge, with families advocating for their child to remain in school. The VTRA process may involve temporarily removing the child from school, when it is safe to do so, while assessments are completed, and interventions are designed. As a result, gaining the family’s “buy-in” from the start requires careful planning. Schools do not want to be perceived as disciplining, instead emphasizing the need to slow the process to ensure all variables are considered.

Securing parental or caregiver “buy-in” will begin with a thorough explanation of the VTRA process and identifying one point person to be the family-school liaison. The professional who contacts the home should be someone the family trusts, and is familiar with, as well as knowledgeable about the specific neurodiversity involved. They will share the team’s efforts to create a thriving environment for all students and the concern about an escalated or new behaviour they have observed or been informed of. When this behaviour is atypical for the student, and the parent is also concerned it may indicate a shift towards potential targeted or indiscriminate violent acts. Remember, VTRA is meant to be helpful and mitigate potential critical situations, not hurtful. The collaborative assessment process is meant to lower risks and be supportive for the student to remain in the least restrictive environment in their school community.

Notifying parent(s) or caregiver(s) of Stage 1 activation is done at the Team’s “earliest opportunity”. Special consideration, however, needs to be given in cases where the IOC is known to be neurodivergent. Given the exceptionalities and sometimes complexities of the IOC, caregivers may need to be involved sooner rather than later, depending on whether it is thought to be helpful to have them involved from the onset. Parents can sometimes provide a calming presence for the IOC during the interview process. Teams are best situated to make this decision based on their prior experiences of planning with the family (caregiver). When to notify and involve them is a decision that will need to be made on a case-by-case basis. Soliciting caregiver collaboration is best done by an individual who is known to the family or support system and who has knowledge of the specific neurodivergence’s manifestation within the individual. They may be best positioned to discuss with the parent(s) or caregiver(s) the behaviour(s) being observed that are different than what they have known of the IOC.

The three common reasons for delaying notification of the parent(s) or caregiver(s) are the same for all individuals, regardless of neurodiversity. This would be when there are child protection issues, caregivers are potentially a risk to the site of activation, or when there are multiple individuals involved, and teams will need to coordinate when they will be notifying each parent or caregiver.

Effective Collaboration

Effective collaboration among multidisciplinary teams is essential in the Violence Threat Risk Assessment (VTRA) process to ensure comprehensive assessments and interventions. Historically, school systems and schools have taken the lead in the VTRA process. However, since the pandemic, this leadership has sometimes resulted in reduced collaboration with multi-agency organizations. This shift can lead to 'uni-dimensional' education centric assessments, which lack the diverse perspectives necessary for a thorough understanding of the Individual of Concern (IOC). Consequently, this limited approach can result in misinterpretations, overlooked risk factors, and ineffective interventions (e.g., inability to effectively "Match Resource to Risk"). Moreover, such practices may inadvertently perpetuate biases, particularly against neurodiverse individuals, leading to unfair outcomes.

Ten Barriers to Effective Collaboration and Strategies to Overcome Them:

1) Time Constraints and Limited Resources:

Barrier: Professionals across agencies often face demanding schedules and may lack necessary resources, such as personnel or funding, making it challenging to coordinate or attend meetings and share information promptly.

- **Strategy:** Implement flexible scheduling, utilize virtual meetings, and establish clear communication channels to facilitate timely information sharing.
- **Strategy:** Leverage community resources, seek external support opportunities (e.g., extended family, pastors, community organizations, etc.), and prioritize resource allocation to support collaborative efforts.

2) Inadequate Intra-Agency Collaboration:

Barriers: Agency or school system representatives may come to the table ill-prepared, without having collaborated **within** their own organization to ensure thorough data collection and to develop suggestions for interventions based on available resources.

In some instances, the representative assigned to the Violence Threat Risk Assessment (VTRA) multi-disciplinary team may not be the professional directly working with the student. Additionally, there may be multiple agency staff involved who are unable to attend the VTRA meetings and may not understand the terms of information sharing.

- **Strategy:** Ensure effective collaboration and support, by making sure that the attending agency representative is well-informed and possesses all relevant information regarding the IOC.
- **Strategy:** Encourage internal collaboration within each agency prior to VTRA meetings, including comprehensive data gathering and brainstorming potential interventions or supports that align with the agency's resources.
- **Strategy:** Each agency should assess the specific needs of the case and assign personnel with the appropriate expertise to address the identified risks, ensuring effective support and intervention. If an expert is not available, the assigned multi-disciplinary team member should gather all necessary information to make informed and meaningful contributions.
- **Strategy:** Establish clear protocols and agreements that outline the terms of information sharing, ensuring that all parties are comfortable and legal requirements are met.

3) Overemphasis on Incident-Focused Data:

Barrier: Despite claiming a strengths-based approach, teams may focus predominantly on incident-related data that underscores high risk, neglecting the individual's strengths and protective factors.

- **Strategy:** Adopt a balanced approach by actively identifying and discussing the IOC's strengths, resources, and support systems alongside risk factors.

4) Inappropriate Information Sharing:

Barrier: Sharing solely negative information about the IOC, with their parents, or staff without constructive context can reinforce negative perceptions and biases.

- **Strategy:** Establish guidelines for information sharing that emphasize objectivity, relevance, and respect.
- **Strategy:** Ensure that shared information contributes constructively to the assessment.

5) Competing Mandates and Differing Perspectives:

Barrier: Agencies may have competing mandates or differing views on interventions, often based on their specific organizational perspective.

- **Strategy:** Promote open dialogue to understand each agency's mandate and perspective.
- **Strategy:** Establish common goals for the VTRA process to align efforts and reduce conflicts arising from differing viewpoints.

6) Lack of Interdisciplinary Understanding and Bias Toward Parents and Non-Professionals:

Barrier: Professionals may lack appreciation for the perspectives and methods of other disciplines, leading to misunderstandings and undervaluing contributions. Professionals may also harbor biases against input from parents or individuals not seen as "experts," leading to potential oversight of critical information.

- **Strategy:** Organize, or attend, interdisciplinary workshops and cross-training sessions to build mutual understanding and respect among team members.
- **Strategy:** Encourage active participation from parents and caregivers, acknowledging their unique insights into the IOC's behavior and history.

7) Hierarchical Structures and Defensive Behavior:

Barriers: Rigid hierarchies within organizations can create a siloed approach and impede open communication and the free exchange of ideas, as individuals may feel constrained by their position or the authority of others. Defensive attitudes can lead to a breakdown in communication and trust, hindering the sharing of resources and responsibilities.

- **Strategy:** Foster a culture of equality within the VTRA team by encouraging input from all members, regardless of rank or position.
- **Strategy:** Implement flat communication structures (e.g., direct, transparent, and non-hierarchical) to value each member's contribution equally.
- **Strategy:** Promote an environment where feedback is constructive and viewed as an opportunity for growth.

8) Cognitive Biases and Preconceived Notions:

Barrier: Entering the process with preconceived biases, such as labeling the IOC with stigmatizing terms (e.g., “sociopath” or “psychopath”), can hinder objective assessment.

- **Strategy:** Implement training on recognizing and mitigating cognitive biases.
- **Strategy:** Encourage team members to approach each case without preconceived notions, focusing on observable behaviors and evidence.

9) Over-Familiarity Leading to Boundary Issues:

Barrier: Long-term relationships between support personnel (e.g., Educational Assistants, social workers, clinicians, etc.) and the IOC can result in over-familiarity, potentially clouding judgment and leading to boundary issues.

- **Strategy:** Regularly evaluate the dynamics of support relationships.
- **Strategy:** Provide training on maintaining professional boundaries and recognize when a change in personnel might benefit the IOC's progress.

10) Traumatic Stimuli Associated with School Staff:

Barrier: School or agency staff may inadvertently become traumatic stimuli for the IOC and their parents/caregivers, especially if past interactions have been negative.

- **Strategy:** Identify and acknowledge potential triggers within the team.
- **Strategy:** Consider involving neutral parties or external professionals to facilitate discussions when necessary to minimize distress for the IOC and their family.

General Strategies for Enhancing Collaboration:

- 1) **Inclusive Team Composition:** Ensure that all relevant agencies are represented on the multi-disciplinary VTRA team, including community organizations and individuals who can offer unique insights. For instance, involving cultural liaisons or youth workers can provide perspectives that might otherwise be overlooked.
- 2) **Flexible Participation:** Recognize that certain individuals, such as a police officer in full uniform or a social worker associated with past trauma, may act as traumatic stimuli for the IOC and their family. In such cases, it may be more effective to gather input from these professionals without requiring their physical presence at meetings.
- 3) **Active Involvement of Parents/Caregivers:** Engage parents and caregivers as true participants in the process. They can provide valuable information about the IOC's background, behavior patterns, and potential triggers. Additionally, tapping into existing family supports or involving trusted individuals from the family's network can enhance the effectiveness of interventions.
- 4) **Regular Communication:** Establish clear channels for ongoing communication among all team members, including scheduled meetings, shared digital platforms, or regular updates to ensure that everyone remains informed and engaged.
- 5) **Creative Problem-Solving:** Encourage the team to think creatively when addressing barriers such as time constraints or limited resources, which might involve flexible scheduling, virtual meetings, or reallocating resources to prioritize the VTRA process.

- 6) **Continuous Team Training:** Provide joint training sessions for all agencies involved in the VTRA process to ensure a shared understanding of protocols, enhance mutual respect, and foster a cohesive approach to threat assessment and intervention.
- 7) **Staff Training:** It is essential that administrators, counselors, case managers, (i.e., resource, inclusion, and learning services teachers), receive Level One Violence Threat Risk Assessment (VTRA) training. Additionally, all personnel across various agencies, including teachers, educational assistants, social workers, and mental health clinicians, etc., should possess a foundational understanding of the VTRA process. This understanding will help eliminate confusion, and increase meaningful participation in the process, for any staff member who is involved in a VTRA situation.
- 8) **Fair Notice:** Ensure all parents/caregivers receive Fair Notice information (via a letter home, student agenda book, or school website) at the beginning of each school year. Additionally, provide a **Parent Overview: 'What to Expect'** only to parents/caregivers whose child is identified as the Individual of Concern (IOC) in a VTRA process.

By identifying these barriers and implementing targeted strategies to address them, VTRA teams can enhance their collaborative efforts, leading to more comprehensive assessments and effective interventions.

Bead on a String

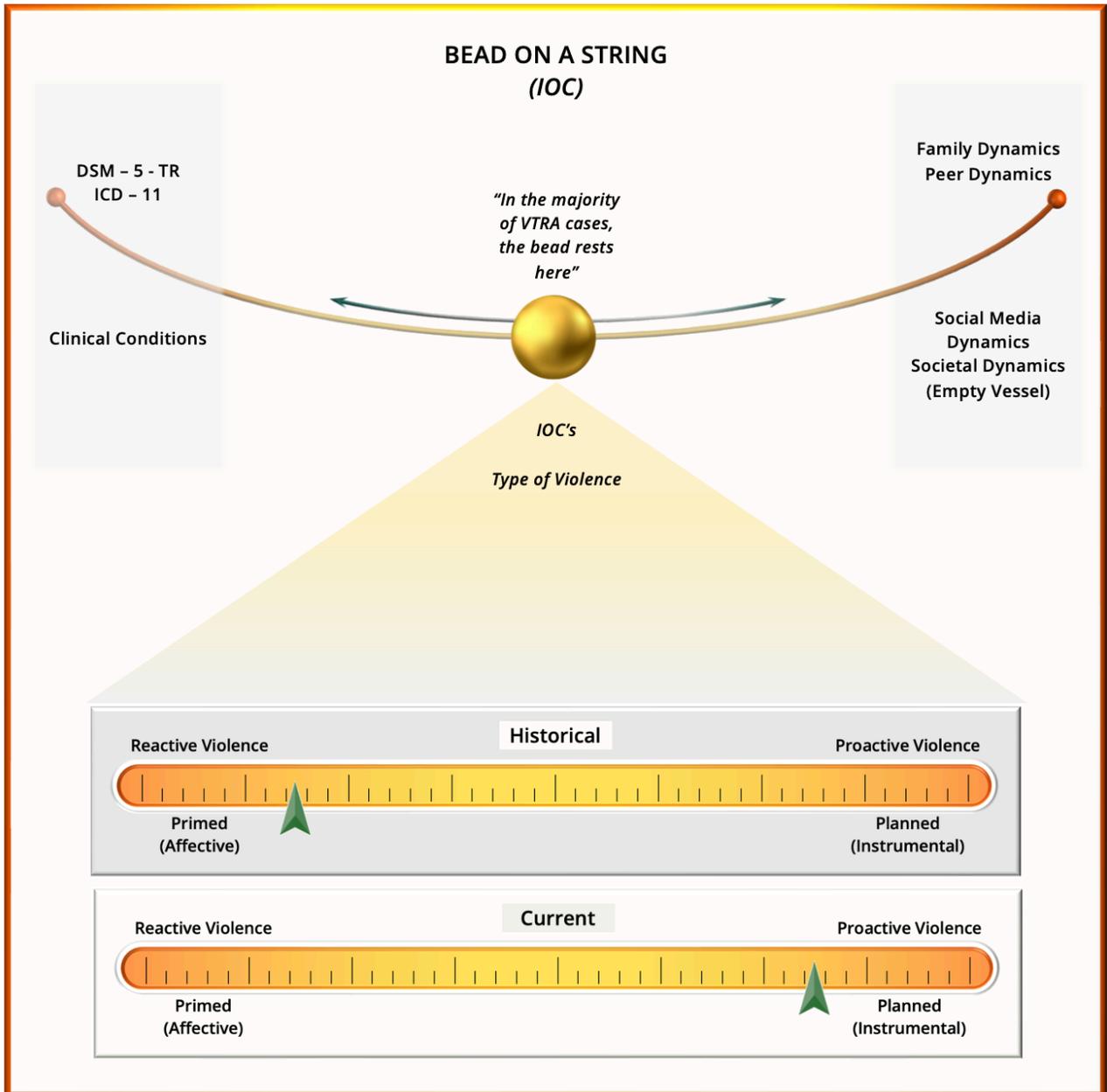
Bead on a string is a visual representation of the VTRA approach to assessment and intervention. If the bead is on the far left, and risk for violence is present, there may be undiagnosed or untreated clinical conditions. It also guides teams to hypothesize that the shift in baseline may be a result of active symptoms, for a known pre-existing condition, that the school has never seen manifest in the IOC before. This could be due to:

- An acute stressor that activated symptoms.
- The IOC has stopped taking psychoactive medication, but school was not informed.
- The IOC is on new medication, but the school was not informed.
- Other.

If the bead is on the far right, and risk for violence is present, the team is hypothesizing external risk enhancers that may be contributing to the IOC's current violent, threat-making or threat-related behaviour. In essence the VTRA team is always weighing, "is the current situation primarily a result of active mental health concerns or clinical/neurodevelopmental manifestations or could there be relational dynamics that are the primary risk enhancer"?

When the bead rests in the middle it means there are both internal and external factor interacting to contribute to risk. Most moderate to high risk for violence cases with neurotypical and neurodivergent children and youth are due to an interaction between both poles.

The VTRA model also distinguishes between affective (emotionally based) violence which denotes the act was more reactionary and instrumental (planned and purposeful) violence which denotes a more sustained commitment by the IOC to engage in the act of violence.





Case Study Eight:

An example of matching resource to risk is a case of sexual violence/threatening behavior, where the IOC (KM), a neurodivergent student, began following another student (ES) around the school after sharing a class together where they shared seats at a group table. The positive interactions in class led the IOC to develop strong feelings for the other student that they felt were reciprocated because the other student treated them with kindness.

KM began acting out in ways that denoted a pathway to harassment and potential violence when they said to ES, "I know you love me, and I love you. I will kill anyone who tries to take you from me." KM continued to follow ES in the halls. Silently watching ES during free time created strong feelings of discomfort for the student being fixated on and others who began noticing the behavior. During one instance KM was observed with their hands in their pants pockets while engaging in what appeared to be self-stimulation while watching ES.

ES was an athlete and some of their teammates later cornered KM in the bathroom after school and pushed them up against the wall several times telling KM that they were a pervert and to leave their friend alone. KM laid low for a couple of days, keeping distance from ES while avoiding ES's teammates. Then KM began carrying a knife to school in case anything happened again. KM began researching where ES lived and how ES got home after school. A journal found in KM's bedroom indicated the following: "When the timing is right, I will make ES my crush forever, ES will love me...."

In this case, interpretation of feelings and social cues contributed to KM moving along a pathway to violence potential and to being the recipient of violence. As the VTRA process was activated initial risk enhancers were identified including puberty, social media, peer dynamics and Mom's new boyfriend teasing KM 'what's wrong with you, why don't you have an intimate partner yet?'

With all PBA's being present and a high SCS (obtaining and bringing a weapon to school along with stalking-like behaviour) KM and ES were assessed, by the VTRA team, to be contextually safer by KM remaining home until a comprehensive "Whole Person Assessment" (WPA) was complete. NRN was implemented as part of the initial intervention. As well as finding and removing all knives and constant supervision by parent/caregiver of KM, further data and insights were being collected and considered.

KM's pornography addiction, and fascination with knives more clearly came to light as all the adults collaborated on the shift in baseline. Stepdads' lack of understanding regarding how his teasing of KM about why they didn't have a partner also contributed to risk as well as the typical hormonal changes of adolescence that weren't being considered. The stalking and sexualized harassment had also been present for some time, Triple C dynamics became evident as staff members appeared to underreact because KM was cute, and school staff had assumed that their behaviour was "typical" of students diagnosed with ASD.

Short-term **NRN** was also necessary to protect KM from friends of ES who were making vigilante threats as well as addressing that KM had become traumatic stimuli to ES who initially feared for their safety.

Case Study Eight (Continued):

In this case we would say the initial fixation by KM was reactive because of being shown kindness by ES. However, to have such a steep increase in baseline is usually because the IOC was already primed to find and fixate on a partner: in this case exacerbated by a pornography addiction. Bringing the knife was proactive because of fear of further violence from their peers but in interviews KM had not processed what they would do with the knife. This denotes a lower risk intent to harm others but a higher risk 'compartmentalized' intent to protect themselves. Nevertheless, access to the means is a significant risk enhancer and whether KM's potential for violence was likely to be reactive or proactive was, at the time of the assessment, a moot point.

The multiagency (school and community) VTRA team conducted a high-level Stage Two VTRA that included re-evaluation of diagnoses, medication and developmental factors as seen through a neurodivergent brain in order to plan re-entry back to the regular school setting. Crisis response support for ES and their parents/caregivers as well as a modified restorative practice strategies laid the foundation for KM's quick return to their school.

Supporting Neurodivergent Students/Families in The Rural Context

This section focuses on the challenges of facilitating a multidisciplinary Violence Threat Risk Assessment (VTRA) process in rural and remote settings, particularly when individuals with neurodivergent exceptionalities are the Individuals of Concern (IOC). Research on neurodivergence shows that many specialized programs, training opportunities, and interventions are concentrated in larger urban areas. These supports primarily follow medical models of intervention. As a result, access to these resources is naturally more limited in rural and remote settings. The development of interventions and supports tends to center around urban hubs, creating a significant gap in availability for individuals in less urbanized areas.

VTRA trained practitioners in rural settings recognize the challenges and limitations of activating a multi-disciplinary and cross-sector VTRA. Some of the challenges and barriers noted by our colleagues are focused on resource depletion, multiple demands placed on agencies, and limitation of specified community-based interventions for neurodivergent IOC's as a few of the presenting barriers. This notion is also represented extensively in the research. Tomeny et al. (2023) echoing the same concerns, stating that access to specialized services, trained mental health professionals, and delays in diagnosis all contribute to the compounding stress that families and their children experience related to proximal support. Hoogsteen & Woodgate (2013) discuss similar challenges facing professionals in the rural Canadian context, stating that limited resources for case specific interventions and respite care are considerably challenging in rural and remote settings.

The standard for complex cases in VTRA, applicable to both rural and urban communities, is simply stated as any case (Cameron, 2014) where a VTRA team identifies two or more risk enhancers that require the involvement of at least two agencies to lower the level of risk and sustain interventions for the IOC. In rural communities, this can be quite challenging. For example, a police officer may be needed to provide information during a Stage One VTRA but cannot be at the meeting because they need to attend to a car crash that has occurred on a local highway nearby. Similarly, a mental health professional's input may be required for a Stage Two VTRA but, because they are on a 3-day rotation serving multiple communities, they are not available for the meeting. In addition to this, an IOC who is actively threatening to harm someone may require temporary isolation from a target but there may be no safe places for intervention. Furthermore, even when an IOC gets connected to a specialized professional, the recommendations made by the professional are often not accessible or adaptable within the resources available in a rural community. For example, providing sensory rooms for a student diagnosed with ASD may not be an option for a school that has no more space.

While the limitations and barriers are sometimes the focus for professionals, especially in high profile VTRA cases, not everything rural is limiting. Rural communities have many natural strengths that permeate through diverse relationship systems and can serve positively in supporting neurodivergent students at risk of violence. As mentioned in the previous section, those professionals trained in VTRA understand that 'matching resources to risk' has application ranging from formal programs and professions to more natural supports that exist in communities. Matching resources to risk is established on the core principle and belief that families and communities have established 'agency' to solve some of the most complex of issues.

Considerations to this End:

1) What were the family's supports prior to the VTRA:

Prior to racing to the resource finish line, VTRA trained professionals should consider the level of resilience and protective factors that are present in the family system by exploratory probes such as:

- a) What have been some of your biggest challenges and how did you bounce back as a family?
- b) Who are some people in the community you relied on both emotionally, physically, and spiritually to support you?
- c) Has there been time recently where your child has done really well in the community (arena, pool, nearby museum, library etc.)?
- d) How have you noticed any of these successes and supports building your family's strength, fortitude, and connections with others?
- e) What family activities does the family enjoy together? Do they have dinner together? Watch tv together (or is everyone in isolated in their rooms?)

2) Rural communities have natural empathy:

Because many of our rural communities are more connective and personal, there is a natural tendency to join hands when times are tough. Examining a family's connections to community and assessing the community's empathy towards a family are crucial steps. If empathy and community bonds are present, it can be a primary risk reducing intervention in high profile cases. It is often the smaller, meaningful (based on the perception of the IOC and family) connections that are as impactful to managing anxiety.

3) Psychoeducational Assessments:

Emphasize strengths, such as creativity, problem-solving, or resilience, that can be leveraged to mitigate risks and promote positive behaviours (Doyle et al., 2019; Disability Rights California, n.d.). By reframing behaviours previously perceived as threatening, these tools foster a more supportive and accurate understanding of neurodiverse individuals (Young et al., 2020).

4) Multidisciplinary VTRA Team's in Rural Communities:

Communities with established VTRA protocols play a critical role in high-profile cases, especially in rural and remote areas where programs and resources are often limited. While urban VTRA teams are vital, rural teams have unique strengths. Their deep, historic knowledge of the Individuals of Concern (IOC), their families, and natural community networks enables them to implement effective risk-reducing interventions. For example, if an IOC poses a risk to both staff and a sibling, a temporary intervention might involve arranging for the sibling to stay at a friend's home until the situation stabilizes. This type of response reflects the close-knit nature of rural communities, where personal connections can be leveraged to address acute risks. In VTRA trainings, it is often noted that urban schools strive to make their 'big schools feel small,' while rural schools face the opposite

challenge: making their 'small schools feel big' with more resources. Actively functioning VTRA teams in rural and remote communities build on a key strength of these areas: a sense of connection and resilience. As an Indigenous Elder in Inuvik, observed, "Just because we live in a remote part of Canada, does not mean we feel isolated."

5) Isolation and Loneliness as Dominant Variables:

The World Health Organization has recently raised the level of concern around [*isolation and loneliness*](#) stating it is increasingly becoming a public health and policy issue across the world (World Health Organization, 2021).

For school systems, schools and families that support neurodivergent students, this dynamic can be intensified further when communities and support agencies work in siloed approaches. For example, because an IOC has threatened a target, and that threat has crossed a criminal line (possession of weapon), sometimes the response is that it is a 'police problem' and criminalization is the only intervention possible. Naturally, most VTRA teams would counter this narrative because everything we do in VTRA is meant to be helpful and not hurtful including "trauma-informed and least intrusive interventions" (Cameron 2023).

The anecdote to loneliness and isolation is connection. While this applies to both the urban and rural context, the advantage of rural communities is that VTRA teams can determine more quickly the natural connections of a family and the IOC. In assessing SCS, it is imperative that professionals fully explore the true nature of connections, ensuring they are risk reducing and bidirectional. The IOC and their families may have natural connections that are not agreeable to all team members, however, so many solutions become available to teams when we approach the question of connection with an open mind. For example, a family may offer to provide a temporary respite intervention that does not meet the general criteria of "family" as defined by children's services (but put in the context of a more remote community) may be reasonable.

VTRAs are enhanced by psychoeducational assessments, as they facilitate collaboration among educators, mental health professionals, and families to develop proactive safety and support plans (Dombrowski & McGill, 2024; Young et al., 2020). These multidisciplinary approaches ensure a comprehensive understanding of neurodiverse individuals and their needs (Bulut, 2024).

Preparing for the Intervention

Risk and Need Accommodations:

As indicated, those presenting with neurodivergence have unique differences from those who present as neurotypical. They possess numerous strengths and often provide valuable insights into their needs and the necessary accommodations, which others may otherwise overlook (Dwyer, 2022; Lollar & Horner-Johnson, 2017). However, when it comes to the potential for serious violence, it is critical to take action to mitigate risks.

Consider a differing abilities framework that accompanies many accommodations designed for individuals with exceptional needs (Lollar & Horner-Johnson, 2017). Accommodation experts match needs to appropriate accommodations based on formal assessment data. Psychoeducational assessments, for example, guide the creation of interventions tailored to individual needs. For neurodivergent individuals, this includes accommodations for sensory sensitivities and executive functioning challenges, such as implementing clear communication strategies or reducing sensory overload (Disability Rights California, 2021.; Young et al., 2020). By addressing these triggers proactively, these tools enhance safety and reduce risks (Doyle et al., 2019). For instance, if there is a mobility concern, a suitable mobility accommodation is provided, ensuring more inclusive education (Dwyer, 2022). Similarly, if there is a literacy support need, decoding or reading supports are provided so the student can benefit from

learning alongside their peers. For those with neurodivergent needs, accommodations are tailored to their unique learning, social, emotional, and relational profiles, with the goal of ensuring they can be meaningfully included and benefit from the learning environment.

However, when there is foreseeable extreme behaviours and violence, school systems must accommodate both needs *and* risks (Chua et al., 2014; Drawbridge et al., 2021). Effective risk accommodations must be based on thorough assessments, such as VTRA, which provide a comprehensive understanding of the student's potential for extreme behaviours and serious violence. While students still require need-based accommodations, they also require risk-based accommodations tailored to their specific threats and potential targets.

Schools are built and resourced for the academic and social development of students, not for managing high-risk extreme behavior. Despite the best efforts of many school system and staff, extreme behaviour based accommodations are frequently reactive rather than proactive due to limited time, training, knowledge, resources, and existing legislation/policy. Consequently, these measures are often implemented hastily and lack thorough preparation, breadth, and efficacy. Staff typically lack the expertise for such situations, and schools are not physically designed with these considerations in mind. In cases where the risk of extreme behaviours is very high, the student's needs and risks might be better addressed outside the school setting to prevent any lasting negative impact on safety and lives of others and their own.

“While students still require need-based accommodations, they also require risk-based accommodations tailored to their specific threats and potential targets.”

Dr. Coralee Pringle-Nelson

Effective risk accommodations must be commensurate with serious violence potential. This involves creating individualized risk assessment and intervention plans in collaboration with community supports, ensuring the responsibility does not fall solely on the school systems and schools (Chua, et al., 2014). Other systems need to be involved, and school systems and schools should be empowered to state, with supporting data (VTRA), that the violence potential is too high, and the student cannot be at school until an accommodation plan based on their risks and needs is established.

If possible, the aim is resolution and restoration between the student and the school. Students, despite their unique abilities and differences, still have developing brains, and their capacity for understanding cause and effect can vary widely. Within neurodivergence, there are differences in how students comprehend the consequences of their actions, and some may not fully understand the implications of engaging in extreme behaviours. Given these differences, it's crucial to develop an individualized and comprehensive plan that accommodates their unique risks and needs, elevating safety for the school and community. When practicable, the goal is to have them return to their school, or another suitable education program, with this plan in place.

Data-Driven Interventions:

The first step for developing data-driven interventions is to identify confirmed data-driven risk enhancers. In many cases, the current interventions or Individual Program [Education] Plans (IPP/IEPs) do not match the original recommendations of the psychological assessments. Or the original recommendations were so unachievable by the school, usually due to lack of resources, that the school developed their 'intuitive' program with varying degrees of success. What follows is an overview of our current post-pandemic context and the primary risk enhancers we are seeing in our VTRA cases with neurodivergent students.

In the Canadian context, the majority of **pre**-pandemic VTRA cases in schools that were assessed as moderate to high risk for violence, involved neurotypical students. In the **post**-pandemic mental health phase, which CTIP has referred to as the 'predictable delayed response to a worldwide traumatic event, we estimate 70% to 80% percent of VTRA cases are now with neurodivergent students*. This seems to be consistent with many post-secondary settings as well.

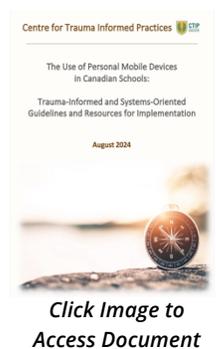
In properly conducted multidisciplinary (multiagency) VTRA's, with full buy-in from parents/caregivers, external professionals, and school professionals, combined with skillful interviewing and understanding of the IOC, we are finding consistent risk enhancers and areas for intervention. A foundational concept/variable in VTRA is "the higher the anxiety the greater the symptom development". As noted in the updated version "[Effects of Quarantine on Post-Pandemic Mental Health](#)", for some families the pandemic caused emotional and, in some cases, traumatic harm. Families with neurodivergent children were not immune to the "impaired closeness-distance cycle".

Although CTIP has not quantified VTRA cases with neurodivergent students according to risk enhancers, a qualitative look at a little over 100 VTRA/ARTO complex case consults this academic year identified the following **10 leading risk enhancers**:

- 1) Triple C:** Transition from elementary to middle/junior high and from middle/junior high to high school, have not always resulted in an accurate assessment of current functioning compared to the time of original diagnosis. Without updated behaviour management or modification plans, some students remain locked in the same concerning behaviours as in early elementary school. However, now the behaviour is viewed as 'critical' because the students are in bigger bodies. We are also seeing that some staff have not managed or modified their own behaviour and, thus, get locked into a routinized stimulus-response relationship with the IOC.
- 2) VTRA teams not seeing, hypothesizing, or too fearful to explore, the possibility that a parent(s)/caregiver(s) may be neurodivergent as well:** We hear many professionals say that parents/caregivers seem to be open and collaborative but never follow through. Although there can be many reasons why follow through does not occur, being a neurodivergent adult overwhelmed by parenting a neurodivergent child may be part of that reason.
- 3) Peer Dynamics:** For over two decades, VTRA teams have been trained that 'students with special needs' (now often referred to as neurodivergence) are the preferred puppets of our "puppet masters" Considering the range of neurodivergence, some students who are more socially and affectively driven with diagnoses like ADHD, FASD, or mild ID, are perfect for skilled peers to add to the justification process for violence.
- 4) Family-Generated:** As noted, coming out of the pandemic we have seen a significant increase in the SCS, with some cases culminating in serious violence causing bodily harm. Prior to the violence toward staff and peers, most schools were rightfully concerned about increasing risk, but the message they were receiving from some senior leaders, health professionals, as well as parents/caregivers, was often 'you're overreacting' or 'they are neurodivergent so it's your job to manage/accommodate their behaviour/risk no matter what'. In cases with dramatic shifts in baseline, we have found acute exposure to adverse childhood experience's (ACEs) or rekindled adverse childhood experiences. One of the most common challenges has been parents/caregivers saying, 'everything is fine at home' so the escalation is clearly a 'school issue.' It isn't until the VTRA team members activate the protocol and find that the police had never been to the student's home prior to the pandemic but, during the pandemic, they had 2-3-4 or more contacts with the residence due to intimate partner violence. These incidents of violence within the home, which the student (IOC) witnessed, are risk enhancers. Furthermore, witnessing ongoing abuse, or being abused, have always been considered common risk enhancers.

* Over 60 Canadian School Boards/District/Division Superintendents, Directors, and/or VTRA leads shared de-identified VTRA data with CTIP leadership from September 2024 to February 2025 distinguishing neurotypical VTRA cases versus neurodivergent VTRA cases.

- 5) **Traumatized by their own acts of violence:** Some young people may “identify with the aggressor” (<https://dictionary.apa.org/identification-with-the-aggressor>) when exposed to family violence or intense power imbalances in the home. What has been less understood but becoming more apparent in case work with both neurodivergent and neurotypical children and youth, is that some violent individuals are traumatized by their own acts of violence. At school, some escalations directed towards staff followed on the heels of a child assaulting their own parent for the first time and now, guilt ridden, acts it out towards a staff member who is a symbolic representation of their shame.
- 6) **Empty Vessel inducted into targeted online violent ideation:** Permissive, overwhelmed, or uninformed parents/caregivers often allow an inordinate amount of unsupervised cell phone/iPad/computer access. Coupled with the bedroom dynamic, this alone can be a primary risk enhancer for shifts in baseline and an increase in violent ideation or potential. Pandemic quarantine resulted in many students “getting in over their heads online”. VTRA trained professionals that work in the Countering Violence Extremism (CVE) space understand that an IOC fixated and inducted into a radicalized online echo-chambers like Involuntary Celibacy (INCEL) may be more prone to be influenced because they have no proximal connection to a healthy emotionally mature adult and not primarily because of neurodivergent diagnoses.
- 7) **Addicted to the internet and/or social media:** See *“The Use of Personal Mobile Devices in Canadian Schools: Trauma-Informed and Systems Oriented Guidelines for Implementation”*. To be addicted, an individual must meet the following criterion:
- Preoccupation or engagement with a substance or activity that has hijacked or overrode one or more of that individual's Major Life Areas (physical health, sleep/wake cycle, relationships, work / school performance, finances, hobbies and leisure).
 - A development of tolerance and dependency on the substance or activity that forms not only a reliance, but also a need of more of the same thing to achieve the desired result.
- Media and social media have become the gateway drug to actual substance use and misuse as well adding to the justification process for serious violence in all its' form. This includes the use pornography which has contributed to the many cases of students engaging in detailed sexualized threats and acts towards peers and others with a frequency and intensity we have never seen in Canadian schools before.
- 8) **New or intensified substance misuse:** Both during and after the pandemic, we've seen a notable increase in substance misuse among students, which serves as a significant risk enhancer. The isolation, stress, and disruptions caused by the pandemic have contributed to higher rates of substance use, leading to impaired judgment and heightened impulsivity. Additionally, increased parental substance use during the pandemic has adversely affected children, contributing to behavioral issues and emotional distress. This escalation not only intensifies existing behavioral concerns but also introduces new challenges in assessing and managing potential threats within schools.
- 9) **Self-perpetuating circular dynamic:** With an increasing number of school system and school staff accessing leaves of absence and the frequency and intensity of extreme behaviours and threat-related cases increasing, including weapons possession in schools, the overall anxiety in many school systems is higher this year compared to pre-pandemic functioning. In some cases, the IOCs were low on the SCS and had minor shifts in baseline school leaders, teachers or support staff were, and still are, so overwhelmed in general, that they see the neurodivergent student as a potential extreme risk when they may not have posed a risk at all. However, when a staff member who had the primary connection with a student starts to withdraw from them because of fear, it creates the “self-perpetuating circular dynamic.” Consequently, the more the staff member pulls away, the more the student escalates, and the more the student escalates, the more the staff member pulls away. This dynamic occurs between parents/caregivers and their children, as well as between siblings and friends. In this case, the important person, who is now distancing from the neurodivergent student, is ‘inadvertently



making themselves a justifiable target'. Unless there is a moderate to high for violence, towards that target, the primary intervention is to reconnect and halt the circular dynamic.

10) Need for medication review: Disruptions in healthcare access and routine during the pandemic have led to lapses in medication adherence among students with prescribed treatments. This inconsistency can result in unmanaged symptoms, increasing the risk of behavioral escalations. Additionally, parental substance misuse during the pandemic, combined with limited access to medical professionals, may have contributed to lapses in overseeing their children's medication regimens. Regular medication reviews are essential to ensure effective management of conditions and to mitigate potential risks in the school environment.

"Not Right Now" (NRN) More Fully Explained:

Depending on the nature of the threat or the severity of the aggressive or violent act, some of the above risk enhancers could not be addressed without a case specific **"Not Right Now"** (NRN) approach. This includes some cases where the VTRA team may be aware that the intent or capacity to carry out a threat is not present but, due to how the threat was delivered, the IOC sometimes makes themselves:

- 1) A justifiable target from some of their peers, and
- 2) Traumatic stimuli to the targets and other members of the student, staff, and parent/caregiver community aware of the threat.

Case Study Nine:



A student diagnosed with mild ID, ADHD, and generalized anxiety began using a new substance. Their peers were becoming concerned because the IOC was starting to physically roughhouse with them, which they had never done before. The IOC was grabbing and pinning their peers to the floor (independent of gender), and it was feeling to them like the IOC was using roughhousing as an excuse for sexual contact. One peer, after being pinned by the IOC, jumped up in anger and called them a "pervert!" The IOC shortly after airdropped a threat to the whole school that they were "coming back with a gun and were going to shoot them all". The multidisciplinary VTRA team, including police were able to determine quickly that the IOC did not have a gun or pose a risk to 'shoot up the school'. However, gangs were a growing issue in this region and earlier in the same academic year, a same age youth from their school was shot and killed just a few feet off school property. For the two reasons noted above, NRN was a primary intervention to allow more comprehensive assessment (of the sexual acting out, etc.), intervention, and a cooling off period for the students, staff and parents (caregivers) before the IOC returned to their school.

While the above example is more typical of pre-pandemic VTRA cases with neurodivergent students, another reason for these guidelines is the increase in severity (intensity) of violent acting out by students in this academic year. Complicating the increase in frequency and intensity of extreme behaviours, violent or threat making is that some school systems and schools are being pressured by external professionals, parents/caregivers, and in some cases, senior leaders to accommodate all neurodivergent students no matter what the degree of dangerousness. This has included attacks with knives, machetes, bats, clubs, homemade shanks, shards of glass, fire and accelerants, etc. No matter what the diagnosis, if there is a dramatic shift in baseline and a high level of dangerousness then their needs to be a VTRA for stabilization and intervention planning. In many cases, the acts have been so extreme that charges have been laid, and expulsion has occurred. Independent of criminal investigations and student discipline, NRN needs to occur.

Schools Are Not Secure Treatment Facilities

Many of the authors have worked in secure treatment and/or residential treatment facilities. These programs are usually not the preferred intervention in most cases. Better assessments and interventions by all the adults involved (medical professionals, education professionals, parents, caregivers, etc.) at an earlier age, when prodromal symptoms were emerging, would have prevented much of the escalated behaviour we are seeing now. This applies to neurotypical and neurodiverse young people. However, there are some circumstances where controlled respite or an actual secure setting is required. Many education professionals are not aware of the process for a young person to lose their liberty and be confined for treatment purposes. Below is the general criteria for a court ordered placement of a young person in a secure setting. We chose the Ontario legislation, as a general template, to represent the process and standards of risk necessary for admission across Canada:

Government of Ontario (Criteria for secure treatment admission)

Under Section 164 of the CYFSA:

1. The court may order that a child be committed to a secure treatment program only where the court is satisfied that,
 - the child has a mental disorder.
 - the child has, as a result of the mental disorder, within the 45 days immediately preceding,
 - the application under subsection 161 (1),
 - the child's detention or custody under the Youth Criminal Justice Act (Canada) or under the Provincial Offences Act, or
 - the child's admission to a psychiatric facility under the Mental Health Act as an involuntary patient,
 - caused or attempted to cause serious bodily harm to himself or another person.
 - the child has,
 - within the 12 months immediately preceding the application, but on another occasion than that referred to in clause (b), caused, attempted to cause or by words or conduct made a substantial threat to cause serious bodily harm to himself or another person, or
 - in committing the act or attempt referred to in clause (b), caused or attempted to cause a person's death.
 - the secure treatment program would be effective to prevent the child from causing or attempting to cause serious bodily harm to himself or another person.
 - treatment appropriate for the child's mental disorder is available at the place of secure treatment to which the application relates; and
 - no less restrictive method of providing treatment appropriate for the child's mental disorder is appropriate in the circumstances.

Notwithstanding the above reference, there have never been enough secure treatment beds in Canada for all the young people who have had, or currently do have, acute and chronic risk for 'continuing' on with serious violence ,let alone those who **"attempted to cause or by words or conduct made a substantial threat to cause serious bodily harm to themselves or another person"** ([Section 164 of the CYFSA](#)).

The difficulty over the years is that many other Ministry/Department leads (Health, Child and Family Services / Child Protection, Probation, etc.) and local community support agencies have assumed the school is:

- 1) The safest place for a child to be under ALL circumstances, or
- 2) That school has more resources than anyone else to manage a student with a high SCS, or
- 3) Schools are required to accommodate ALL students notwithstanding risk to others.

Complicating this is the belief of many educators, school, and school system leads that somehow if the IOC is neurodivergent or has another special designation, then schools are supposed to act like secure treatment facilities. This misconception has been perpetuated over the years in many ways too exhaustive to be addressed in these guidelines. What does need to be openly discussed and represented is VTRA's with neurodivergent students who are high on the SCS. An active case where extreme behaviours resulting serious violence occurred or was likely to occur without Stage One VTRA and 'immediate risk reducing interventions' would meet the criteria for secure treatment. And secure treatment facilities have:

- 1) Larger staff to client ratios,
- 2) Highly trained staff,
- 3) Highly skilled staff,
- 4) Professionals from multiple disciplines including psychiatry,
- 5) Work within an entirely secure facility,
- 6) Can contextually de-escalate an IOC because they are removed from the primary risk enhancers:
 - a) Dysfunctional family dynamics,
 - b) Dysfunctional peer dynamics,
 - c) Dysfunctional social media/online dynamics, or
 - d) A preferred drug of choice,
 - e) Etc.

Schools, on the other hand, have:

- 1) Smaller staff to client ratios,
- 2) No trained staff (or rare) with experience working in secure treatment,
- 3) Highly skilled staff trained in positive behaviour supports but not the treatment of homicidality,
- 4) Without effective VTRA protocols, no prompt or streamlined access to professionals from multiple disciplines including psychiatry,
- 5) Are not an entirely secure facility,
- 6) May not be able to safely de-escalate an IOC because if IOC is still proximal to the target they threatened, assaulted, or attempted to attack and their primary risk enhancers are still active:
 - a) Dysfunctional family dynamics,
 - b) Dysfunctional peer dynamics,
 - c) Dysfunctional social media/online dynamics, or
 - d) A preferred drug of choice,
 - e) Etc.

In complex VTRA cases where the IOC is high on the SCS and NRN is being considered, a standard in VTRA has always been that if a student is not able to be in the regular school setting for a period of time, the VTRA team must ask the question "Is the place we are sending them to going to decrease their level of risk or increase it?"

The multi-disciplinary/multi-ministry team can discuss options including the IOC remaining in school systems if:

- 1) The school system has or will be loaned (from VTRA protocol partners or others) adequate resources to manage initial ongoing risk.
- 2) The skill level of the personnel or additional personnel is a 'matched resource to risk'.
- 3) The target(s) have been supported via crisis/trauma response team intervention.
- 4) The IOC has not become blatant traumatic stimuli to the larger school system community whose current presence will impair the school administration's ability to ensure a safe and caring learning environment for all.

"Not Right Now" (NRN) for System Leaders

System leaders and school-based professionals trained in Violence Threat Risk Assessment (VTRA) understand that the VTRA process is built upon a fundamental principle that **"VTRA is meant to be helpful, not hurtful."** This guiding belief is also one of the best practices for securing **parental/caregiver buy-in**, a sentiment echoed by many VTRA-trained professionals. However, fostering and strengthening parental/caregiver engagement in an NRN strategy must begin **long before a VTRA is activated**.

Proactive Engagement with Parents and Caregivers:

To effectively support neurodivergent learners, it is crucial to examine how the system interacts with families **before** any crisis occurs. Highly effective school - based VTRA teams are reflective in considering the following:

- Are parent meetings only called when there is a problem, or is there an ongoing effort to celebrate student successes?
- Do school systems work with school teams to proactively engage with families beyond report card nights or formal Individualized Program (IP) meetings?
- Are parent/caregiver strategies openly considered and accepted.

A systemic approach that recognizes and acknowledges the strengths of neurodivergent learners - not just their challenges - lays the foundation for trust and cooperation when difficult situations arise.

Avoiding Reactionary Interventions:

High-profile VTRA cases often generate heightened anxiety among professionals, parents/caregivers, and students alike. This anxiety can lead to **time-bound, reactionary interventions** that, while initially reducing stress, may not allow for a thorough assessment. When interventions are perceived primarily as risk mitigation measures—such as suspensions or criminal charges—they can:

- Limit professional space for meaningful assessment.
- Shift focus toward justifying immediate actions rather than conducting a comprehensive evaluation.
- Focus on a the most recent diagnosis as the primary risk enhancer.
- Make decisions that concentrate on alleviating political or libelous risk.

The Role of "Not Right Now" (NRN) in Thoughtful Decision-Making:

The NRN strategy is grounded in the principle of **using the least intrusive measures** to support students, families, and the broader school community. Many mental health and child protection policies already incorporate a "**window of assessment**" - a period that allows professionals to evaluate situations carefully before taking action. By embedding NRN into systemic practices, schools can:

- Prioritize **thorough, thoughtful assessments** over immediate disciplinary responses.
- Reduce the pressure for quick decisions that may have long-term consequences.
- Create a culture where safety and support are balanced with **measured, data driven interventions**.

Moving Toward a More Supportive System:

For NRN to be effective, system leaders must champion:

- 1) **Proactive family engagement**—Building relationships with parents and caregivers before crises arise.
- 2) **A shift from reactionary to measured responses** - Ensuring professionals have the time and space to make informed decisions.
- 3) **Alignment with mental health and child protection frameworks** - Recognizing NRN as a validated approach within broader assessment practices, this allows community partners to support families by providing temporary respite, providing immediate mandate friendly services, provide the parents and caregivers some time to inquire about some of their natural support connections (i.e.) spiritual leaders, elders, extended family, friends etc.
- 4) A collective understanding that students and their families require support beyond school hours and that they and their families are citizens of the broader community context requiring creative solutions beyond the formalized mandated programs.

By fostering a systemic understanding of NRN, educational leaders can help create an environment where interventions are **helpful, not harmful**, and where all stakeholders feel supported through the assessment and response process.



Case Study Ten:

Stabilizing Risk from the Lens of “Least Intrusiveness” (Least intrusive and trauma-informed interventions does not mean we are doing nothing!)

A 10-year-old boy was described by school staff as “explosive” and “impulsive” and the unpredictability of his behavior had many staff concerned because of his indiscriminate target selection. Though his school records indicated that he was diagnosed with an “Intellectual Disability”, professionals were not clear who diagnosed the student or when. According to his biological mother, it was while she left her husband, the IOC’s stepfather. The mother also reported that she had been having a “bad spell” for the past year and had trouble getting up in the mornings and was currently being medicated for her depression.

Due to her mental health struggles, external agencies began wraparound supports for her. As the mother felt supported, she agreed to follow-through with meeting her physician who then arranged a psychiatric appointment for her son. Based on the information provided by the school and the mother, the medical team determined that the IOC had severe ADHD and was started on new medication. The ID diagnosis was neither confirmed nor disconfirmed. While the new medication did reduce the intensity and frequency of the outburst, the IOC continued to struggle at school.

The VTRA protocol was activated after two students were arguing in the classroom and the IOC started running around the room, screaming and verbalizing general threats, and grabbing multiple objects (bags, boots etc.) and throwing them randomly, before pulling a large spike (that he found near the railroad tracks earlier in the day) and attempted to attack his EA/TA.

The VTRA team collected comprehensive data which included the first ever home visit by children’s services and found that the IOC had consistently resided in overcrowded conditions in his home with multiple family members and friends coming and going. The day before the incident at school, one of mom’s friends was pressuring her for sex and she rebuffed them. Her son took advantage of his mother’s anger at the friend and told her that the friend had been “touching” him. The mother called her son a “liar”. The next day at school when he saw the EA/TA doing “nothing”, when the students were fighting, he attempted to use the spike on her. He acknowledged during the interview that the spike was for his mother’s “friend” if he ever tried to “touch” him again.

Because the classroom incident was so high profile, the IOC stayed with grandparents who had been emotionally cutoff by his mother for the past five years. With this new relationship he thrived in his new home and attended a different school sporadically for the remainder of the year. The family placement (with mom’s parents) allowed the IOC to more fully disclose the extent of the sexual abuse he was subject to from several men including his stepfather.

Before returning to his mother’s care, the psychiatrist deemed ID a misdiagnosis and added the diagnosis of reactive attachment disorder. As part of the return to his original school, the mother and son met with the school administration team, the counselors and later the EA/TA for reconciliation. At the request of the IOC, the school let him use a little portable “fifty-dollar tent” his grandparents bought him that he took to his favorite chosen location whenever he needed to feel safe, de-escalate, and recalibrate for what staff called the “miracle year” at “his” school.

SECTION TWO

CTIP Perspective on Neurodivergence
&
Trauma-Informed VTRA



CTIP Perspective on Neurodivergence & Trauma-Informed VTRA

As previously discussed, the ICF framework integrates biological, psychological, and social elements to provide a comprehensive understanding of individual differences. These elements help in understanding how various factors contribute to a person's overall functioning. While the ICF framework offers a broad perspective, the American Centers for Disease Control's (CDC) approach tends to focus more on the medical aspects of conditions. To clarify, neurodivergent is not a medical term. It's a way to describe people using words other than "normal" and "abnormal." From that perspective, Information from the American Centers for Disease Control (CDC) indicate that beside ADHD - anxiety, depression and the behaviour problems associated with them - are the most commonly diagnosed mental disorders in children. Pre-pandemic (2016 to 2019) estimates for ever having a diagnosis among children aged 3-17 years are as follows:

- ADHD 9.8%
- Anxiety 9.4%
- Behaviour problems 8.9%
- Depression 4.4%

This is extremely relevant from a VTRA perspective because many of our post-pandemic cases of neurotypical and neurodivergent students have uncovered undiagnosed depression and anxiety. This includes IOC's whose primary or only diagnosis was viewed as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) until the case was viewed through a trauma-informed VTRA lens.

Standard View of Neurodivergence

Fetal Alcohol Spectrum Disorder	(FASD)
Attention Deficit Hyperactivity Disorder	(ADHD)
Autism Spectrum Disorder	(ASD)
Intellectual Disability	(ID)
Traumatic Brain Injury	(TBI)
Learning Disability	(LD)
Subthreshold Not Otherwise Specified Diagnoses	(Sub-NOS)

CTIP Expanded View of Trauma-Generated Neurodivergence: Includes the above and:



Post-Traumatic Stress Disorder	(PTSD)
Complex Post-Traumatic Stress Disorder	(C-PTSD)
Depression	(MDD)
Anxiety	(GAD)
Oppositional Defiant Disorder	(ODD)
Conduct Disorder	(CD)
Others	

For over twenty years the CTIP approach has challenged the idea that a single diagnosis or condition, that had been manageable in school prior to an act of major violence, was ever the single cause for the violence.

Comparing the information with 'School Aggressor' rates as reported by the US Secret Service in their publication [Protecting America's Schools: A U.S. Secret Service Analysis of Targeted School Violence](#) (2019) U.S. Department of Homeland Security and the United States Secret Service National Threat Assessment Center, found that the most common diagnoses and concerns are heavily weighted in the following four areas.

- Depression 63%
- Suicidal Ideation 60%
- Anxiety 29%
- Psychosis 20%

This is why when there is a significant shift in baseline and the SCS is high, the three primary hypotheses for Stage One VTRA for both neurotypical and neurodivergent IOCs are:

- Hypothesis #1 Cry for Help.
- Hypothesis #2 Conspiracy of Two or More.
- Hypothesis #3 Fluidity.

Following the 1999 shooting in Taber, Alberta the Government of Alberta organized the *Premier's Task Force on Children at Risk*. In the report that followed, *"Start Young, Start Now" (2000)* the primary author, for these 2025 guidelines, co-authored the first ever *"Interim Protocol for Dealing with High-Risk Behaviours"* in Canada. In that initial iteration the first risk enhancer identified was "witnessed or been a victim of abuse or neglect in the home". In the year following the shootings in Littleton, Colorado and Taber, Alberta we were already seeing that 'undiagnosed or untreated trauma' was a risk enhancer.

[Click Image to Access Document](#)



The VTRA model was expanded in 2023 to more formally focus the Stage One VTRA team on the role of trauma as a potential risk enhancer. We also recommended that school-based teams refer to Stage One VTRA as an "Assessment of Risk To Others" (ARTO) when working with children, youth and their parents/caregivers because it is softer language. Included in the ARTO process is the first time that CTIP included a formal query about an IOC's potential Adverse Childhood Experiences (ACEs) Score.

ACEs Background:

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACEs) study is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being. The original ACE study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors.

Felitti, Vincent J et al., Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. May 1998. American Journal of Preventive Medicine, Volume 14, Issue 4, 245 – 258

Methodology: A questionnaire about adverse childhood experiences was mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 (70.5%) responded. Seven categories of adverse childhood experiences were studied: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number of categories of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease.

Findings: Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4 - to 12 - fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2 - to 4 - fold increase in smoking, poor self-rated health, ≥ 50 sexual intercourse partners, and sexually transmitted disease; and a 1.4 - to 1.6 - fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

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The seven categories have since been expanded to 10 and applied, not retrospectively to adults as in the original study but to children currently in preschool through age 17. These children and adolescents may or may not have been assigned a formal diagnosis. However, it is noted that the negative health and mental health effects increase with the number of ACEs in the child's life. These negative effects may include toxic levels of stress (Harvard Center for the Developing Child), physical emotional, social and relational problems in their current development and future lives.

The 10 Adverse Childhood Experiences (ACEs) identify the following childhood traumatic events that can impact a person into adulthood:

- **Physical abuse:** Hitting, punching, or beating a child
- **Sexual abuse:** Inappropriate touching. Harming or injuring a child sexually; sexual exploitation, forcing the child into pornographic situations
- **Emotional abuse:** Swearing at, insulting, or cruel criticism of a child
 - Belittling, Rejecting, Ridiculing, Blaming, Threatening. Isolating, Restricting social interactions
- Physical neglect: Not providing food, clothing, shelter, or medical care
- Emotional neglect: Not providing emotional support, Denying the child an emotional response; Purposely not talking to the child for extended periods
- Mental illness: Living with someone who has a serious mental illness
- Divorce: Separation of a parent or parents
- Substance abuse: Living with someone who abuses alcohol or drugs
- Domestic Violence: Witnessing violence against a mother
- Incarceration: Living with someone who has been incarcerated

Effects of ACEs:

A high ACEs score (4 or more of the possible 10) generates toxic stress which often manifests itself in the form of high-risk behaviors such as substance abuse or misuse, rage and aggression, unsafe sexual practices, and/or endangering oneself or others. In addition, the higher the ACE score, the higher the risk of chronic health concerns, mental health impairment, and chronic relational/social difficulties.

Underpinning the above are the impacts on brain architecture experienced by persons with high ACEs scores. These individuals could be considered 'divergent' in that their functioning becomes impacted by the dominance of their amygdala which, when activated, sends a hormonal distress signal to the hypothalamus. This area of the brain functions like a command center, communicating with the rest of the body through the nervous system so that the person has the energy to fight or flee. Chronic stress or toxic stress such as ongoing abuse or neglect maintain this dominance of the amygdala and dampens the functioning of the prefrontal cortex (whose task it is to take in new information and disseminate reactions in the form of logic, critical thinking, and evaluation, as well as being the center which determines the 'best' or 'next' course of behavior or reaction).

Therefore, persons with high ACEs scores are, quite literally, wired differently with regard to how they interpret the world around them. Unlike persons with low (3 or less) scores, who have full, robust access to sophisticated skills like discernment, nuance, rationality, and ambivalence, people with high ACEs tend to remain governed by their Reactive Brain (the aforementioned amygdala) which is primarily geared to respond to threat and danger. A high ACEs brain, due to its over-exposure to chronic adversity, becomes 'pre-loaded' for a strong negativity bias—and this bias cultivates a cognitive distortion (or 'faulty belief') that the surrounding world is a hostile, dangerous place within which one must perpetually remain 'on guard' (or reactive) in order to stay safe. This cognitive distortion—that the world is a place of perpetual threat, peril, or danger—can be strong enough that even neutral stimuli will be interpreted as aggressive or combative. The rationale for this reaction is that the high ACEs brain, 'pre-loaded' with its belief that the environment is hostile, will 'err on the side of caution' when facing neutral stimuli. In other words, when facing a person or circumstance that is "gray", the high ACEs brain will say, "I cannot decide if this is aggressive or benign—therefore I will interpret it as hostile just in case."

Understanding this broad-strokes—and, yes, faulty—interpretation can help us make sense of why some of our most high-risk individuals appear to approach the world in general with such indiscriminate, free-floating hostility; it is not that they are looking for trouble, but rather that they sincerely believe they are faced with it. Other cognitive distortions consistent with individuals with high ACEs scores can include:

- Over-generalizations (things tend to be interpreted as "all good" or "all bad")
- Generalized and indiscriminate pessimism
- Loneliness, specifically in the sense that they chronically feel misunderstood
- Lack of belief that healing is possible
- Over-arching mistrust / paranoia (especially of authority figures—which can mimic traits consistent with Oppositional Defiant Disorder)
- Generalized and indiscriminate belief that others are ill-intended
- A belief that they are not likeable, worthy, and that they have few, if any, true friends.

Note that world affairs occurring at both the national and international level are rife with conflict and threat at all levels, thus dysregulating even adult brains, and certainly serving to amplify reactions from adults with pre-existing high ACEs scores. This prevalence can have serious immediate and lifelong consequences, particularly when we tabulate the grim number of individuals who are, indeed, faced with measurable adversity. Consider: In the US, the CDC estimates that nearly half of children have experienced at least one adverse childhood experience (ACE).

- About 45% of children have experienced at least one ACE
- About 21% of children have experienced two or more ACEs
- About 1 in 10 children have experienced three or more ACEs

Suffice to say pre-existing levels of traumatic stress in the form of Adverse Childhood Experiences add a complexity to the VTRA process—requiring an assessment that makes excellent history-taking incumbent on clinical members of the VTRA team in order to tabulate pre-existing factors and developmental dynamics.

Applying a Preventive Approach (Matching Resource To Risk)

Risk-Reducing variables, those positive childhood experiences we label as Markers of Resiliency, also affect the architecture of the developing brain. Experiences such as supportive relationships with emotionally mature adults dampen the aforementioned dominance of the amygdala and allow for the Executive Function arena of the brain (such as the prefrontal cortex) to function more effectively, therefore allowing for interactive communication (also known as Serve and Return), nuanced interpretation of information, the acceptance of adult help and an overall ease of the dysregulation caused by overwhelming traumatic stress.

When building resiliency (or, ascribing to VTRA language, “Matching Resource to Risk”), the team must attune to the following factors regarding the neurodivergence of a high ACEs individual:

- 1) Appreciate the profound impact of traumatic stress, and that traumatic stress is the direct result of chronic adversity in the form of the 10 Points of the ACEs scale. Once that acknowledgement is made, members of a threat assessment team should then identify which of the ten ACEs are currently active or part of the psychosocial history of the child making threats. Further (and as detailed by the chart below), the team should consider the age and developmental stage the child was at when that ACE first occurred. This will provide the team insight as to what skills and or abilities (if any) was that child perhaps able to form more robustly prior to the occurrence of the ACE? (For example, a child who has experienced the bulk of their adversity at age 12 and onward will, ostensibly, have more access to latent internal coping skills than a child for whom ACEs existed from birth).
- 2) Recognize that the balance of risk factors in a child's life may weigh more heavily (or outweigh altogether) the protective factors.
- 3) Be prepared to respond in a trauma informed manner from a strength-based methodology. Focus initial actions on developing and implementing an individualized ‘care’ plan as part of ‘threat management’, ideally composed of services and interventions that strengthen the number of protective factors (e.g., increasing positive connections to people and programs, introducing the child or youth to adult mentors, generating positive peer influences) and to offset risk factors such as social isolation, cognitive distortions, poor decision making, angry aggressive behavior, etc.
- 4) Resist Re-traumatizing the child by reacting in a purely punitive fashion to negative behaviors; shift focus to educating the student with empathy about how their trauma has altered the way they perceive the world. Oftentimes, it is highly therapeutic to help someone understand why they do the things they do. Then—

- 5) Assist the child or youth in attaining or re-learning self-soothing skills that will strengthen the abilities within their pre-frontal cortex, thereby lowering Baseline Behaviour to a more manageable place and affording greater life satisfaction in each of the following major life areas: the physical, emotional, behavioral, cognitive and spiritual realms.
- 6) Lastly, be willing to get creative and 'think outside the box' for strategies that will affect the greatest change in High ACEs youth. Just as their lived experience has been different from most of their peers, so too will be the most effective strategies that will re-align high risk behaviour.

**Effects of Trauma and Stress on the Developing Brain and
Cognitive Behavioral Intervention for Trauma in Schools (CBITS),
an evidenced based intervention for use in schools.**

**Herringa, R. J. (2017). Trauma, PTSD, and the developing brain. *Current Psychiatry Reports*, 19(10).
<https://doi.org/10.1007/s11920-017-0825-3>**

Approximately two thirds of youth are exposed to trauma during childhood. By age 18, approximately 8% of traumatized youth have met clinical criteria for a diagnosis of PTSD. The rates increase to 40% in children and adolescents who are victims of sexual abuse and physical assault. PTSD is also associated with lower academic achievement, depression, suicide attempts and substance abuse. The subsequent cost of these negative outcomes, including maltreatment, health care, and other public programs required over the lifespan, is estimated to be \$500 billion. Recent studies of childhood PTSD, point to abnormal neurodevelopment, abnormal structure and functions in the brain regions that play a crucial role in emotional processing and cognitive flexibility. This may contribute to increased reactivity to perceive threat, and less emotional regulation as these youths age.

McEwan, B. (2017). Neurobiological and systemic effects of chronic stress (Vol. 1, pp. 1–11).

The brain perceives and determines what is threatening as well as determines the behavioural and physiological responses to the stressor(s). It can promote adaptive us or 'pathophysiology' when it is overloaded or overused leading to an imbalance of basic brain circuitry negatively impacting cognition, decision making, anxiety, and mood.

Adverse childhood experiences can produce lasting effects on the brain and body, changing brain architecture, impairing the development of effective impulse control, judgment and self-esteem. In short, the author states, "the brain is a biological organ that changes in its architecture, its molecular profile and its neurochemistry under acute and chronic stress and directs many systems of the body – metabolic, cardiovascular and immune – that are involved in the short- and long-term consequences of being 'stressed out' and the consequent health and mental health damaging behaviors."

McLaughlin, K. A., & Lambert, H. K. (2017). Child trauma exposure and psychopathology: Mechanisms of risk and resilience. *Current Opinion in Psychology*, 14(14), 29–34.
<https://doi.org/10.1016/j.copsyc.2016.10.004>

Exposure to trauma in childhood is associated with elevated risk for multiple forms of psychopathology. It is linked to increased fear, heightened emotional responses to perceived threat, and difficulty disengaging from negative emotional content.

Approximately one in five children in the US will experience interpersonal violence by the time they reach adulthood. Exposure to interpersonal violence in the home or community such as physical abuse, sexual abuse, or witnessing domestic violence alters affective and neurobiological development. Altered learning ability, elevated emotional reactivity, and problems with emotional regulations are often the result. Children with trauma histories classify a wider range of emotions as ‘anger’. They perceive and engage in angry behaviours and interactions and take longer to disengage from anger. They can misread non-threatening behavioural cues in others and can generate and attribute hostility to others as compared to children without a trauma history. Because of these misperceptions, they have difficulty discriminating between safe and dangerous situations. An example is a child who has a history of physical abuse from an adult family member who perceives all adults in authority as dangerous.

Caregivers who provide positive interactions, connectivity, support and feedback can be a protective factor to counteract the risk factors of exposure to violence and childhood PTSD.

If treatment is indicated, as part of a threat management plan, Cognitive Behavioural Therapy (CBT) is currently the most effective, researched based form of therapeutic intervention for trauma related psychopathology.

Nadeem, E., Jaycox, L., Langley, A., Wong, M., Kataoka, S., & Stein, B. (2014). Handbook of school mental health: Research, training, practice, and policy: Issues in clinical child psychology (M. D. Weist, N. A. Lever, C. P. Bradshaw, & J. Owens, Eds.; 2nd ed., pp. 145–157). Springer.

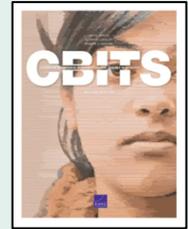
Behaviour

Exposure to traumatic events among youth is relatively common. Almost all youth experience initial distress as a reaction to such events, but for most, natural resilience causes the distress to gradually subside. However, a substantial minority continue to experience distress in the months after trauma exposure. The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is designed for use with groups of students who have experienced significant traumatic experiences and are suffering from related emotional or behavioural problems, particularly symptoms of post-traumatic stress disorder. Delivered by school-based clinicians and taking into account cultural context, it uses a variety of proven cognitive behavioural techniques in an early intervention approach, including psychoeducation about trauma and its consequences, relaxation training, learning to monitor stress or anxiety levels, recognizing maladaptive thinking, challenging unhelpful thoughts, social problem-solving, creating a trauma narrative and processing the traumatic event, and facing trauma-related anxieties rather than avoiding them. CBITS focuses primarily on three goals: **1)** decreasing current symptoms related to trauma exposure; **2)** building skills for handling stress and anxiety; and **3)** building peer and caregiver support.

The second edition provides updates and implementation guidance based on two decades of using CBITS across the US. The CBITS Manual is available at no cost on the RAND.org website.

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Between the “Trauma-Violence Continuum” (TVC): Depression-Anger

For years CTIP has stated that the “fields of crisis/trauma response and Violence Threat Risk Assessment (VTRA) are inseparably connected”. We explained the interconnectedness by developing the “Trauma-Violence Continuum” (TVC), which addresses the experience of many traumatized individuals, and how “serious violence can beget trauma, but trauma, in and of itself, can also beget serious violence”. In-between the TVC, for some, is profound depression and anxiety and other associated clinical and sub-clinical conditions. From a CTIP perspective, these would be children whose brain functions are considered neurodivergent as well. They would also be students who are either still exposed to an abusive or unsafe environment or functioning as if they are still in the harm-causing environment.

Extensive research has shown a significant link between depressive symptoms and violent behaviour in children and adolescents. For example, early signs of depression have been found to predict violent actions, especially in those with conduct disorder. The DSM-5's introduction of "mood dysregulation disorder" highlighted the importance of recognizing persistent irritability and frequent episodes of extreme behavioural instability, which can include violent behaviour. Children and adolescents with these symptoms are often seen as less happy and are at a higher risk of developing unipolar depressive disorders later in life (Krakowski & Nolan, 2017).

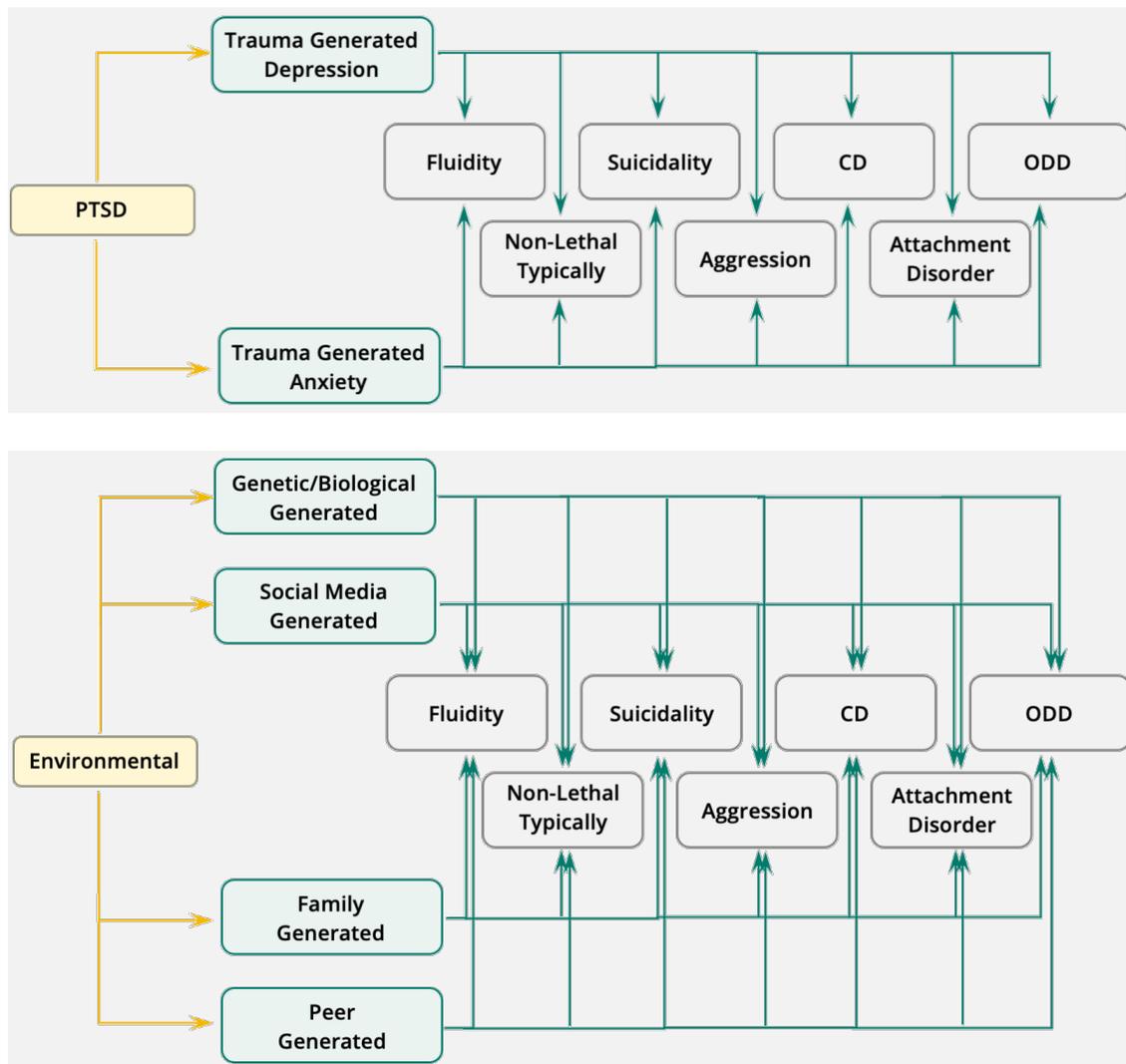
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The connection between depression and violence is also seen in children and adolescents with PTSD, where violent behaviour is often first directed at family members. Young people who have experienced physical abuse are more likely to exhibit violent behaviour. This suggests that factors like childhood trauma may contribute to both depression and violent tendencies. Anger and irritability, common in mood disorders, can further complicate this relationship, leading to violence in those predisposed to such behaviour. While trauma and depression are distinct issues, they often occur together, creating a complex interplay that can increase the risk of violence (Krakowski & Nolan, 2017).

When evaluating the risk of violence in children and adolescents with depressive symptoms, it is important to consider the context as well as the specific disorder present. Depressive symptoms can occur in various conditions, such as major depressive disorder, bipolar disorder, PTSD, or other mood disorders (Krakowski & Nolan, 2017). Additionally, the environment, including home, community, school, and peer relationships, plays a crucial role in shaping these behaviours. Assessing and treating the underlying disorder is essential. Equally is the understanding that the link between aggression and depressive symptoms is influenced by various demographic and historical factors. Given that most schools lack the necessary resources to accommodate these needs, treatment for these disorders is often most effective when provided outside the school context.

This comprehensive approach aligns with the concept of the "Trauma-Violence Continuum" (TVC), which illustrates the two-way relationship between trauma and violence. The TVC emphasizes that trauma can lead to serious violence and vice versa. This continuum is further complicated by the presence of depression, anxiety, and other related conditions. From a neurodivergent perspective, these children and adolescents often remain in or perceive themselves to be in harmful environments, potentially continuing a cycle of trauma and violence. Emotional dysregulation, including depression and anger, can amplify aggressive impulses and reduce the decision-making processes that prevent violent actions, highlighting the importance of addressing these interconnected issues in both clinical and educational settings (Krakowski & Nolan, 2017).





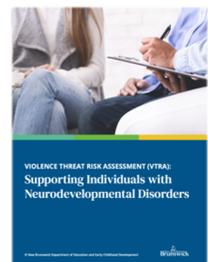
To access complete article, click on Logo above

<u>Post Traumatic Stress Disorder Symptoms</u>	<u>Complex Post Traumatic Stress Disorder Symptoms</u>
	Difficulties with emotional regulation
	Impairment in relationships and daily functioning
	Interpersonal problems
Re-experiencing the trauma	Re-experiencing the trauma
Avoidance of people, places, or thoughts that remind you of the trauma	Avoidance of people, places, or thoughts that remind you of the trauma
Impairment in relationships and daily functioning	Impairment in relationships and daily functioning
Alertness and reactivity	Alertness and reactivity

PLEASE NOTE: People with PTSD may also experience these additional symptoms in the C-PTSD column.

Violence Threat Risk Assessment (VTRA): Supporting Individuals with Neurodevelopmental Disorders

The Violence Threat Risk Assessment (VTRA) Supporting Individuals with Neurodevelopmental Disorders was a supporting document developed to support VTRA teams in a offering neuro-affirming approach to **interviewing** neurodivergent individuals. Intentional practices to interview should be applied by teams to promote safe and supportive interviewing techniques, strategic interviewing plans, and stress reducing environments and accommodations that take into consideration primary and/or secondary diagnosis, or the potential diagnosis, of the individual(s). This document was developed by the New Brunswick Ministry of Education in collaboration with J. Kevin Cameron, provincial VTRA leads, and specialists whose expertise is focused on supporting neurodivergent individuals.



[Click Image to Access Document](#)

Whole Person Assessment (WPA) Worksheet

A "Whole Person Assessment" (WPA) is the process of consciously humanizing the Individual of Concern (IOC) rather than the myopic standard of seeing the individual through the diagnosis only. Whenever PBAs are elevated and they are moderate to high on the SCS, along with a moderate to high likelihood of carrying out the threat, or continuing with the escalated behaviour, a comprehensive VTRA/ARTO should be conducted. Effective threat / risk assessment in neurodivergent populations requires a comprehensive, individualized approach that includes **professionals with expertise** in the diverse presentations and unique vulnerabilities of these individuals. Incorporating an understanding of neurodivergent traits, environmental influences, and personal histories into assessment practice is essential for accurately identifying and mitigating potential or current risks.

Plausibility (Moderate to High SCS) + Significant Shift in Baseline + Attack-Related Behaviours = Stage One VTRA/ARTO. When the initial Stage One findings, in a case with a neurodivergent student, confirm moderate to high risk, the school and district (division) VTRA/ARTO team should activate the community VTRA Protocol and conduct a Whole Person Assessment (WPA). The possible range of adults beyond parents and caregivers, necessary to collaborate on a WPA can include one, two or many of the following depending on the severity of the threat or the violence that has already occurred:

- Mental health,
- Health,
- Psychology,
- Forensic psychology,
- Psychiatry,
- Pediatricians,
- Child and family services (child protection),
- Probation,
- Family physician,
- Police of jurisdiction,
- Specialized police services (Intimate Partner Violence (IPV), Countering Violent Extremism (CVE),
- Etc.

Step One (General Review)

VTRA/ARTO teams use multiple data-points across time to determine if the current behaviour of concern is:

- a) Typical baseline,
- b) An isolated incident, or
- c) Significant shift in violent acting out or violence potential.

Step Three (Baseline Review)

“Triple C”

Cute from: Age_____ to Age_____

Concerning from: Age_____ to Age_____

Critical from: Age_____ to Current VTRA/ARTO

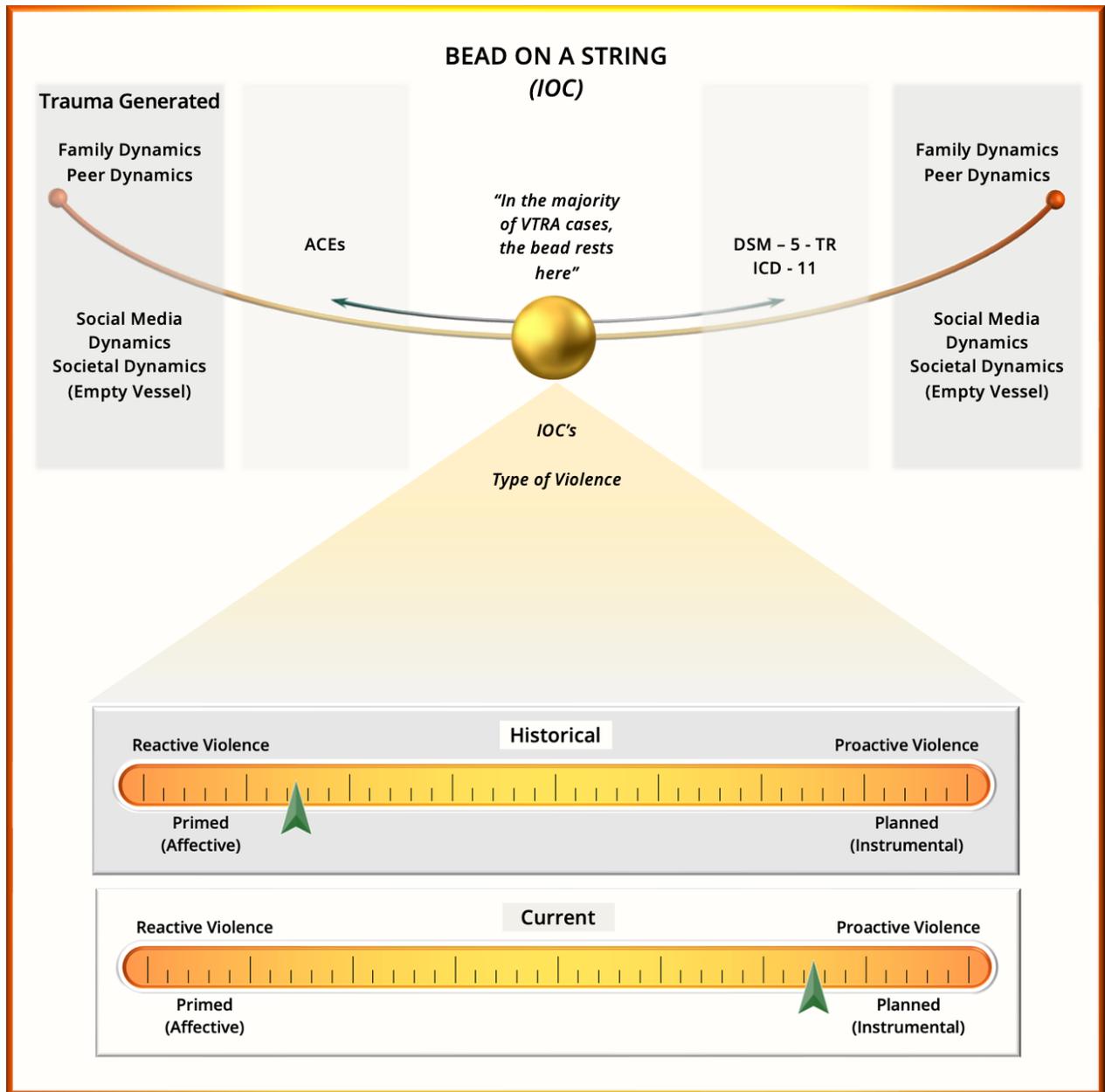
*There are cases where the baseline has not shifted and is pure version Triple C but the capacity to commit serious harm is real. In these cases a WPA should still be considered as a means to reassess and recalibrate current interventions that are no longer working.

Notes:

Step Four (Bead on a String)

Based on initial data, if they do pose a risk, how much, if at all, does the primary diagnosis contribute to their current level of risk?

Notes:



Standard View of Neurodivergence

Fetal Alcohol Spectrum Disorder	(FASD)
Attention Deficit Hyperactivity Disorder	(ADHD)
Autism Spectrum Disorder	(ASD)
Intellectual Disability	(ID)
Traumatic Brain Injury	(TBI)
Learning Disability	(LD)
Subthreshold <i>Not Otherwise Specified</i> Diagnoses	(Sub-NOS)

**CTIP Expanded View of Trauma-Generated Neurodivergence:
Includes the above and:**



Post-Traumatic Stress Disorder	(PTSD)
Complex Post-Traumatic Stress Disorder	(C-PTSD)
Depression	(MDD)
Anxiety	(GAD)
Oppositional Defiant Disorder	(ODD)
Conduct Disorder	(CD)
Others	

Step Seven (Primary Versus First Diagnosis)

VTRA/ARTO teams and parents (caregivers) may become focused on the first diagnosis that was made (often years earlier) and believe it is the cause for why the IOC has engaged in aggression (reactive), violence (proactive), threat-making, or threat related behaviour. While assumed in some cases, there are many other cases where the first diagnosis was a misdiagnosis, or **the first diagnosis is not the primary risk enhancer**. A neurodivergent IOC may have a significant shift in baseline (e.g. verbal (plausible) threat to kill a peer) caused **not** by their diagnosis, but because they (the IOC) are being profoundly bullied and assaulted from time to time by their peers and their threat to kill was the only way they could “scare off the bullies”: an escalation or action many neurotypical IOC’s have taken.

As well, in some cases, FASD has been the first diagnosis and viewed as the primary diagnosis for elevated risk. Yet in some cases, the escalated behaviours and conflicts with peers have been the result of dynamics like uncontrolled sibling conflict at home being acted out towards peers at school (parallel process). There are other cases where the secondary diagnosis (i.e. ADHD) is **the primary risk enhancer** contributing to the student’s escalation. The constellation and ordering of diagnoses related to risk can be complex and less likely to result in lasting gains if all interventions are psychopharmacological. Whereas a WPA can identify (Bead on a String) data-driven internal, external and dynamic risk enhancers resulting in more comprehensive and lasting data-driven interventions.

Notes:

Step Eight (Additional Considerations)

- a) Is there a peer relationship dynamic contributing to risk?
- b) Is there a 'puppet master' in the background?
- c) Is there a current crisis or loss in the school or community that has elevated overall school anxiety?
- d) Is there a social media dynamic contributing to risk?
- e) Is there an AI relationship or is there online exposure (e.g., exposed to images on the dark web or gaming) that has triggered an acute response?
- f) An acute stressor that activated symptoms?
- g) The IOC has stopped taking psychoactive medication, but school was not informed?
- h) The IOC is on new medication, but the school was not informed?
- i) Other?

Notes:

Step Nine (Fluidity)

Depression has been linked to aggression and violence. Some IOC's may engage in threat-making behaviour who do not pose a risk to do it but may pose a risk to themselves. But there are other depressed IOCs (neurotypical and neurodivergent) who may vacillate between violence risk to self and violence risk to others or a combination of both.

Notes:

Step Ten (Trauma-Generated Symptoms)

Following on the next two pages are two timeline charts that allow VTRA/ARTO teams to move beyond a numerical ACEs score to actually plotting out what ACEs have been experienced by the IOC and if they are a current risk enhancer. Introductory and detailed training for use of these guidelines, worksheets, and ACEs timeline charts is available for VTRA/ARTO teams and district/division leaders and any staff from VTRA regions working with neurodivergent students (i.e. teachers, educational/teacher assistants, etc.).

ACEs – Timeline Tracking Form (IOC)

Instructions:

For each ACE (*located at the bottom of this form*), plot on the chart below:

- Age of *First Exposure* with **"F"**. If exposure lasted for several successive years, mark with **"F"** for each consecutive year.
- Age of *Re-Exposure* with **"R"**. If re-exposure lasted for several successive years, mark with **"R"** for each consecutive year.
- Age of *Parallel Process (Rekindling)* appears with **"P"**. If Parallel Process (Rekindling) lasted for several successive years, mark with **"P"** for each consecutive year.

ACE	*IU – In Utero																		
	IU*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1)																			
2)																			
3)																			
4)																			
5)																			
6)																			
7)																			
8)																			
9)																			
10)																			
11)																			

While the IOC was growing up, during their first 18 years of life . . .

- 1) Did a parent or other adult in the household often or very often... Swear at the **IOC**, insult the **IOC**, put the **IOC** down, or humiliate the **IOC**? or Act in a way that made the **IOC** afraid that they might be physically hurt? (If yes, score 1)
- 2) Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at the **IOC**? or ever hit the **IOC** so hard that they had marks or were injured? (If yes, score 1)
- 3) Did an adult or person at least 5 years older than the **IOC** ever... Touch or fondle the **IOC** or have the **IOC** touch their body in a sexual way? or attempt or actually have oral, anal, or vaginal intercourse with the **IOC**? (If yes, score 1)
- 4) Did the **IOC** often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other? (If yes, score 1)
- 5) Did you often or very often feel that ... the **IOC** didn't have enough to eat, had to wear dirty clothes, and had no one to protect the **IOC**? or their parents were too drunk or high to take care of the **IOC** or take them to the doctor if they needed it? (If yes, score 1)
- 6) Were the **IOC's** parents ever separated or divorced? (If yes, score 1)
- 7) Was the **IOC's** mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or ever repeatedly hit at least a few minutes or threatened with a gun or knife? (If yes, score 1)
- 8) Did the **IOC** live with anyone who was a problem drinker or alcoholic or who used street drugs? (If yes, score 1)
- 9) Was a household member depressed or mentally ill, or did a household member attempt suicide? (If yes, score 1)
- 10) Did a household member go to prison? (If yes, score 1)
- 11) Other.

Developed by: J. Kevin Cameron

Adapted from: http://www.acestudy.org/files/ACE_Score_Calculator.pdf, 092406RA4CR

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The Twelve Unofficial ACEs – Timeline Tracking Form (IOC)

Instructions:

For each ACE (*located at the bottom of this form*), plot on the chart below:

- Age of *First Exposure* with **"F"**. If exposure lasted for several successive years, mark with **"F"** for each consecutive year.
- Age of *Re-Exposure* with **"R"**. If re-exposure lasted for several successive years, mark with **"R"** for each consecutive year.
- Age of *Parallel Process (Rekindling)* appears with **"P"**. If Parallel Process (Rekindling) lasted for several successive years, mark with **"P"** for each consecutive year.

ACE	Age of IOC																		
	*IU - In Utero	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1)																			
2)																			
3)																			
4)																			
5)																			
6)																			
7)																			
8)																			
9)																			
10)																			
11)																			
12)																			

Following is a list of twelve often forgotten, or overlooked, challenges which act as 'Force Multipliers' that contribute to the 'hyperactive amygdala' / over-active 'Fear Centre' High-Risk IOCs struggle with. They are:

- 1) In Utero Trauma (IU)
- 2) Attachment Trauma
- 3) Frequent Family Conflict (including siblings - sibling aggression makes up 30% of domestic violence)
- 4) Inconsistent Parenting
- 5) Neighborhood Violence
- 6) Social Isolation (remember—* 14% of a child's time will be spent in school)
- 7) Spiritual Abuse
- 8) Bullying
- 9) Placement in Foster Care
- 10) Discrimination—for ANY reason
- 11) Arrest of a Family Member
- 12) Adoption

Developed by: J. Kevin Cameron

Adapted from: <https://www.unh.edu/ccrc/sites/default/files/media/2022-02/improving-the-adverse-childhood-experiences-study-scale.pdf>

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Concluding Case Study

P.J., 8-Year-Old Male

PJ came to the attention of the VTRA team due to chronic aggressive outbursts directed at his teacher and indiscriminately, at classmates in his Grade Three room. The antecedent for most of PJ's violent outbursts was typically when he was asked to engage in his assignments or during transition times when the class would be shifting from one subject to another.

PJ's Baseline Behaviour looked like hitting, kicking, verbal aggression in the form of profanity and threats, and attempts to flee the school when the aforementioned antecedents took place. His escalations were typically rapid, and PJ, while not tearful after his outbursts, would offer apologies that were both prompted and unprompted after the fact.

PJ's ACEs history was troubling; he was the oldest of three siblings, and prior to all three children entering into the care of Social Services, he had frequently been the primary caregiver to his younger siblings (despite his own tender age) as both parents were heavily involved in drug use and sex trafficking. PJ had experienced and witnessed physical and verbal abuse, and currently he lives with Grandparents in a strict religious home as both of his parents are incarcerated. His younger siblings are in foster care in a different community.

PJ misses his younger siblings deeply, and his classroom teacher has noted an escalation in his Baseline Behaviour both before and after PJ's social worker arranges visits between he and his brother and sister.

PJ struggles with both literacy and numeracy and has classic "Mixed Typology" behaviour in that he approaches most situations with free-floating hostility and poor control of his temper.

Matching Resource to Risk for P.J.

When asked to report on lulls in PJ's Baseline ("Are there times when he is complacent or appears regulated?") the classroom teacher shared that, interestingly, PJ functions best on the days when another additional needs child, a non-verbal autistic boy, who requires both feeding and toileting assistance, is present in the room. Teacher reports that on those days, PJ's behaviour is "unrecognizable" as he becomes the equivalent of a classroom "ambassador" and a helper to additional needs child's EA. His interactions with the autistic child are conscientious, gentle, and he is even able to settle down and do some of his own academic work between "helping shifts". PJ's mood demonstrably improves, he is able to engage positively in his relations with peers, and his normal baseline of being both ornery and combative shifts to a much sunnier disposition—to the degree that he even shows appropriate (and sometimes even self-deprecating!) humor. When the child with additional needs is not in the room, however, it is back to status quo; angry, hostile, and hair-triggered aggressive outbursts directed at anyone who may inadvertently cross him and particularly if that person is an authority figure.

Given these two very disparate sets of Baseline Behaviours, and PJs ACEs history, the following were considered as we formed a hypothesis that might match resource to risk:

Concluding Case Study - Continued

- The presence of the child whose needs and lack of capacity eclipse PJ's own; suddenly he's not the child who "is the problem" in the classroom. As such, this bolsters PJ's own self-worth reminding him that he is capable and 'normal' (challenging his cognitive distortion that he is not).
- Further, PJ engaging, unprompted, in helping this child does not only allow for him to be in an 'Authority' position but is also reminiscent of his own caregiver role with his beloved siblings—thus generating a Parallel Process that is soothing for his emotionally stressed brain.
- Feeling valued and worthy in the role of helper allows for re-regulation—which is evidenced by his ability to not only focus on schoolwork, but in the marked improvement in his ability to relate and connect with others.
- Therefore, a **Risk-Reducing Variable** to try when on the days when our child with additional needs is not in the room → allow PJ to be a helper to the EA in the kindergarten room where he can assist younger children in various ways, thus meeting his need to "parent" and also allowing for breaks for both he and his classmates—with the expectation that, between helping "shifts", he engage in his own work at his desk.

Now, given this case, we'd be remiss if we did not say that clearly the parentification of a child is far from an ideal situation. But consider PJ's complexion of ACEs, which include loss and grief. Consider too the resiliency factor: when PJ felt most in control in his short life was when he was caring for his siblings. Recreating this dynamic in a safe, supervised environment has bespoken remarkable changes in this once "uncontrollable", high baseline, high ACEs child.

Becoming creative, therefore, and appreciating the lived experiences our high ACEs children have had (which often require a maturity that is beyond their years) can present us with opportunities to "speak into their strengths;" emboldening skills and abilities that require effort from their less-muscular pre-frontal cortex—which in turn will affect lasting change and happily, will become part of their lasting Resiliency Factors.

Theory to Practice and Practice to Policy

Final Considerations:

Upholding and balancing the children's rights that are enshrined in provincial and federal legislation, international conventions, the Education Act, and the United Nations Convention on the Rights of the Child, where every child has access to an education is foundational to our work with schools across the country. Access to education takes into consideration the supports and individual needs required, while balancing their individual embedded right with the rights of all students. The Supreme Court of Canada's 1981 ruling, *Myers v. Peel (County) Board of Education* defined the standard of care to be exercised by school authorities in providing for the supervision and protection of students for whom they are responsible, as that of a **careful and prudent parent**. The safety of the greater student community must outweigh the rights of the individual. Safety for the greater community versus the rights of one can produce complicated decision trees with a host of variables. As stated earlier, schools are not secure treatment centres and may require implementing the use of "not right now" in situations where the need to protect the greater student population supersedes the individual rights of the student [Supreme Court of Canada 1998 ruling in *R. vs M (M.R.)*].

These guidelines should prompt government ministries, school board trustees, senior school district/division leaders to create/expand policy and practices that require timely multidisciplinary assessments and intervention with neurodiverse students where NRN is deemed the safest and/or most prudent initial risk-reducing intervention. Multi-ministry collaboration (education, health, mental health, child and family services, justice, etc.) needs to be more formally organized around consistent:

- Variables for assessing risk.
- Minimum requirements for what professionals (Ministries) should be part of the assessment.
- Minimum requirements for what professionals (Ministries) should be part of the planning.
- Reasonable timeframe for a more comprehensive assessment if the Stage One VTRA team recommends NRN.
- Etc.

A gold standard case example, of how to move from theory to practice and practice to policy, can be found in the work the New Brunswick government has undertaken to create a more systemic approach to the VTRA/ARTO model. They have learned and applied the various iterations of the VTRA/ARTO model for almost two decades. Work over the last 5 years, has been to move away from VTRA being viewed as a school model to a model that is understood and utilized by many branches of government, law enforcement, and community. This has seen the theory to practice being realized within the VTRA/ARTO context. New Brunswick does not want to be in the position where VTRA work becomes dependent on a person or individual, they have longed for a systemic approach to practice. To move from practice to policy a formal provincial and community protocol guide was developed to create a broader sense of ownership and moral imperative focused on the groundbreaking work that is the VTRA/ARTO model.

New Brunswick chose to marry the VTRA work with its existing model of Integrated Service Delivery (ISD) where the departments of Education, Justice Public Safety, Health, and Social Development, were already collaborating; the natural partners who could help lead such change (Attached below are the key elements for ISD). Not without imperfections, ISD structures will allow a seamless network to build upon a true multi-disciplinary and collaborate approach to risk reduction and wrap around supports. With the strengths a model such as ISD offers, combined with a formal provincial and community guide, VTRA is being cemented as a foundational means to creating safer communities where no child, youth, family, or community are left behind.

Key Elements of Transformation: New Brunswick Integrated Service Delivery Framework (ISD)

Framework Overview and Goals:

The ISD Framework is committed to addressing system gaps in the provision of services to youth with emotional, behavioural and mental health concerns. This is accomplished through inter-professional team approaches that integrate departmental services and programs, and that empower youth and families to be active participants in their process of recovery. A key focus of the framework is the enhancement of system service delivery capacity to respond in a timely, effective and integrated manner, striving to provide the right service, at the right time and at the right intensity in settings that are close to youth and their families. A second and equally important focus of the framework is the creation of positive environments in school and community settings that contribute to the psychological well-being needs of relatedness (being welcomed, known and supported) competency (recognizing and using strengths, and building confidence) and autonomy support (having voice, choice and opportunities to be generous to others). Key goals and desired outcomes associated with the ISD Framework include:

Positive Child and Youth Development

- Enhanced family and community attachments
- Increased school engagement and academic success
- Increased school retention rates
- Decreased levels of high risk/complex needs
- Positive growth and development of children and youth
- Increased diversion of youth from the criminal justice system

Accessible and Timely Services

- Increased awareness of service availability on a continuum among family members and service providers
- Increased identification of needs at earlier stages (prevention and early intervention)
- Decreased wait times for assessment and direct service provision

Effective Case Planning Practices

- Increased continuity of case planning for children, youth, and their families
- Increased capacity to adjust service intensity and duration according to child and family needs
- Increased collaboration between partners to ensure multi-disciplinary intervention approaches and integrated ownership of common case plans

Enhanced Relationships

- Enhanced collaborative alliances among service providers and youth and their families
- Increased sharing of information among partners and collaboration with community stakeholders
- Increased job satisfaction among service providers who serve youth, children, and their families

System Efficiencies

- Increased coordination of services and resources provided by partners and community
- Increased collaboration between partners in the provision of services and assessments, and reduction of redundancies and duplications
- Enhanced information management processes
- Enhanced regional service delivery capacity

Effective Use of Resources

- Decreased use of out-of-home placements pending assessment and intervention services
- Provision of and access to the right service, at the right time, and at the right intensity

The guiding principles of the ISD Framework assert that the appropriate service delivery intensity must be matched to youth and family needs at all system levels. Emphasis is placed on structuring and managing inter-departmental resources in a manner that allows for flexible and timely intervention responses. Targeted risk/need approaches are complemented and balanced by assessment, intervention and case management practices that draw on the strengths and capacities of youth, their families, and the wider community. Person-centered approaches are committed to the engagement and empowerment of youth and their families. In some instances, outreach and advocacy are required to ensure their full participation and collaboration in service provision and case planning activities.

Central to the implementation of the ISD Framework is shared departmental responsibility for ensuring the allocation of financial resources to support and sustain a unified service delivery system for youth mental health. Such efforts include the development of common human resource policies and practices to support the formation of multi-disciplinary and integrated Child and Youth Teams. Similarly, the provision of integrated services also implies the adoption of common access processes across departmental systems, and the development of training for departmental stakeholders and service providers on how to facilitate access to services for youth and families where every door is the right door.

New Brunswick - Violence Threat Risk Assessment (VTRA/ARTO) *(Click on the icon to view the video)*



VTRA is a collaborative model that leverages a trauma-informed approach to assessing risk to others and worrisome behaviour. It is a model that has been used throughout New Brunswick schools for almost 20 years.

Nouveau-Brunswick - Évaluation de la Menace et Risque de Violence (EMRV/ÉRA) *(Cliquez sur l'icône pour visionner la vidéo)*



L'EMRV est un modèle de collaboration qui s'appuie sur une approche fondée sur les traumatismes pour évaluer les risques pour les autres et les comportements inquiétants. Ce modèle est utilisé dans les écoles du Nouveau-Brunswick depuis près de 20 ans.

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