Guidance for Trauma Screening in Schools

A product of the Defending Childhood State Policy Initiative

National Center for
Mental Health
and
Juvenile Justice

DEFENDING CHILDHOOD
PROTECT HEAL THRIVE

Guidance for Trauma Screening in Schools

A Product of the Defending Childhood State Policy Initiative

September, 2016

Dr. Katie Eklund | eklundk@missouri.edu

Katie Eklund, Ph.D., is an Assistant Professor in the Educational, School, and Counseling Psychology Program at the University of Missouri. She has worked in public schools for over 10 years as a school psychologist, social worker, and school administrator; she is currently a licensed psychologist and Nationally Certified School Psychologist. Dr. Eklund's current research interests include early identification and intervention for children's behavioral and emotional concerns, school mental health, school climate, and school safety.

Dr. Eric Rossen | erossen@naspweb.org

Eric Rossen, PhD, is a Nationally Certified School Psychologist and licensed psychologist in Maryland. He has experience working in public schools and independent practice, as adjunct faculty, and is currently the Director of Professional Development and Standards for the National Association of School Psychologists. Eric has published and presented on issues related to crisis response, trauma, professional practice, and school safety, and is co-editor of Supporting and Educating Traumatized Students: A Guide for School-Based Professionals published by Oxford University Press.

The National Center for Mental Health and Juvenile Justice

345 Delaware Avenue, Delmar, NY, 12054 | www.ncmhjj.com
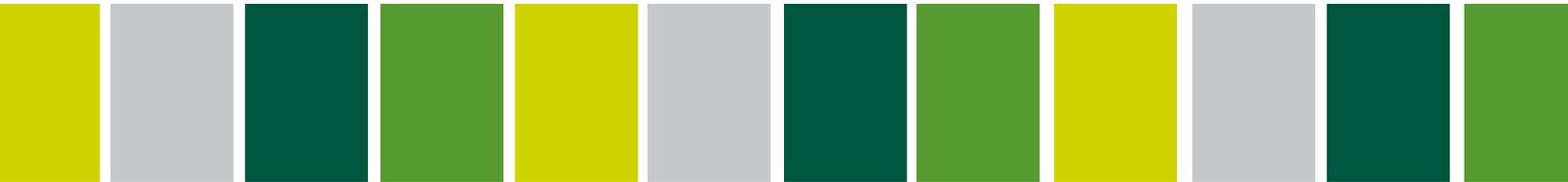
Educators and mental health professionals have grown increasingly concerned about the exposure to and experience of traumatic life among children and adolescents. Addressing and responding to trauma is essential to the mission and purpose of schools: learning (Rossen & Cowan, 2013). As a result, the need for thorough and accurate assessment of trauma, including screening and assessment measures, has grown in recent years. Despite a widening array of available measures for the assessment of trauma (See NCTSN, n.d.), the administration of these measures within school settings is relatively new, with very little evidence supporting the utility of these practices within schools. The following brief provides an overview of the prevalence and impact of trauma among children and adolescents, the role of screening and assessment in the identification of trauma, school-based screening considerations, and how to link screening data with potential interventions within schools.

Background

Nearly a century of literature on trauma has focused on adults, particularly related to tragic accidents, military casualties, and violent injury or death. Only since the mid- to late-1990s (See Adverse Childhood Experiences (ACE) Study; Felitti et al., 1998) has childhood stress and trauma been consistently linked to negative academic, occupational, physical, behavioral, and mental health outcomes. This laid the foundation for a growing recognition of the prevalence and impact of childhood adversity, stress, and trauma on children and youth.

Among the school-aged population, childhood adversity and trauma are associated with lower achievement, truancy and dropout, behavioral problems, mental illness, neurobiological changes, and difficulty managing emotions and social relationships (Hertel & Johnson, 2013). The range of stressors and experiences that contribute to such outcomes are broad, wide-ranging, ongoing, and present within all communities. These stressors include household challenges (e.g., domestic abuse or parental separation, mental illness, and incarceration); childhood maltreatment (i.e., abuse or neglect); and environmental stressors (e.g., community violence, natural disaster). While no clear causal links exist among childhood adversity, trauma, and potential negative outcomes, the association among them is well-established. Childhood adversity and trauma has emerged as one of the most critical public health concerns for children and youth (Blaustein, 2013), making this both relevant and necessary for schools to address. Recently, in light of these findings, many school districts have considered the use of universal screening to help identify traumatized students and to use this data to guide the delivery of interventions and supports at school.

Universal Screening

Universal screening is a proactive approach of using brief and efficient measures to identify students at risk for future difficulties (Eklund & Dowdy, 2014; Jenkins, Hudson, & Johnson, 2007). Data is then used to help connect children with much needed services and supports.

Schools provide an ideal setting for identifying at-risk students due to the large number of youth in school and the ability to provide follow-up care (Levitt et al., 2007; Glover & Albers, 2007) without some of the traditional barriers to accessing care in the community (e.g., cost, insurance, transportation). On the basis of research that shows positive outcomes may be achieved through early identification and intervention, recent educational policy and legislation places an increased focus on using universal screening measures to help provide supports to children in schools (IDEA, 2004; New Freedom Commission on Mental Health, 2003).

Despite this research and screening's status as an essential component of multi-tiered systems of support (MTSS) or three-tiered models of service delivery, only one in eight schools have adopted universal screening procedures (Bruhn, Woods-Groves, & Huddle, 2014). While initial research demonstrates that screening helps identify at-risk students often previously unknown to school staff and/or not receiving services (Eklund & Dowdy, 2014), myriad reasons for such limited implementation of universal screening exist including a lack of awareness of screening practices, concerns about consent procedures, and limited time and resources within schools (Chafouleas, Kilgus, & Wallach, 2010).

Universal screening procedures typically include assessing an entire population (e.g., all students, parents, and/or teachers) about a specified concern through short and efficient surveys and/or uses teacher nomination procedures where teachers rank order students with concerns in their classroom. These data are then used to determine if a student demonstrates risk of current or future concerns. When a school leadership team makes the decision to conduct any type of screenings, there are many options available to meet a school's needs. Key considerations during the planning and decision-making process are included in the text box below.

Trauma Screening Considerations

- Identifying which concern(s) to examine (e.g., internalizing behaviors, trauma symptoms, sources of adversity or stress)

- Identifying which screening tool to use

- Examining costs associated with purchasing screening measures

- Calculating personnel time, training, and effort needed to administer measures, score data, analyze and interpret findings, as well as connect data to interventions

- Identifying who will complete measures (e.g., teacher, parent, student, etc.)

- Ensuring that adolescents, parents, and school personnel are aware of the purposes and use of screening tools (i.e., informed consent)

- Determining the number and timing of screening administrations (e.g., fall and spring)
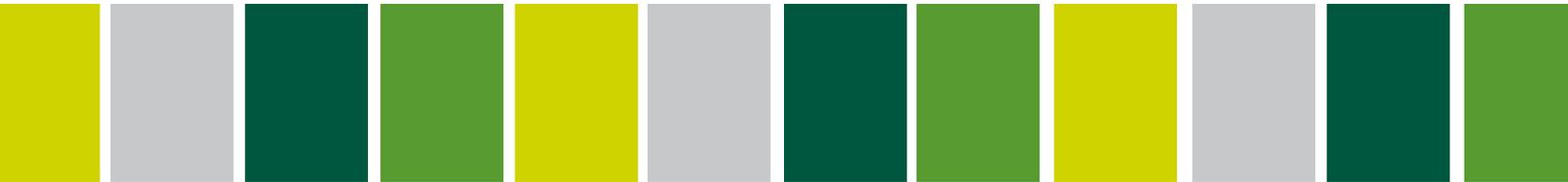
As screening measures are by definition brief, they typically only alert educators that a problem exists and do not provide information regarding the specific nature of that risk. While most universal screening efforts lead to the identification of individual students considered "at risk" that warrant additional assessment or follow-up, universal screening data may also help identify the scope of a problem among a community of students.

Screening for Trauma in Schools

Implementing early screening and identification for childhood trauma is seemingly intuitive as elevated trauma symptoms are predictive of negative short- and long-term academic and health outcomes (Alisic, Jongmans, van Wesel, & Kleber, 2011). Further, the likelihood of adverse experiences that may lead to trauma are prevalent and ubiquitous. Approximately two-thirds of all students report one or more adverse experiences during their school-aged years (Gonzalez, Monzon, Solis, Jaycox, & Langley, 2016; Jaycox et al., 2002; Kataoka et al., 2003). Thus, systematic processes to identify the extent and severity of the problem as well as individuals' resilience and ability to cope after traumatic experiences can assist professionals to adequately respond with appropriate individualized, school-wide, and community-based services.

Initial studies into screening for traumatic risk among students have used a variety of methods to improve the feasibility and utility of screening within schools. This has included consideration of consent procedures; who might serve as the best informant of assessing traumatic risk among students (e.g., self-report, parents, teachers); how to use developmentally appropriate methods for assessing youth (e.g., interviews, rating scale); and planning for the amount of time needed to engage in universal screening practices.

Parental consent

Due to the sensitive nature of asking children about their exposure to potentially traumatic experiences, parental consent becomes a critical consideration when engaging in school-based screening procedures. Challenges include obtaining active parental consent to ensure true "universal" screening procedures can be employed. In previous studies of universal screening for trauma or adverse experiences, less than half of students' caregivers gave consent to participate when using active consent procedures (Gonzalez et al., 2016; Woodbridge et al., 2016). Some schools use passive consent, whereby consent is implied unless a caregiver actively "opts out," though some view this process as less ethical, particularly in communities with high populations of illiteracy or non-English speaking families. Finally, parental consent may lead to self-selection bias if parents are knowingly contributing to stressful experiences (e.g., a parent who regularly physically abuses their child may be less likely to issue consent). Despite the potential for lower response rate, active consent procedures are recommended if schools wish to engage in trauma-related screenings. Ensuring that caregivers are fully informed about the rationale for the questions, have a clear sense of the potential benefit, and believe their information will be handled safely increases the likelihood of consent (Blodgett, 2012).
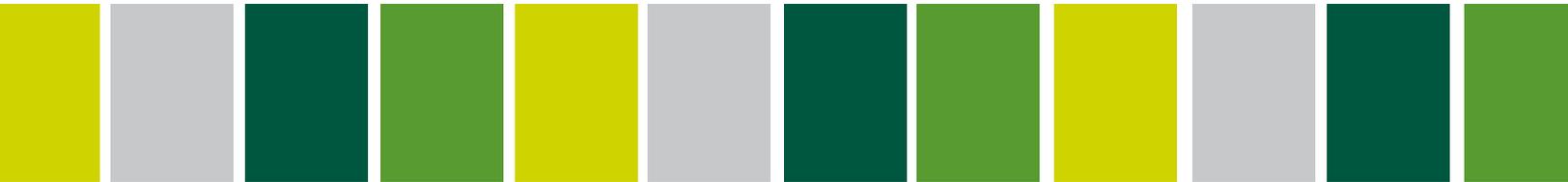
Developmentally appropriate screening methods

Of the few studies that have explored universal screening for trauma risk, most have utilized either rating scales or individual student interviews (Gonzalez et al., 2016; Woodbridge et al., 2016). As teachers spend the most time with students during the school day, they may arguably serve as an important informant in the identification of student risk. However, many teachers report a lack of knowledge of trauma-related symptoms and reactions among students and desire more trauma education as part of their own professional in-service training (Baweja, Santiago, Vona, Pears, Langley, & Kataoka, 2016). Teachers may also be unaware of student's adverse experiences outside of school. As a result, increased focus has been placed on student self-report data through the use of rating scales and individual student interviews.

As student reading levels vary, even among upper elementary, middle, and high school students, it is important to ensure adequate comprehension before administering individual surveys. Similarly, adults conducting individual student surveys will want to consider student comprehension of survey items or interview questions. This may include the need to make developmentally appropriate modifications to measures. In some cases, measures can be modified by verbally administering screening instruments so that clarifications can be made to words that are unfamiliar to youth and using visual aids to help students understand response options (Gonzalez et al., 2016). This ensures that students are able to accurately understand what is being asked of them and for researchers to ascertain accurate information on the nature and severity of student's traumatic risk. Accurate identification relies upon both student understanding of items and adherence to appropriate standardization procedures for making such high stakes decisions.

Time considerations

When conducting screening interviews and/or measures with students, administration time has varied from 5-10 minutes per student for students not experiencing trauma or adversity, and 15-25 minutes for those that endorse one or more adverse experiences (Gonzalez et al., 2016) as additional in-depth questions are often required. When administering student self-reports via paper and pencil to adolescents with age appropriate reading levels, group screening measures took, on average, 15 minutes (Woodbridge, 2016). Schools will want to consider the length of time needed to conduct interviews, self-reported surveys, and/or teacher reported data when scheduling screening administration in schools. Additionally, schools should consider the time and expertise required to analyze and interpret any findings; interpreting interview data, while providing more in-depth information, can require significant effort.

Cautions for Trauma Screening in Schools

School-based screening for trauma exposure is relatively new, with very few studies demonstrating evidence for the utility of these practices within schools. Further, despite promising development of trauma screening tools (See Table 1) and its use even in increasing awareness of trauma among educators (See Gonzalez et al., 2016), others caution against it. For example, Cole, Eisner, Gregory, and Ristuccia (2013) state,
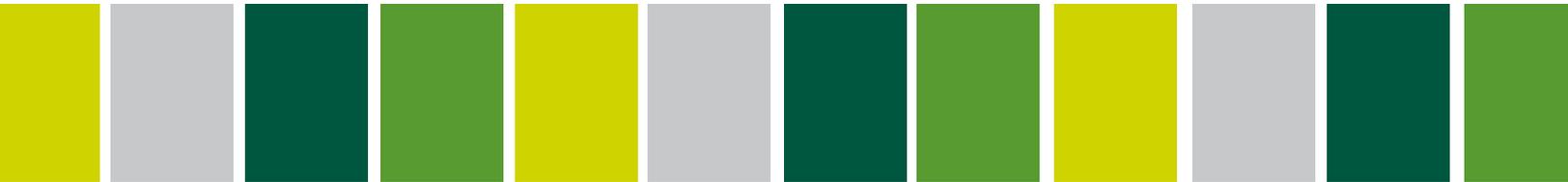
"a common reaction to the whole-staff presentation is the notion that trauma sensitivity requires screening and identifying all children who have had traumatic experiences. In fact, this is not recommended and could be quite harmful. In addition to stigmatizing some children, this approach also reinforces the idea that trauma sensitivity is solely about applying interventions to particular children instead of creating a safe whole-school environment for all children." (p. 54).

At present, few studies clearly articulate best practices for school-based screening procedures and methods for identifying trauma-exposed youth.

Additional concerns arise from challenges in obtaining reliable and valid measurements. The first major concern relates to what will be screened. Trauma refers to the individual's response to adverse and overwhelming conditions or experiences (e.g., fear, loss of sleep, emotional lability), rather than the experience itself (e.g., loss of a parent; Hertel & Johnson, 2013). With varying definitions coupled with the subjectivity of trauma, its accurate measurement among large groups of individuals has proven both challenging and unwieldy, particularly within a screening process. Measuring objectively defined sources of stress or adversity (e.g., child maltreatment, parental incarceration), on the other hand, can be done more efficiently and effectively. However, some stressors may occur within a context of silence and secrecy (e.g., childhood sexual abuse), creating an additional barrier to accurate reporting.

Often, schools engaging in trauma screening ask questions about the experienced sources of stress (e.g., Have you ever experienced childhood maltreatment?) rather than the individual responses or behaviors to adversity (e.g., Do you have recurring nightmares or think a lot about _____?). While simply experiencing adversity or stress in childhood increases the risk of a range of negative outcomes, only a minority of those individuals will ever demonstrate clinical symptoms of traumatic stress (Alisic, Zalta, van Wesel, Larsen, Hafsted, Hassanpour, & Smid, 2014). Even a known stressor leading to a known traumatic response does not perfectly predict negative school or life outcomes.

Currently, no diagnosis exists that can account for the cluster of symptoms that often occur among children with trauma histories (D'Andrea, Ford, Stobach, Spinazolla, & van der Kolk, 2012). Therefore, while screening for adverse experiences likely yields the most measurable and accurate information quickly, its utility in identifying students or groups experiencing clinical trauma or in need of services is less accurate.

A second caution rests with who completes a universal screening measure. Parents and children, historically, do not demonstrate high agreement when reporting on a child's experiences with adversity and trauma (Shemesh et al., 2005; Stover, Hahn, Im, & Berkowitz, 2010). Additional concerns, as with most forms of screening, relate to the school's ability to respond to identified needs. With the known prevalence of adversity and stress among children and youth, some schools have simply opted to not ask the questions they are not prepared to know the answers to. As an example, Gonzalez et al. (2016) noted that administrators within the study requested that the screening not include questions regarding sexual abuse histories.

Put simply, the extant literature has established that adversity may lead to trauma and increases the risk of negative outcomes, and those findings may differ based on several factors within the screening
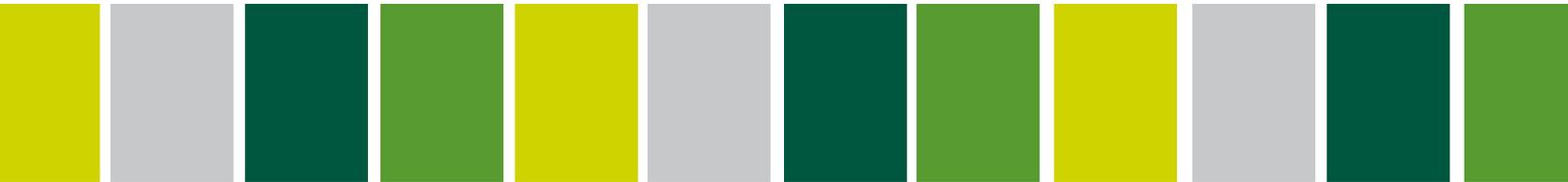
process (e.g., who completes the tool). Such uncertainty, while common in social science research, implicates the need for caution when considering universal screening for trauma in schools.

Trauma Screening Measures

A number of brief trauma risk screening measures have emerged from clinical settings and initial research has explored their utility in school settings. While there is limited research on their use within schools, initial data is available that supports their psychometric properties. Table 1 provides an overview of a few of these measures, describing the instrument, the construct(s) assessed, length, informant, and age range of each measure, and the evidence to support their reliability and validity. Additional measures can be found by visiting the National Child Traumatic Stress Network (n.d.).

Linking Trauma Screening Data to Interventions

Practical and accurate screening methods, when deployed appropriately and with adequate staff buy-in and commitment, better inform schools about where to focus resources for youth. The same could be said for using trauma screening data to consider how schools can allocate training, professional development, and/or services to the school community, based on survey results. For example, an examination of school-wide trauma screening data can be used to determine what percentage of the school population may be experiencing chronic stress, exposed to community violence, or at-risk for trauma-related symptoms.

Multiple studies have replicated the pervasive nature of adverse childhood experiences; many communities find the majority of students have experienced at least one adversity or stressor during their school years (Blaustein, 2013). However, providing targeted or intensive (also referred to as Tier 2 or Tier 3) interventions for greater than 20% of students is problematic. These interventions require significant resources (e.g., staff and student time) and are not effective at preventing significant problems from developing among other students in the future. Instead, universal (or Tier 1) supports focused on positive behavioral support frameworks, efforts to improve school safety and connectedness, restorative practices, and trauma-informed approaches present a more appropriate and viable solution to supporting traumatized students (Rossen & Cowan, 2013).

Trauma Informed Schools

While any school would benefit from a trauma-informed, or trauma-sensitive approach, an appropriate trauma screening can perhaps help identify to what degree such approaches may positively impact the school community. Trauma-informed schools recognize that many problematic student behaviors reflect a developmental response to their experiences rather than willful, purposeful misbehavior. They reflect a shift from asking, "what is wrong with you?" to "what happened to you?" Adults in trauma-informed schools assume a shared awareness and sensitivity to the potential impact of trauma and adverse experiences on students' lives.

Multiple trauma-informed models exist, such as the Attachment, Self-Regulation, and Competency (ARC; Kinniburgh & Blaustein, 2005) framework; the Flexible Framework (Cole, O'Brien, Gadd, Ristuccia, Wallace, & Gregory, 2005); Healthy Environments and Response to Trauma in Schools (HEARTS; Dorado,
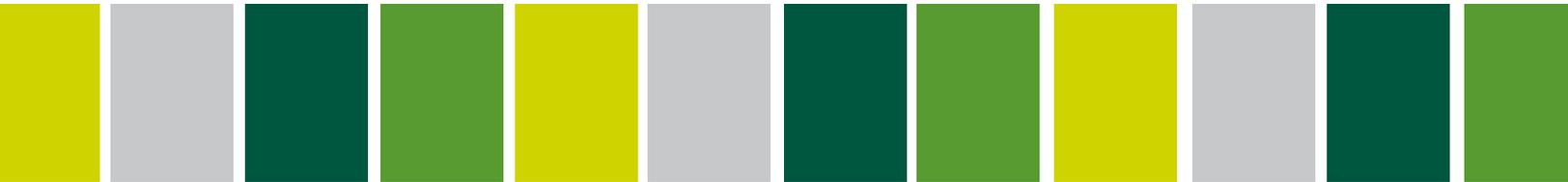
Martinez, McArthur, & Liebovitz, 2016); and even a Trauma-Informed Approach from the Substance Abuse and Mental Health Services Administration (see http://www.samhsa.gov/nctic/trauma-interventions). While each framework has unique features and strengths, the common components of a trauma-informed school include:

1. School-wide focus. Includes recognition that while many students are not impacted, and that there is often a range of stress, only providing direct treatment to those experiencing trauma symptoms is akin to "waiting to fail." Approaches should focus on the entire school's policies and practices (e.g., discipline, family engagement, positive behavior supports).
2. Dedication to a safe school environment. See the Framework for Safe and Successful Schools for additional information (Cowan, Vaillancourt, Rossen, & Pollitt, 2013).
3. Building student capacities. Includes recognition that skills associated with resilience, coping, and relationship building can, and should, be explicitly taught and nurtured.
4. Building staff capacities. Professional development should focus on awareness building, effective discipline, educational strategies to support students experiencing stress and trauma, and strategies to prevent burnout

Trauma-informed practices do not constitute a separate program, yet is part of an overall framework for how schools identify needs, utilize resources, and provide services and supports. In this manner, trauma-informed practices fit well within an overall MTSS framework, as well as other best practices for school crisis prevention and management (e.g., PREPaRE; Brock et al., 2016). Likewise, within MTSS, some students may benefit from more intensive, or targeted interventions, particularly those identified through a screening process.

Targeted Trauma Interventions

Trauma screening data can be used to determine how impacted a given classroom or grade may be. School mental health professionals, such as a school psychologist or school counselor, can use this needs assessment to determine how to structure time, resources, and student support throughout the year. For example, school-wide screening data may indicate one classroom of fifth grade students are in need of support for addressing signs of traumatic stress. In such cases, several targeted interventions have demonstrated positive outcomes among students experiencing trauma, including Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, Kataoka, Stein, Langley, & Wong, 2012); trauma-focused cognitive behavioral therapy (TF-CBT; Child Welfare Information Gateway, 2012); or Head Start Trauma Start (Holmes et al., 2014), a program used in Head Start classrooms. However, the most effective approaches are those that exist within an overall school environment that institutes trauma-informed practices consistently and sustainably throughout the entire school community.
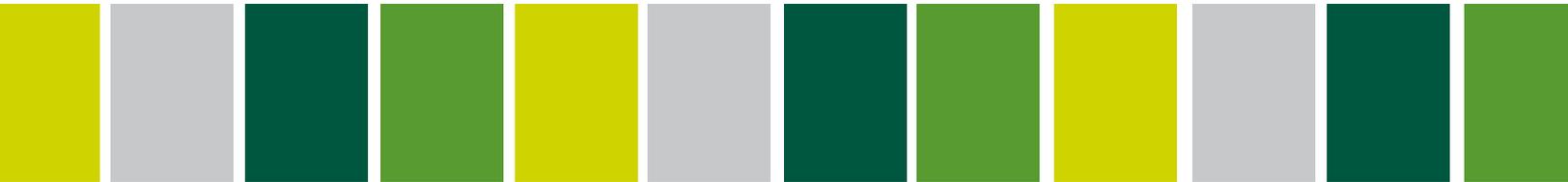
Trauma Screening in Schools: Key Summary Points

- Screening for exposure to adversity can serve as a useful tool to determine potential risk for stress or trauma among students in schools
- Always obtain active parental informed consent for screening
- Screening tools administered to students may be more accurate than other informants (e.g., teachers, parents), though must be provided at a developmentally appropriate level
- Outcomes of screenings can help identify the severity or degree of need in a school community and help direct resources to support traumatized students
- Schools should consider existing resources and processes to address identified needs prior to implementing trauma screening in schools
- Supports should be provided through an MTSS framework, with a trauma-informed approach and implementation of more targeted, intensive interventions as necessary
- Individual services should not be determined solely through the screening process; follow-up assessment and individualized determination of needs are critical

References

Alisic, E., Zalta, A. K., Van Wesel, F., Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). Rates of post-traumatic stressdisorder in trauma-exposed children and adolescents: Meta-analysis. *British Journal of Psychiatry, 204,* 335-340.

Baweja, S. Santiago, C. D., Vona, P., Pears, G., Langley, A., & Kataoka, S. (2016). Improving implementation of a school-based program for traumatized stduents: Identifying factors that promote teacher support and collaboration. *School Mental Health, 8,* 120-131.

Bernstein, D. P., Ahluvalia, T., Pogge, D., & Handelsman, L. (1997). Validity of the Childhood Trauma Questionnaire in an adolescent psychiatric population. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*, 340-348.

Bernstein, D. P, & Fink, L. (1998). *Childhood Trauma Questionnaire: A retrospective self-report manual.* San Antonio, TX: The Psychological Corporation.

Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., ... & Zule, W. (2003). Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child Abuse & Neglect*, *27*, 169-190.

Blaustein, M. E. (2013). Childhood trauma and a framework for intervention. In E. Rossen and R. Hull (Eds.), *Supporting and educating traumatized students: A guide for school-based professionals* (pp. 1–21). New York: Oxford University Press.

Blodgett, C. (2012). *Adopting ACEs screening and assessment in child serving systems.* Working Paper. WSU Area Health Education Center.

Briere, J. (1996). Trauma symptom checklist for children. *Odessa, FL: Psychological Assessment Resources*.

Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., ... & Ernst, V. (2001). The Trauma Symptom Checklist for Young Children (TSCYC): Reliability and association with abuse exposure in a multi-site study. *Child Abuse & Neglect*, *25*, 1001-1014.

Brock, S. E., Nickerson, A. B., Louvar Reeves, M.,Conolly, C., Jimerson, S. R., Pesce, R., & Lazzaro, B. (2016). *School crisis prevention and intervention: The PREPaRE Model* (2nd ed.)*.* Bethesda, MD: National Association of School Psychologists.

Brophy-Herb, H. E., Lee, R. E., Nievar, M. A., & Stollak, G. (2007). Preschoolers' social competence: Relations to family characteristics, teacher behaviors and classroom climate. *Journal of Applied Developmental Psychology*, *28*, 134-148.

Bruhn, A. L., Woods-Groves, S., & Huddle, S. (2014). A preliminary investigation of emotional and behavioral screening practices in K-12 schools*. Education and Treatment of Children, 37*,
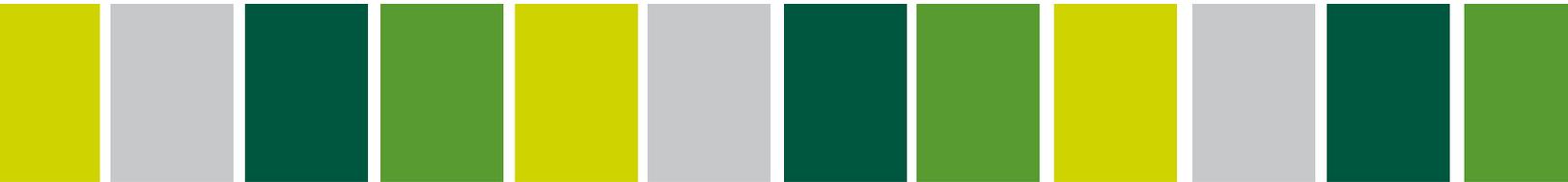
611-634.

Chafouleas, S. M., Kilgus, S. P., & Wallach, N. (2010). Ethical dilemmas in school-based behavioral screening. *Assessment for Effective Intervention, 35,* 245–252.

Child Welfare Information Gateway. (2012). *Trauma-focused cognitive behavioral therapy for children affected by sexual abuse or trauma* (Issue brief). Washington, DC: Author.

Cole, S. F., O'Brien, J. G., Gadd, M. G., Ristuccia, J., Wallace, D. L., & Gregory, M. (2005). *Helping traumatized children learn: Supportive school environments for children traumatized by family violence*. Boston, MA: Massachusetts Advocates for Children, Trauma and Learning Policy Initiative.

Cole, S. F., Eisner, A., Gregory, M., & Ristuccia, J. (2013). *Helping traumatized children learn: Creating and advocating for trauma-sensitive schools.* Boston, MA: Massachusetts Advocates for Children.

Cowan, K. C., Vaillancourt, K., Rossen, E., & Pollitt, K. (2013). A framework for safe and successful schools [Brief]. Bethesda, MD: National Association of School Psychologists.

D'Andrea, W., Ford, J., Stobach, B., Spinazolla, J., & van der Kolk, B. A. (2012). Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *American Journal of Orthopsychiatry, 82*, 187–200.

Davis, W. B., Mooney, D., Racusin, R., Ford, J. D., Fleischer, A., & McHugo, G. (2000). Predicting post-traumatic stress after hospitalization for pediatric injury. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 576–583.

Dorado, J. S., Martinez, M., McArthur, L. E., & Liebovitz, T. (2016). Healthy Environments and Response to Trauma in Schools (HEARTS): A school-based, multi-level comprehensive prevention and intervention program for creating trauma-informed, safe and supportive schools. *School Mental Health.* doi:10.1007/s12310-016-9177-0

Eklund K., & Dowdy, E. (2014). Screening for behavioral and emotional risk versus traditional school identification methods. *School Mental Health, 6*, 40-49.

Eklund, K., & Tanner, N. (2014). Providing multi-tiered systems of support for behavior: Conducting behavior screening at school. *Principal Leadership, 10,* 50-52.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). The relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Jouranl of Preventive Medicine, 14,* 245–258.

Ford, J. D. (2008). Diagnosis of traumatic stress disorders (DSM and ICD). In G. Reyes, J. D. Elhai, & J. D. Ford (Eds.), *Encyclopedia of psychological trauma* (pp. 200–208). Hoboken, NJ: Wiley.

Ford, J. D., Racusin, R., Rogers, K., Ellis, C., Schiffman, J., Ribbe, D., ... & Edwards, J. (2002). Traumatic Events Screening Inventory for Children (TESI-C) Version 8.4. *National Center for PTSD and Dartmouth Child Psychiatry Research Group, Dartmouth VT*.

Forness, S. R., Freeman, S. F., N. Paparella, T., Kauffman, J. M., & Walker, H. M. (2012). Special education implications of point and cumulative prevalence for children with emotional or behavioral disorders. *Journal of Emotional and Behavioral Disorders, 20*, 4-18.

Gonzalez, A., Monzon, N., Solis, D., Jaycox, L., & Langley, A. K., (2016). Trauma exposure in elementary school children: Description of screening procedures, level of exposure, and stress symptoms. *School Mental Health, 8*, 77-88.

Glover, T. A., & Albers, C. A. (2007). Considerations for evaluating universal assessments. *Journal of School Psychology, 45,* 117– 135. doi: 10.1016/j.jsp.2006.05.005

Hertel, R., & Johnson, M. M., (2013). How the traumatic experiences of students manifest in school settings. In E. Rossen & R. Hull, Supporting and educating traumatized students (23-47). New York: Oxford University Press.

Holmes, C., Levy, M., Smith, A., Pinne, S., & Neese, P. (2014). A model for creating a supportive trauma-informed culture. *Journal of Child and Family Studies, 24*, 1650–1659.

Jaycox, L. H., Kataoka, S. H., Stein, B. D., Langley, A. K., & Wong, M. (2012). Cognitive behavioral intervention for trauma in schools. *Journal of Applied School Psychology*, *28*, 239-255.

Jaycox, L. H., Stein, B. D., Kataoka, S. H., Wong, M., Fink, A., Escudero, P., et al. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant school children. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 1104–1110.

Jenkins, J. R., & Hudson, R. F., & Johnson, E. S. (2007). Screening for at-risk readers in a response to intervention framework. *School Psychology Review, 36*, 582-600.

Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., et al. (2003). A school-based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*, 311–318.

Kinniburgh, K., & Blaustein, M. (2005). *Attachment, Self-Regulation, and Comptency: A comprehensive framework for intervention with complexly traumatized youth. A treatment manual.* Boston, MA: Author.

Lane, K. L., Carter, E. W., Pierson, M. R., & Glaeser, B. C. (2006). Academic, social, and behavioral characteristics of high school students with emotional disturbance or learning disabilities. *Journal of Emotional and Behavioral Disorders, 14,* 108-117.

Levitt, J. M., Saka, N., Romanelli, L. H., & Hoagwood, K. (2007). Early identification of mental health problems in schools: The status of instrumentation. *Journal of School Psychology, 45*, 163–191.

National Child Traumatic Stress Network. (n.d.). *Standardized measures to assess complex trauma.* Retrieved from http://www.nctsnet.org/trauma-types/complex-trauma/standardized-measures-assess-complex-trauma

Oakes, W. P., Lane, K. L., Cox, M. L., & Messenger, M. (2014). Logistics of behavior screenings: How and why conduct behavior screenings at our school? *Preventing School Failure: Alternative education for children and youth, 58*(3), 159-170.

O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Academies Press.

Pynoos, R. S., Rodriguez, N., Steinberg, A. S., Struber, A., & Fredrick, C. (1998). The UCLA PTSD reaction index for DSM IV (Revision 1). Los Angeles: UCLA Trauma Psychiatry Program.

Reschly, D. J. (2008). School psychology paradigm shift and beyond. *Best practices in School Psychology V*, *1*, 3-15.

Ribbe, D. (1996). Psychometric review of traumatic events screening inventory for children (TESI-C). In B. H. Stamm (Ed.), Measurement of stress, trauma, and adaptation (pp. 386–387).

Romer, D., & McIntosh, M. (2005). The roles and perspectives of school mental health professionals in promoting adolescent mental health. In D. Evans, E. Foa, R. Gur, H. Hendin, C. O'Brien, M. Seligman, & B. Walsh (Eds.), *Treating and preventing adolescent mental health disorders: What we know and what we don't know* (pp. 598 – 615). New York, NY: Oxford University Press.

Rossen, E., & Cowan, K. C. (2013). The role of schools in supporting traumatized students. *Principal's Research Review, 8*(6), 1–7.

Roussos, A., Goenjian, A. K., Steinberg, A. M., Sotiropoulou, C., Kakaki, M., Kabakos, C., ... & Manouras, V. (2005). Posttraumatic stress and depressive reactions among children and adolescents after the 1999 earthquake in Ano Liosia, Greece. *American Journal of Psychiatry*, *162*, 530-537.

Severson, H. H., Walker, H. M., Hope-Doolittle, J., Kratochwill, T. R., & Gresham, F. M. (2007). Proactive, early screening to detect behaviorally at-risk students: Issues, approaches, emerging innovations, and professional practices. *Journal of School Psychology*, *45*, 193-223.

Shemesh, E., Newcorn, J. H., Rockmore, L., Shneider, B. L., Emre, S., Gelb, B. D., & Yehuda, R. (2005). Comparison of parent and child reports of emotional trauma symptoms in pediatric outpatient settings. *Pediatrics, 115*, e582–e589. doi:10.1542/peds.2004-2201

Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles posttraumatic stress disorder reaction index. *Current Psychiatry Reports, 6,* 96–100.

Stover, C. S., Hahn, H., Im, J. J. Y., & Berkowitz, S. (2010). Agreement of parent and child reports of trauma exposure and symptoms in the early aftermath of a traumatic event. *Psychological Trauma: Theory, Research, Practice, and Policy, 2*, 159–168. doi:10.1037/a0019156

Tilly, W. D. (2008). The evolution of school psychology to science-based practice: Problem solving and the three tiered model. In A. Thomas & J. Grimes (Eds.), *Best Practices in School Psychology V* (pp. 17–35). Bethesda, MD: National Association of School Psychologists

Appendix A

Table 1. Sample of Trauma Screening Measures Currently Available for Use with Children and Youth			
Instrument	**Construct(s) addressed**	**Length, informants, age range**	**Reliability and validity**
Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998)	Assesses childhood emotional, physical, & sexual abuse; and emotional & physical neglect	28 items, Child self-report, Ages 12 and up	IC = .81-.95; TRT = .79-.86; VC = .50-.75 (Bernstein & Fink, 1998; Bernstein et al., 2003; Bernstein et al., 1997)
Traumatic Events Screening Inventory for Children – Brief Form (TESI-C-Brief; Davis et al., 2000; Ford et al., 2002)	Assesses exposure to direct or witnessed trauma	21 items, Structured child interview, Ages 6-18	IC = .80; IR =.73-1.00 (Ford et al., 2008; Ribbe, 1996)
Trauma Symptom Checklist-Child Version-Posttraumatic Stress Subscale (TSCC-PTS; Briere, 1996)	Assesses general traumatic stress symptoms	10 item subscale of larger 54-item measure, Child self-report, Ages 8-16	IC = .81-.93 (Briere, 1996; Breire et al., 2001)
UCLA Post-traumatic Stress Disorder Reaction index (RI; Pynoos, Rodriguez, Steinberg, Struber, & Fredrick, 1998)	Assesses child report of post-traumatic stress symptoms during the previous month & frequency of DMV-IV PTSD symptoms	48 items, with 19 items that assess XX, Self Report or interview, Ages 7-18	IC = .90; TRT = .84; VC = .70-.93 (Roussos et al., 2005; Steinberg, Brymer, Decker, & Pynoos, 2004)

Note. IC = Internal Consistency Reliability, TRT = Test-Retest Reliability, VC = Validity Coefficient