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RESEARCH ARTICLE

Addressing trauma in schools: Multitiered service delivery options for practitioners

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Abstract

Hundreds of thousands of children are confronted with traumatic experiences each year in the United States. As trauma-informed care begins to take hold in schools, school mental health providers (e.g., school psychologists, counselors, and social workers) desire concrete service-delivery options for students affected by trauma. This article provides examples from the literature via a narrative review of assessment, intervention, and practitioner support options related to childhood trauma. Specific attention is paid to framing concrete school-based trauma service-delivery options within a multitiered systems of support model to align with existing school practices. Given the large amount of literature on this topic, this article aims to reduce the barriers practitioners face when looking to implement trauma services in their schools by organizing example practices from the literature in a commonly used service-delivery framework.

KEYWORDS

childhood trauma, school mental health, multitiered systems of support

Research examining the widespread prevalence of childhood trauma continues to accumulate. In the United States during 2015, child protective services (CPS) agencies collectively substantiated approximately 680,000 cases of child maltreatment and received 4 million reports of suspected maltreatment (U.S. Department of Health and Human Services, 2017). National prevalence surveys indicate that 13% of all children experience abuse or neglect during the prior year with the lifetime prevalence (up to age 18) of approximately one in four (Finkelhor, Turner, Shattuck, Hamby, & Kracke, 2015). Data collected by state CPS agencies shows that one in eight children in the United States experience substantiated maltreatment by age 18 (Wildeman et al., 2014). If one accounts for other traumas such as car accidents, community violence, and natural disasters, the number of students experiencing trauma increases. Although not all children who experience a potentially traumatic event develop traumatic stress symptoms (Ackerman, Newton, McPherson, Jones, & Dykman, 1998; Copeland, Keeler, Angold, & Costello, 2007), many children develop a variety of psychological concerns that interfere with their educational performance, including but not limited to posttraumatic stress disorder (PTSD) (Perfect, Turley, Carlson, Yohanna, & Saint Gilles, 2016). Furthermore, the estimated lifetime economic cost (in 2010 U.S. dollars) for one case of confirmed and survived maltreatment is ~$210,000, including ~$8,000 toward special education (Fang, Brown, Florence, & Mercy, 2012). Previous guidance (Chafouleas, Johnson, Overstreet, & Santos,

2016) argues that schools hold tremendous promise to serve these students when they employ multitiered systems of support (MTSS) to organize and deliver appropriate instruction and intervention for all students.

Recent scholarship in trauma-informed care (TIC) has noted the proliferation of TIC efforts across sectors, including schools, while calling for clearer operationalization and subsequent empirical measurement of the overarching concept (Berliner & Kolko, 2016; Hanson & Lang, 2016). Similarly, TIC has been criticized as lacking definitional clarity and being insufficiently different from good clinical care (Berliner & Kolko, 2016). A qualitative study of multidisciplinary providers ($N = 126$, including teachers) found that the providers desired more concrete action steps in addition to training in the larger "philosophy" of TIC (Donisch, Bray, & Gewirtz, 2016).

As TIC makes inroads into schools, educators and school mental health professionals (SMHPs) (e.g., school psychologists, school-based clinical psychologists, school social workers, school counselors) are left to translate "the big idea to everyday practice" (Berliner & Kolko, 2016, p. 169). The stakes for this translation are high for districts, schools, staff, families, and, most importantly, for students impacted by trauma. There are also emerging legal pressures. In the recent *Peter P., et al. v. Compton Unified School District, et al.* (2015), students and teachers filed suit against their school district for allegedly failing to respond appropriately to students who experienced trauma. Additionally, the recent Every Student Succeeds Act of 2015 includes a provision for mental health services in schools that are "based on trauma-informed practices that are evidence-based" (ESSA 2015).

MTSS is a commonly adopted public health approach to school-based service provision that blends tiered models of academic, behavioral, and mental health service delivery (Barrett, Eber, & Weist, 2009; Sugai & Horner, 2009). This approach has gained traction since response to intervention (RtI) was codified into law with the 2004 revision of the Individuals with Individuals with Disabilities Education Act (2004; Jacob, Decker, & Hartshorne, 2011). In MTSS frameworks, services are organized into three tiers of increasing intensity (tier 1 or universal, tier 2 or selective, and tier 3 or indicated). Between each tier, data-based decision-making informs an accurate deployment of resources. This paper organizes trauma services within this framework to promote integration into current MTSS models.

Briggs (2013) proposed the addition of a tier 0 to describe the social, political, and historical context in which school services are provided and to account for social determinants of health. In trauma work, tier 0 can be conceptualized as an arena in which practitioners, researchers, and community members intervene to change the social conditions that produce and exacerbate psychological trauma. For example, trauma practitioners at tier 0 might advocate for an end to war and sexual violence (two prevalent risk factors for PTSD; Hoge, Auchterlonie, & Milliken, 2006; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), for social programs that alleviate poverty (a risk factor for trauma exposure; Klest, 2012), for school funding equity, for legislation that reduces the availability of firearms, for interventions that provide families with psychosocial supports, and for universal healthcare to improve treatment access.

Today's educators work in incredibly challenging and under-resourced environments. Staff in high-needs schools may be especially susceptible to secondary traumatic stress. Secondary traumatic stress is the emotional distress that results from hearing trauma narratives and working with clients who have experienced first-hand trauma (National Child Traumatic Stress Network, 2011). Available models cite lack of trauma-specific training, low institutional support, and inadequate resources as key factors in the development of secondary traumatic stress (Pearlman & Saakvitne, 1995). Thus, this review also includes supports for school staff working with trauma-exposed youth.

In this article, we translate the research literature on the assessment and intervention for childhood trauma with the aim of creating an operationalized model of trauma practices that may be suitable for schools. While previous guidance on MTSS trauma models exist (Chafouleas et al., 2016), as do a handful of case studies (Dorado, Martinez, McArthur, & Leibovitz, 2016; Perry & Daniels, 2016; Shamblin, Graham, & Bianco, 2016), the existing literature does not present options for assessments, interventions, and staff supports at each tier. By organizing the literature, this article hopes to reduce the barriers practitioners face in parsing the relevant research. However, many topics necessary for the competent practice of trauma services are beyond the scope of this article and are therefore not addressed. These include laws and ethics around confidentiality and mandatory reporting, informed consent, the clinical skills and sensitivities needed for trauma-informed counseling and assessments, psychopharmacological options, and the complexities of partnering with families who have experienced trauma.

1 | METHOD

A narrative review of the literature was conducted to present a synthesis of options for schools (Grant & Booth, 2009). We began with a search of popular scholarly databases for peer-reviewed articles on school trauma services and used a backward search technique from the reference lists. When school-specific findings were absent or scarce, our searches were expanded into the clinical assessment and treatment realm. We consulted national databases of evidence-based practices (e.g., Institute of Education Sciences What Works Clearinghouse and Substance Abuse and Mental Health Services National Registry of Evidence-Based Programs and Practices) and nationally established trauma organizations (e.g., the National Child Traumatic Stress Network [NCTSN] and the Department of Veterans Affairs National Center for PTSD). A narrative approach was chosen for the flexibility of the method that enabled the authors to better examine fit and feasibility within an MTSS framework and direct applicability to school practitioners. We focused our attention on free to low-cost materials and training possibilities, brevity of assessments and interventions, materials that are already readily available or commonly used, psychometric properties of assessments, racially and economically diverse samples, and the ability to address traumatic stress reactions beyond those of PTSD.

From our review, example practices and interventions were selected for inclusion and further discussion in the construction of an MTSS "menu" of options. The inclusion of one or two example practices from our search serves two purposes: (1) to increase the readability and usability for practitioners, and (2) explain the logic of how the example might fit within an MTSS model. This approach allows practitioners to make use of the underlying rationale for selecting or adapting similar practices that may be more appropriate or available for their individual school/students. To further structure our review and example findings, we chose in advance to present our research across three domains relevant to MTSS: assessment, intervention, and practitioner support. The results below present examples that serve to establish a starting point for practitioners who must choose and adapt evidence-based services based on availability and feasibility in their school context. Last, we attempt to highlight evidence-based practices where possible while also discussing practices that need further validation in school settings.

2 | RESULTS

A summary of results is provided in Table 1. Below, we discuss example practices from the literature and discuss their fit in MTSS frameworks.

2.1 | Tier 1

2.1.1 | Assessment

Universal screening measures within tier 1 of an MTSS framework are essential for accurately identifying students who need more intensive supports. A number of reviews of universal screening practices exist (Kamphaus, Reynolds, & Dever, 2014; Severson, Walker, Hope-Doolittle, Kratochwill, & Gresham, 2007; Whitcomb & Merrell, 2012). Paid screening options are increasingly common in schools, for example, the Systematic Screening for Behavior Disorders (SSBD) (Walker & Severson, 1992) and the Behavioral and Emotional Screening System (BESS) (Reynolds & Kamphaus, 2015). However, there are also free measures that are psychometrically defensible. The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) is a freely available psychosocial screening measure with good psychometrics. A comprehensive review article showed high internal consistencies for the SDQ (above .70) across 26 studies, and evidence of both construct and concurrent validity (Stone, Otten, Engels, Vermulst, & Janssens, 2010). There are teacher rating forms for children 2–4, 5–17, and 18+, as well as parent and self-report forms. The SDQ has been used in over 4,000 studies, is available in over 70 languages, and has national norms for 10 countries (including the United States). Online scoring is available, as well as scoring scripts for the statistics programs R, SPSS, Stata, and SAS. The measure and scoring guidelines are freely available (https://www.sdqinfo.org). Another example of a school-based

TABLE 1 Examples of multitiered service delivery options to address trauma in schools

Tier	Assessment	Intervention	Practitioner Support
Three	University of California at Los Angeles PTSD Reaction Index (Steinberg et al., 2004) The Clinician-Administered PTSD Scale for DSM-5 Child/Adolescent Version (Pynoos et al., 2015) Child PTSD Symptom Scale (CPSS) (Foa et al., 2001) Child and Adolescent Needs and Strengths Manual (Kisiel et al., 2010)	Trauma-focused cognitive behavioral therapy (Cohen et al., 2006, 2012a)	Professional quality of life (Stamm, 2010) Employee assistance programs Referrals to outside clinicians
Two	Behavioral rating scale for children (Reynolds & Kamphaus, 2015) Achenbach System of Empirically Based Assessment (Achenbach & Rescorla, 2001) Trauma Symptom Checklist for Children (Briere, 1996)	Cognitive behavioral intervention for trauma in schools (Stein et al., 2003) Bounce Back (Langley et al., 2015) Support for Students Exposed to Trauma (Jaycox et al., 2009b) DBT skills groups (Mazza et al., 2016)	Consultations from SMH clinicians NCTSN online professional development (https://learn.nctsn.org)
One	Systematic Screening for Behavior Disorders (Walker & Severson, 1992) Behavioral and emotional screening system (Reynolds & Kamphaus, 2015) Strengths and Difficulties Questionnaire (Goodman, 1997) Social, Academic, and Emotional Behavior Risk Screener (Kilgus et al., 2016) Child Trauma Screening Questionnaire (Kenardy et al., 2006) Child Trauma Screen (Lang & Connell, 2017)	Social emotional learning curriculums (Durlak et al., 2011) School-wide positive behavior interventions & supports (Sugai & Horner, 2009) *Helping traumatized children learn* (Cole et al., 2009, 2013) Psychological First Aid in Schools (Brymer et al., 2012)	Attitudes Related to Trauma-Informed Care (Baker et al., 2016) Child Trauma Toolkit for Educators (NCTSN, 2008) Secondary Traumatic Stress: A Fact Sheet for Child-Serving Professionals (NCTSN, 2011) Childhood Adversity Narratives (https://www.canarratives.org) (Putnam et al., 2015)

Note. This table contains examples of services to address student trauma across various components of multitiered systems of support (MTSS) in schools and is not intended to represent a comprehensive review of all available options. Inclusion in the table is not an empirical judgment on the quality of the evidence-base nor a blanket practice recommendation. See results section for a more thorough discussion of the example and its fit into MTSS logic.

social screener is the Social, Academic, and Emotional Behavior Risk Screener (SAEBRS) (Kilgus, Eklund, von der Embse, Taylor, & Sims, 2016). This tool is available through fastbridge.org and has strong evidence of reliability (α = .77–.93 across subscales for teacher ratings), concurrent validity, and diagnostic accuracy for elementary and middle school youth. These screeners may serve as a good front-line identification system for all children who may benefit from more specific tier 2 assessment and intervention, including those who have experienced trauma.

Screening for potentially traumatic events and for trauma symptomatology raises several challenges. Trauma, especially family violence, remains a taboo subject. Parents and schools may object to screeners that ask questions that are perceived to be too invasive, such as items about abuse (Jaycox et al., 2010). School administrators may fear the mandatory reporting concerns universal trauma screening could engender. There are many unanswered questions about the efficacy and ethics of universal screening for adverse childhood experiences (Finkelhor, 2017). Thus, we present broad screeners that suggest difficulties across multiple behavioral/social-emotional domains at tier 1. Once difficulties are identified, brief trauma assessments may occur at tier 2 if indicated, as discussed below. Broad screening may (1) have more social validity in school contexts among parents and administrators, and (2) provide information about a wider range of concerns than direct trauma screening at the tier 1 level. As many schools will only have the resources to

dedicate to one social/emotional/behavioral screening method, a broad screening might better serve the need of all students, including those who have experienced trauma.

However, screening for specific trauma exposure or trauma-related symptoms may be more acceptable within communities that have experienced a natural disaster (Jaycox et al., 2010), political violence (Tol et al., 2008), or armed conflict (Berger, Pat-Horenczyk, & Gelkopf, 2007), in which most of the school community would be expected to be impacted or in which there is strong community support for addressing trauma. An option for trauma-specific screening is the 10-item Child Trauma Screening Questionnaire (CTSQ) (Kenardy, Spence, & Macleod, 2006). This tool was shown to have adequate reliability ($\alpha = .69$), and evidence of convergent validity, sensitivity, and specificity. The screening has been used successfully in the school context (see Charuvastra, Goldfarb, Petkova, & Cloitre, 2010). A promising option for trauma screening that asks about both events and symptoms consistent with the DSM-5 is the 10-item Child Trauma Screen (Lang & Connell, 2017). The screening has child and caregiver versions, is freely available, and has strong psychometric qualities (e.g., child report $\alpha = .78$; parent report $\alpha = .82$; Lang & Connell, 2017).

2.1.2 | Intervention

Two well-supported approaches to broad mental health prevention and promotion in schools include universal social-emotional learning (SEL) curricula and school-wide Positive Behavior Interventions and Supports (PBIS). Alhough there is wide variation across specific SEL curricula, this approach emphasizes increasing success and well-being for all students by directly teaching about emotion identification, emotion regulation, and social problem-solving (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). PBIS promotes prosocial behaviors by developing and teaching consistent expectations and increasing rates of positive teacher-to-student interactions (Sugai & Horner, 2009). Tier 1 components of these programs include explicit instruction around social, emotional, and behavioral expectations and serve as examples of commonly used school-wide universal interventions that promote resiliency, consistency, adaptive coping, connectedness, positive behavior, and well-being for all students, including those who have been exposed to trauma.

In addition to tier 1 components of PBIS and SEL, trauma-informed teaching practices serve as a foundation to addressing the needs of traumatized students within the classroom. An example framework of trauma-informed teaching practices is described in two free volumes titled *Helping Traumatized Children Learn* (Cole et al., 2009; Cole, Eisner, Gregory, & Ristuccia, 2013). Trauma-informed teaching recognizes the frequency and classroom impacts of childhood trauma, focuses on relationship building and emotional regulation instruction instead of punishment, and emotional safety and consistency, and tries to support the "whole student" in the classroom.

One potential complimentary action to TIC is for school staff to implement psychological first aid (PFA). PFA is a set of actions (not psychological treatments or psychotherapy) designed to be implemented by anyone after crisis situations occur and is supported by the NCTSN and the National Center for PTSD (Brymer et al., 2006). PFA aims to increase social support, increase positive coping mechanisms, and encourage problem solving for immediate needs. The NCTSN produced a free guide on PFA in schools (PFA-S) (Brymer et al., 2012). More extensive information about responding to school-based crises is available through the PREPaRE curriculum (Brock et al., 2016).

2.1.3 | Practitioner support

Han and Weiss (2005) suggest that school-based mental health interventions requiring implementation by teachers are only sustainable when they are supported by administrators, acceptable to teachers, viewed as effective, are flexible and adaptable, and are feasible to implement with limited support/resources. Therefore, teachers must themselves be involved in prevention and intervention approaches and receive training related to trauma The *Helping Traumatized Children Learn* volumes emphasize that adopting a "trauma lens" is a whole-school (and statewide) effort that involves multiple stakeholders across multiple sectors (Cole et al., 2009, 2013). To be sustainable, school trauma services must be organized systematically in ways that emphasize prevention, early intervention, and judicious resource allocation.

A tool that may help understand staff readiness for trauma-informed practices is the Attitudes Related to Trauma-Informed Care (ARTIC) scale (Baker, Brown, Wilcox, Overstreet, & Arora, 2016). The ARTIC scale has evidence for

reliability and validity of multiple versions, including an abbreviated 10-item scale ($\alpha = .82$), a 35-item version ($\alpha = .91$), and the full 45-item measure ($\alpha = .93$). A seven-factor structure was confirmed to fit the data well. The seven subscales include (1) underlying causes of problem behavior and symptoms, (2) responses to problem behavior and symptoms, (3) on-the-job behavior, (4) self-efficacy at work, (5) reactions to the work, (6) personal support of TIC, and (7) systems-wide support for TIC (α range from .71 to .81) (Baker et al., 2016). This scale is filled out by school staff to help school systems-change agents more thoroughly understand school readiness for trauma services to address implementation barriers and monitor changes in staff attitudes as interventions are put in place.

Several free resources exist that can be used to provide professional development around trauma informed practices. The Child Trauma Toolkit for Educators (NCTSN, 2008) is a freely available teacher reference. This guide reviews prevalence rates of psychological trauma, symptom pictures for all age ranges, and suggestions for recognizing and working with students who have experienced trauma. Importantly, this overview has a section dedicated to the effects and prevention of secondary traumatic stress. The NCTSN also has a free resource titled, "Secondary Traumatic Stress: A Fact Sheet for Child-Serving Professionals" (NCTSN, 2011). A free presentation on childhood adverse experiences by university researchers is also publicly available (https://www.canarratives.org) (Putnam, Harris, Lieberman, Putnam, & Amaya-Jackson, 2015).

2.2 | Tier 2

2.2.1 | Assessment

Students who screen positive for social, emotional, or behavioral concerns at the universal level may require more targeted assessment to better understand these concerns. Unless the whole community was affected (i.e., by a natural disaster, broadly viewed violent crime), the indication of a trauma concern is often from a reporting party (i.e., parents/guardians, the student, and/or CPS). It is important to note that trauma-informed assessments do not assume a history of trauma or that a history of trauma is causing a given symptom presentation. Tishelman, Haney, O'Brien, and Blaustein (2010) explain:

> *[A] child's difficulties at school can be unrelated to trauma, trauma can be a contributing factor, or trauma can account for most of the observed difficulties. Adopting a "trauma lens" can ensure that trauma is considered as a hypothesis when appropriate but should not be used to overshadow other important etiologies for a child's presentation or lead to an overemphasis on trauma as an explanatory variable when other factors are more salient. (pp. 281–282).*

Thus, practitioners are reminded that trauma is only one hypothesis of many for a child's difficulties. Even when past trauma is documented, it is not an absolute that the current difficulties stem from reactions to the traumatic event. Not all children who experience potentially traumatic events will develop symptoms and these symptoms in children are frequently comorbid with, or may mimic, a number of other conditions, including other anxiety disorders, attention deficit hyperactivity disorder, and oppositional defiant disorder (Ackerman et al., 1998; nd et al., 2007).

Two widely used commercial broadband assessment measures are the Behavioral Rating Scale for Children, Third Edition (BASC-3) (Reynolds & Kamphaus, 2015) and the Achenbach System of Empirically Based Assessment (ASEBA) (Achenbach & Rescorla, 2001). Both of these assessments include protocols for multiple informants across multiple contexts and have a number of subscales that portray a wide range of social, emotional, and behavioral concerns. These assessments may yield information that guide treatment planning and suggest paths for differential and/or comorbid diagnosis. More importantly, these rating scales may provide more targets for intervention for a wide range of symptom presentations beyond traumatic stress.

Trauma assessments that evaluate a wide variety of symptoms and impairments may be an appropriate tier 2 assessment when a traumatic exposure is confirmed. One broadband child trauma measure is the 54-item self-report Trauma Symptom Checklist for Children (TSCC) (Briere, 1996) suitable for ages 8–16. The TSCC takes approximately 15–20 minutes to complete and yields two validity scales and six clinical scales: anxiety, depression, anger,

posttraumatic stress, dissociation, and sexual concerns, each with alpha coefficients ranging from .77 to .89. Spanish forms and computer scoring are available, as are versions of the measure without reference to sexual issues. There is also a-report version called Trauma Symptom Checklist for Young Children (TSCYC) for children 3–12 years old that also demonstrates strong reliability ($\alpha = .82–.93$ across the clinical subscales) (Briere et al., 2001).

It is important not to conflate the mental health assessment of confirmed trauma exposure with assessments/investigations from CPS and/or the legal system. School staff, regardless of their level of training, are cautioned against conducting investigatory or forensic interviews as these are the purview of CPS and/or legal authorities. Great care should be taken not to interfere with or otherwise compromise an ongoing CPS investigation and school staff are cautioned against conducting trauma assessments while any investigation is ongoing. Each child in the CPS system has many individuals potentially involved in their care (social workers, case workers, potential outside therapists, etc.) that may warrant consultation and collaboration.

2.2.2 | Intervention

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a group cognitive-behavioral therapy designed to be delivered in schools. A randomized controlled trial found very large effect sizes (1.08 standard deviations) in the reduction of PTSD scores, moderate effects on depression (.45 standard deviations), and large reductions in parent-reported psychosocial dysfunction (.77 standard deviations) (Stein et al., 2003). CBITS has been studied in multiple states, internationally, with racial minorities, foster care youth, urban and rural youth, children on tribal reservations, and Spanish-speaking youth (Jaycox, 2004; Morsette et al., 2009; Ngo et al., 2008; Schultz et al., 2010). The manual is low cost and the program materials and training are available for free (see www.cbitsprogram.org). CBITS consists of 10 group cognitive-behavioral sessions aimed at reducing PTSD, depression, and anxiety symptoms among trauma-affected youth ages 11 and older. The intervention sequence also includes two parent education sessions and one teacher education session.

A downward extension of CBITS, called Bounce Back, was designed for younger children (grades K-5). A randomized controlled trial ($N = 74$) of racially diverse youth found Bounce Back to be moderately effective (Cohen's $f^2 = .15$ for child report, .09 for parent report) in reducing symptoms of traumatic stress (Langley, Gonzalez, Sugar, Solis, & Jaycox, 2015) and highly acceptable to the children and their families. Although the intervention is based on well-established cognitive behavioral principles, further study is needed (free materials and training are available at https://bouncebackprogram.org).

Support for Students Exposed to Trauma (SSET) is an adaptation of CBITS that is designed to be implemented by classroom teachers (Jaycox, Langley, & Dean, 2009b). The SSET program follows a similar 10-session group format as CBITS. SSET does not, however, include one-on-one sessions with a clinician and has less parent involvement than CBITS (Jaycox et al., 2009b). Whereas SSET has not been as extensively studied as CBITS, a small-scale study showed preliminary effectiveness in reducing PTSD symptoms (ES = -.23) and depression (ES = -.32) (Jaycox et al., 2009a). SSET may be an especially promising program because it relies on teacher implementation and thus may be able to reach larger numbers of students than an intervention administered by an SMHP. Additionally, for school systems in which most students have experienced trauma (e.g., following a natural disaster) SSET holds promise to serve whole communities of students. However, more studies are still needed. Free materials on the SSET program are available (https://ssetprogram.org).

Adaptations of dialectical behavior therapy (DBT), specifically using the skills group component as a tier 2 curriculum for adolescents, have made inroads into schools. DBT is an evidence-based intervention that has demonstrated success in addressing borderline personality disorder and has been used with adolescents who have experienced trauma (Panos, Jackson, Hasan, & Panos, 2014; Geddes, Dziurawiec, & Lee, 2013). DBT skills groups have been used in schools successfully in middle-school samples to reduce health-risk behaviors (Zapolski & Smith, 2017) and behavior concerns (Ricard, Lerma, & Heard, 2013). There is also a published manual to guide the use of DBT skills groups in schools (Mazza, Dexter-Mazza, Miller, Rathus, & Murphy, 2016). Empirical validation of DBT skills groups in school for students who have experienced trauma is needed.

2.2.3 | Practitioner support

It is important for schools to have a system in place through which teachers ask for and receive clinical consultation when needed. This clinical support is likely crucial in guarding against secondary traumatic stress in teachers. This support system is essential because teachers may not have enough opportunities for support outside of potential evaluation contexts (i.e., administrators) (Mahan et al., 2010). Ongoing feedback from consultants has also been linked to sustainability of school-based interventions (Han & Weiss, 2005).

Teachers, administrators, and school mental health providers may also desire more specialized training options to better support students exposed to trauma. The NCTSN has a number of free online trainings for both clinical and nonclinical staff (these online courses are available at https://learn.nctsn.org).

School staff support following a crisis is an important area that needs further research. Group interventions for educators to move forward after experiencing crises have anecdotal reports. For example, Harper High School in Chicago implemented after-action reviews (AARs) in response to 29 of their students being shot in separate community incidents over the course of 1 year, with eight fatalities (Glass, 2013). The U.S. military developed the AAR model to review key events and identify strategies for future responses (Headquarters of the Department of the Army, 1993). Other sectors (most notably emergency services personnel) have used Critical Incident Stress Management (CISM) programs to help staff cope with trauma exposure (Everly, Flannery, & Eyler, 2002). However, certain variants of psychological debriefing following trauma have received criticism for possible iatrogenic effects, warranting caution (Deahl, 2000). Psychoeducation, supportive counseling, and short-term crisis counseling for school staff dealing with trauma material may be beneficial, although more empirical evidence is needed for these uses (Daniels, Bradley, & Hays, 2007). Much more research is needed in the area of formalized methods to support staff in schools in addressing any first-hand exposure and secondary exposure to the traumatic experiences of their students.

2.3 | Tier 3

2.3.1 | Assessment

Over 25 assessment measures exist for psychological trauma in children and adolescents (Strand, Sarmiento, & Pasquale, 2005). There is a public, searchable database of childhood trauma measures maintained by the NCTSN (https://nctsn.org/resources/online-research/measures-review) as well as a list maintained by the National Center for PTSD (https://www.ptsd.va.gov/professional/assessment/child/index.asp). The University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA PTSD RI) (Steinberg, Brymer, Decker, & Pynoos, 2004) is commonly used in the child traumatic stress literature. The UCLA PTSD RI measures both trauma exposure and symptoms, is available for approximately $3 per administration, and has child, adolescent, and parent measures. Evidence of internal consistency reliability ($\alpha = .88–.91$ for total scores across age, gender, and racial/ethnic groups) and convergent validity has been found in a large national sample for the DSM-IV version (Steinberg et al., 2013), and a version aligned with DSM-5 is also available (https://www.reactionindex.com/as-uc-ptsd-ri-dsm5-ca.html). The Clinician-Administered PTSD Scale for DSM-5 Child/Adolescent Version (CAPS-CA-5) (Pynoos et al., 2015) is a semistructured interview tool for the diagnosis of PTSD in children age 7 and above and can be requested from the National Center for PTSD after proof of clinical licensure and appropriate training.

Another measure that may be useful in clinical assessments at tier 3 is the Child PTSD Symptom Scale (CPSS) (Foa, Johnson, Feeny, & Treadwell, 2001). The CPSS has a recently revised version (CPSS-5) to align with DSM-5 criteria and is available as a 27-item interview or self-report that assesses trauma experiences, PTSD symptoms, and associated impairment (Foa, Asnaani, Zang, Capaldi, & Yeh, 2017). Evidence of internal consistency ($\alpha = .92$ for total score for interview and self-report versions), test–retest reliability, as well as convergent and discriminant validity has been demonstrated (Foa et al., 2017). An additional measure, the Child and Adolescent Needs and Strengths (CANS) Trauma Comprehensive version may also be useful to know as this tool is sometimes used by child-welfare agencies to coordinate services and is freely available from the NCTSN (Kisiel et al., 2010). Training and certification is required for

reliable and ethical administration of the CANS (Kisiel et al., 2010). Lyons (2009) reports reliability of .85 for the CANS as a case review method conducted by individuals who have been certified.

Great care and caution should be exercised in the comprehensive clinical assessment of childhood trauma. Practitioners should seek supervision and never operate outside their areas of training. Tier 3 assessments of childhood trauma may warrant outside referral to a clinician with expertise in this area. However, familiarity with clinical instruments is likely to facilitate increased communication and collaboration with outside providers. It is imperative that tier 3 assessments be multi-method, multi-source, and multi-setting in considering a number of possible etiologies both related and unrelated to traumatic stress reactions. As discussed previously, assessing only PTSD symptoms is likely to miss other important areas of concern. Schools and school clinicians are a key source of this information in comprehensive assessments.

2.3.2 | Intervention

A number of studies support the effectiveness of cognitive behavioral therapy for a variety childhood psychopathologies, including traumatic stress (Butler, Chapman, Forman, & Beck, 2006; Feeny, Foa, Treadwell, & March, 2004). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino, & Deblinger, 2006; Cohen, Mannarino, & Deblinger, 2012a) is a widely studied individual treatment of children and adolescents with trauma symptoms. A meta-analysis identified 21 studies for inclusion and found a mean effect size of -1.48 when compared to no treatment controls and a mean effect size of -.28 compared to alternative treatment controls (Lenz & Hollenbaugh, 2015). TF-CBT has been successfully adapted to various contexts and populations, including with racial minorities, youth in foster care, international settings, military settings, children with developmental disabilities, and youth with complex trauma (Cohen et al., 2012a; Cohen, Mannarino, Kliethermes, & Murray, 2012b). A free implementation manual for TF-CBT is also available from the NCTSN (https://www.nctsnet.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf). SMHPs can access free TF-CBT training online (https://tfcbt.musc.edu).

Although this intervention is most often delivered in clinics, we believe, given Rivera's (2012) account of school-based implementation, that TF-CBT treatment could be feasibly delivered as a tier 3 intervention in schools by SMHPs or outside therapists. There is evidence that schools are both acceptable sites of trauma treatment and sites that reduce barriers to trauma care. A study that compared school-based CBITS to clinic-based TF-CBT in a post-hurricane context found significant barriers to students accessing clinic-based TF-CBT (Jaycox et al., 2010). Of the 60 students assigned to clinic-based TF-CBT, 38 did not come for the intake. Of those children that did begin TF-CBT treatment in the clinic, only 15% finished treatment. Comparatively, 91% of students who began school-based CBITS finished treatment. Some parents in the study did, however, ask for TF-CBT to be provided in schools (Jaycox et al., 2010). Although some states have undertaken large-scale efforts to increase implementation of TF-CBT in child social services and community mental health centers (Sigel et al., 2013), schools have unfortunately not yet received the same level of attention in these efforts.

2.3.3 | Practitioner support

The types of systems required for school-based trauma treatment will likely vary largely in relation to district resources and personnel. These might include organized referral and case-management systems and organizational practices that guard against vicarious traumatization. Examples of such practices include the equitable distribution of trauma client caseloads, clinical supervision, and the promotion of self-care strategies for teachers and SMHPs. Staff may also choose to monitor their own levels of distress. The Professional Quality of Life measure (ProQOL; https://proqol.org/ProQol_Test.html) (Stamm, 2010) is a freely available nondiagnostic measure that aims to assess the well-being of helping professionals. The measure consists of two scales, compassion satisfaction and compassion fatigue. The latter scale is made up of two subscales, burnout and secondary traumatic stress. High scores on burnout and secondary traumatic stress subscales may indicate that an educator needs additional support to best care for themselves and their students. SMHPs may be seen as trusted staff to facilitate outside referrals for school staff needing more intensive support. Many school districts provide support for staff though Employee

Assistance Programs. A review of evidence-based trauma services for adults is beyond the scope of this article; however, the National Center for PTSD has helpful resources related to adult traumatic stress as well (https://www.ptsd.va.gov/professional/treatment/overview/index.asp).

2.4 | Limitations

Our study does not include a systematic meta-analysis of the effect sizes of available trauma interventions, and thus cannot make recommendations based on empirical data or claim that this model is effective. Similarly, we do not systematically compare the psychometric properties of the multiple traumatic stress assessment instruments, and thus cannot discuss the superiority of any particular measures. Narrative reviews have inherent limitations, including a lack of reproducibility and a high degree of subjectivity. Despite authors' efforts to review the available literature, key studies may have been missed. There are many challenges to implementing trauma services in schools and thus these example practices may not always be feasible or appropriate. Rather, our review presents one way of organizing the literature that may aid school-based practitioners. Importantly, this article does not cover the range of clinical skills, training, and ethical and legal considerations in working with children who have experienced trauma. This article does not provide practice advice, but instead presents information from the literature organized within a commonly used framework.

Last, schools may be reluctant to assess and treat trauma. Concerns about mandatory reporting and how to adequately respond to disclosures of potentially traumatic events pose challenges for many school providers and such work may not be seen as appropriate by all parents and all school personnel. It is also important to note that implementation of any MTSS model requires administrative support and an effective student services team—resources that are not currently in place in all schools. We recognize that systems-level changes in school-based service delivery take tremendous amounts of energy, dedication, staffing, and time, and we hope that the organization of past research in this article serves as a starting point for bringing this research into practice.

3 | CONCLUSION

As schools recognize the need to provide TIC, concrete options are needed for SMHPs to help turn the promise of TIC into realities for the school community. We believe SMHPs are uniquely positioned to provide evidence-based trauma services to all young people. However, to be effective, services must be well organized, prevention focused, data-based, involve the whole school community, and be resource efficient. We organize past literature into three tiers of support, including examples of assessments, interventions, and staff supports at each tier to align with the data, systems, and practices focus of an MTSS service delivery model (Sugai & Horner, 2009). Further evidence is needed in many areas of school services, especially research in implementation science that examines the drivers and barriers to school-based trauma services. We hope compiling example options of trauma care from the existing literature in an MTSS model will encourage increased consideration of evidence-based practices and spur further research related to the implementation and outcomes associated with school trauma services.

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