

Screening Kids from Birth to Age 5 for Trauma

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Introduction

The groundbreaking Adverse Childhood Experiences (ACEs) study¹ demonstrated that a child's exposure to traumatic events substantially impacts his or her long-term health. The findings make identifying a child's exposure to abuse, neglect, discrimination, violence and other adverse experiences—and connecting children and families to early intervention services that can help families heal from trauma or slow or reverse the expected negative health outcomes—a core component of children's health care.

“The impact of ACEs can now only be ignored as a matter of conscious choice. With this information comes the responsibility to use it²”

Screening children for exposure to adversity can help practitioners identify children at high risk for experiencing toxic stress (frequent and/or prolonged activation of a stress response due to adversity or trauma). Screening in primary care settings can help prevent further exposure to adverse experiences, and – when a strong referral system is in place – can provide appropriate education for parents and caregivers about the relationship between early adversity and negative health outcomes. Screening also informs the pediatrician's care plan by identifying children who are at high risk for health problems due to toxic stress, which may be an underlying cause of clinical symptoms.³ By identifying and intervening, there is an opportunity to reverse some of the neurological and physical effects of severe adversity that are common when not addressed early. Indeed, potential future trauma can be prevented altogether if screening is done well, prompting more clinicians to explore the role of screening for trauma with young children.

This brief focuses on children from birth to age 5, outlining key principles and recommendations that California and its child-serving organizations can adopt and implement when exploring how to effectively screen children for trauma in this age group.

WHY Should California Screen Young Children for Trauma?

Nationally, 75 percent of children who die from abuse or neglect are under the age of 3.

Far too often, traumatic events such as abuse, neglect, and neighborhood violence can be toxic for children, leading to health consequences such as heart disease, diabetes, and depression, as well as social consequences like academic failure, homelessness, victimization, and crime. A recent national survey estimates that **nearly two out of three children are exposed to violence in their homes, schools, or communities**, and longitudinal research shows that by age 5, approximately **one in seven children born in California will have experienced reported maltreatment**.⁴ While there is interest from advocates and pediatric primary health care providers in screening young children and their families for elevated risk of and/or exposure to trauma, trauma screening is inconsistent.

From the prenatal period to the first few years of a child's life, the brain is establishing the foundational neural connections that form its architecture, influencing future behavior, learning and health.

For instance, one study⁵ showed that children who were placed into orphanages at a young age with conditions of severe neglect had significantly lessened brain activity compared to children who were never placed in orphanages. When those same children who experienced extreme neglect were moved to a responsive foster care family before age 2, their IQs increased substantially and their brain activity and attachment relationships became comparable to children who had not experienced extreme neglect.

These positive outcomes were lessened if they were placed after the age of 2; showing that in most cases, intervening as early as possible is most effective, and signaling that early adversities can lead to lifelong problems with a child's physical and mental health.⁶

Since there is no universal definition of "childhood adversity," experts tend to create their own definition based on clinical experiences. Nevertheless, the most commonly used definition is from the Substance Abuse and Mental Health Services Administration (SAMSHA), which states:

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."⁷

Examples of trauma include, but are not limited to, the following: experiencing or observing physical, sexual, and emotional abuse; childhood neglect; having a family member with a mental health or substance use disorder; experiencing or witnessing violence in the community or while serving in the military; and poverty and systemic discrimination.⁸





Screening vs Assessment

It is important to note that screening and assessment are two different practices. Both occur in a pediatric setting. Trauma screening refers to a brief and focused tool or process to determine whether an individual has experienced one or more traumatic events, has had reactions to such events, has specific mental or behavioral health needs, and/or needs a referral for a comprehensive trauma-informed mental health assessment. A trauma assessment refers to a more comprehensive tool or process that includes a clinical interview and behavioral observations designed to gather an in-depth understanding of the nature, timing, and severity of the traumatic events, the effects of those events, current trauma-related symptoms, and any functional impairment. Providers use the assessment to understand a child's trauma history and symptom profile and to determine whether a child is developmentally on target in social, emotional, and behavioral domains.⁹

Current Screening Landscape

Nationally, screening for trauma is evolving but uneven. States, cities and communities independently decide if and how they want to utilize trauma screenings. While most pediatricians agree on the importance of screening for trauma, very few actually screen.¹⁰ Pediatricians cite concerns about time restraints during exams, not knowing how to have the difficult conversation with parents about traumatic events, and their inability to provide the necessary resources to families. The clinicians who decide to screen tend to be part of larger systems like hospitals, participate in pilot programs, or have leaders who are committed to making a trauma-informed environment the norm. Outside of pediatric settings, many schools, child welfare agencies and juvenile justice facilities already screen for trauma, given the nature of how children enter these systems.

Recently, a number of states have begun enacting legislation that would give child-serving organizations the legal backing to engage in the prevention and treatment of trauma. The following enacted bills signal states' growing recognition of the need to promote trauma-informed practices:

-  **Illinois-Senate Bill 565** – requires social and emotional screenings as part of school entry examinations.¹¹
-  **New York-Assembly Bill 3424** – establishes a task force to identify evidence-based and evidence-informed solutions to reduce children's exposure to adverse childhood experiences.¹²
-  **Texas-Senate Bill 1356** – requires the state juvenile justice department to provide trauma-informed training for juvenile probation and supervision officers.¹³
-  **Vermont-House Bill 508** – bolsters the state's response to early childhood toxic stress through a series of steps, including encouraging state colleges and universities to include ACEs and the impact of trauma in their curricula.¹⁴

In California, the state passed Assembly Bill 340 in 2017, which directed the Department of Health Care Services (DHCS) to convene a stakeholder workgroup to identify and recommend, if appropriate, ways to screen children for trauma under Medi-Cal's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. Advocates focused on identifying ways to screen for trauma under the EPSDT benefit because its goal is to ensure that health problems are averted or diagnosed and treated as early as possible.¹⁵ Specifically, AB 340 states:

“This bill would require...an advisory working group to update, amend, or develop, if appropriate, tools and protocols for screening children for trauma as defined, within the EPSDT benefit, as specified. The bill would require this group to report its findings and recommendations, as well as any appropriations necessary to implement those recommendations, to the department and to the Legislature's budget subcommittees on health and human services no later than May 1, 2019....”¹⁶

The stakeholder workgroup began meeting in April 2018. The workgroup has largely focused on examining evidence-based screening tools, their feasibility to be administered within a pediatric practice, the types of trauma-related questions asked, the target population to be screened (child vs. parent), and the age group the screening tool targeted. At the time of this brief, the workgroup was still underway.

The AB 340 Workgroup is considering several evidence-based tools for trauma screening. However, there has been very little focus on trauma screening tools for very young children. Based on expert discussions within the workgroup and available research, below are four screening tools that were created solely for the very young child.

- The **Young Child PTSD Screen (YCPS)**¹⁷ – The YCPS is a screening tool for young children to be filled out by caregivers. With a questionnaire that is only 6 items, it is used only to identify children who have at least five Post Traumatic Stress Disorder (PTSD) symptoms so that they can be referred for clinical treatment for PTSD. While the YCPS has not been used in a study, the wording of this screen was created by a practitioner with years of experience conducting interviews and designing diagnostic interviews for PTSD with caregivers.¹⁸
- **Child Behavioral Checklist (CBCL)** – The CBCL can be used by parents and other caregivers, as well as teachers, to report a child’s behaviors. One version of the CBCL is geared for preschoolers, allowing a parent to screen for emotional, behavioral, and social problems. Unlike many tools, the CBCL has been reported to be used widely beyond just medical settings – in schools, child and family services, Health Maintenance Organizations and public health agencies.¹⁹ The CBCL’s questions are associated with concerns like attention problems, rule-breaking behavior, and aggressive behavior.
- **Children’s Trauma Assessment Center Trauma Screening Checklist**²⁰ – The Children’s Trauma Assessment Center’s child trauma screen is used to guide clinicians and child welfare caseworkers in evaluating children who have been exposed to trauma. The questionnaire helps identify emotions, behaviors, attachment concerns, and school problems the child may be experiencing. There are two versions of the screen, one for children between birth and age 5, and one for children ages 6-18 years old. The CTAC trauma screen has been validated through a screening of 95 children in Larimer County, Colorado.²¹
- **Traumatic Events Screening Inventory for Children (TESI-C)**²² – The TESI-C assesses a child’s experience of a variety of potential traumatic events including current and previous injuries, hospitalizations, domestic violence, community violence, disasters, accidents, physical abuse, and sexual abuse. The revised 24-item version is more developmentally sensitive to the traumatic experiences that young children may experience. Additional questions assess DSM-IV PTSD Criterion A and other additional information about the specifics of the event(s).

While there is agreement among medical providers that screening in clinical settings is useful, the field lacks consensus on a number of other important issues. Clinicians do not agree about the appropriate age for children to be screened; there is disagreement on what factors need to be measured to appropriately assess a child’s exposure or potential exposure to trauma; and finally, there is a lack of consensus on the difference between screening for traditional ACEs and the need to identify other family psychosocial risks.²³

California can take a number of steps to support the ultimate goal of trauma screenings for young children. The following section contains a list of recommendations, informed by a series of interviews, stakeholder workgroups and community meetings, that the state and pediatricians should adopt and implement before choosing a specific trauma screening tool(s) to recommend for widespread use. Generally, the state can help by providing the resources that pediatricians need to be able to effectively screen children, and pediatricians can be proactive in seeking existing supports and services.

WHAT Can California Do to Support Screening Children for Trauma?

Shortly after the passage of Assembly Bill 340, the California Legislature adopted Assembly Concurrent Resolution 235, which designated May 22nd as Trauma-Informed Awareness Day in California, to highlight the impact of trauma and the importance of prevention and community resilience through trauma-informed care. While the Legislature's efforts should be applauded, neither AB 340 or ACR 235 directs the state to take a holistic approach to preventing and treating childhood trauma. As such, the California's Health and Human Services Agency (CHHS) needs to consider how to comprehensively and strategically implement a broader trauma-informed strategy for the state. By engaging all of the departments within CHHS' jurisdiction, such as the Department of Public Health, Department of Social Services, and Department of Health Care Services, the state can implement a more robust plan for children and leverage a variety of policy levers and initiatives more effectively. Below are some key principles the CHHS should consider as a commitment to trauma prevention and treatment for kids.

Principles of Trauma Screenings, Prevention, and Treatment

1. Medical settings need to be trauma-informed²⁴

Before screenings are introduced into the pediatric environment, a trauma-informed care environment must be created. Changing both organizational and clinical practices to reflect core principles of a trauma-informed approach to care is necessary to transform a health care setting. For instance, organizations that provide trauma training for clinical as well as non-clinical staff members are able to create a more welcoming environment for patients. In addition to clinicians, front-desk workers and security guards have important roles in setting the tone for patients to feel safe and accepted. Positive interactions with front-desk workers and security guards increase the likelihood families will engage in treatment and return for future appointments. Additionally, adequate lighting for parking lots and exits, clear access to doors in exam rooms, and similar intentional design features can help create a safer environment for people who have experienced trauma.

Trauma-Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma-Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.²⁵

In addition to creating a physically safe environment, organizations must confront implicit bias. Like the broader population, healthcare professionals possess biased thoughts and feelings that are "implicit," in that they show an automatic, unconscious preference, or aversion to, a specific group of people. Unfortunately, the result of implicit bias is that patients may receive a lower level of care because of their race, gender, or other characteristic.²⁶ By confronting issues of implicit bias during trauma-informed training, the healthcare field can ensure staff is treating patients fairly.

Finally, preventing and/or treating secondary traumatic stress for staff is essential to effectively delivering trauma-informed clinical services and care. Secondary trauma is the “emotional duress that results when an individual hears about the firsthand trauma experiences of another.” Often, secondary traumatic stress can lead to chronic fatigue, poor concentration, emotional detachment, avoidance, absenteeism, and physical illness. Strategies to prevent secondary traumatic stress in staff include: providing trainings that raise awareness of secondary traumatic stress; offering opportunities for staff to explore their own trauma histories; supporting reflective supervision, in which a service provider and supervisor meet regularly to address feelings regarding patient interactions; encouraging and incentivizing physical activity, yoga, and meditation; and allowing “mental health days” for staff. While there is acknowledgement that these changes can create the welcoming environment necessary for families, they can also be expensive. There is emerging research showing mid- to longer-term cost savings associated with implementing these strategies, such as reduced workplace stress, decreased sick days, better employee retention, and increased productivity. Nevertheless, while the latest research acknowledges that cost needs to be further evaluated, it is explicit in its recommendation that creating a comforting environment for patients should take priority.²⁷

Recommendation for the State: California should provide guidance and resources to help providers become trauma-informed. Operationally, CHHS can require agencies to work together to develop, align, and issue guidance and expectations about trauma-informed care.

Recommendation for Providers: Pediatricians, primary care physicians, clinics, and hospital systems can seek out continuing medical education credits to be trained in trauma-informed medical care.²⁸ Continuing medical education is a requirement for practicing physicians and serves to maintain, develop, or increase the knowledge and skills of their medical practice. By seeking out this education, providers can maximize their time by participating in an activity that is already required while becoming trauma-informed. Additionally, providers can align these principles with their existing plans for organizational change by implementing systematic training for all staff and organizational policy shifts to address secondary stress and organizational culture issues.²⁹



2. Resources and referral services should be robust and easily accessible.

Providers who screen for trauma must ensure that they can offer appropriate care options and referral resources. Having an understanding of the existing child-serving organizations to refer children and their families to within a given community or system of care is part of responsible care. Currently, California offers an array of state- and federally-funded programs for children birth to age 5. The system of services, however, can be difficult for providers and families to understand because of its complexity. California’s fragmented early childhood array of services includes programs like California State Preschool Program, Medi-Cal County Mental Health Plans, Head Start and Early Head Start, Early Start (IDEA Part C)³⁰, voluntary maternal and child home visiting, and a complex local variety of social safety net programs. Nearly all of California’s early childhood programs are partially supported by federal and state funds and, thus, are subject to oversight by multiple authorizing agencies. This complexity can create confusion and increase the burden of knowing about and providing the necessary resources for families³¹. Therefore, the state and counties must work closely with providers to ensure sufficient resources not only exist but that they are also well known across all

practitioners. Such clinical-community linkages will help to connect pediatricians, community organizations, and public health agencies so they can improve children’s access to services to prevent and treat trauma.

Recommendation for the State: California should help providers identify existing local initiatives and programs, locally innovative practices around coordinated resources and referrals, and, whenever possible, remedy any administrative and policy barriers to local coordination. For example, in some counties, Help Me Grow California, an initiative by the First 5 Association, works with local providers to refer families to needed, relevant local child development resources. By supporting one place for local providers to go when they need to refer a child or family for services, the state can help eliminate the frustration and confusion that exists within the current system.

Recommendation for Providers: Since California has not designated one primary state or local agency to be the host of resources for families, providers will have to gather this information independently. Hospital systems and clinics, which have greater capacity than individual pediatricians, can host community-wide trauma-informed care events in order to recruit potential referral resources. By hosting public events, like-minded organizations will become aware of the organization’s desire to build a robust resource and referral system and may be willing to collaborate.

3. Screenings must be universal.

Experts differ on when and how to screen for trauma. One approach is universal screening of every patient for trauma history at the very first visit to a provider. Proponents of this “upfront,” universal approach assert that it allows providers a better understanding of a patient’s potential trauma history, helps target interventions, provides better aggregate data, quantifies the risk of chronic disease later in life, and eliminates the potential of stereotyping, whereby only certain patients may be asked to take a trauma questionnaire.

However, with upfront screening, patients may not have the opportunity to build trust in providers before being asked about their sensitive trauma history. Those who favor later trauma screening contend that upfront screening removes the patient’s choice of sharing sensitive information, can re-traumatize a patient, and may hinder progress made if there are not appropriate interventions or referrals in place.

An additional concern is how often children should be screened for trauma. Currently, there are no official guidelines for how often (and at what age(s)) pediatricians should screen for trauma. One possible solution is to align trauma screenings with the American Academy of Pediatrics’ periodicity schedule, which has clear timelines for when children should be screened for developmental milestones.³²

Recommendation for the State: California should require that all screenings be universal, regardless of health insurance, ensuring that the state has the ability to identify children’s trauma histories and provide necessary services early, and reducing the risk of racial/ethnic and socioeconomic bias. California should allow providers to decide if screenings will be upfront or after patients have the ability to build trust with the provider.

4. The medical field needs an agreed upon definition of “childhood adversity.”

Currently, the most commonly used definition for “childhood adversity” is from the Substance Abuse and Mental Health Services Administration (see page 3). However, the medical community lacks an agreed upon definition of adversity which can cause confusion about which metrics to capture and where intervention can have the most impact. For example, many studies conflate events that are, by definition, traumatic (sexual assault) and ones that may lead to trauma (parental divorce).

Most agree that examples of childhood adversity include: experiencing or observing physical/sexual/emotional abuse, childhood neglect, experiencing or witnessing violence in the community. However, there is skepticism for other potentially traumatizing events like parental divorce and whether they rise to the level of childhood adversity. This lack of clarity makes choosing a screening tool difficult, as there is no shared understanding of what kids should be screened for.³³ By focusing its definition, providers will be able to better identify interventions and resources prior to screening for trauma.

Recommendation for Providers: California physicians must put forth an agreed upon definition of “childhood adversity.” By agreeing on a definition of “childhood adversity,” providers will be able to better identify what metrics they want to capture, and whether it is the impact of trauma that needs to be identified and/or the event of trauma.

5. Screening should be multigenerational

Understanding children’s perceptions and interpretations of events is critical to helping them deal with trauma.³⁴ Children’s self-report can be meaningful, but only if appropriate techniques are used to gather the information and the child is of an appropriate age to be interviewed directly. The technical concerns around screening very young children involve complications such as question wording, memory capacity, and suggestibility. Some providers question whether children younger than 7 years old have the cognitive skills for effective and systematic questioning and interviews. In reality, each child is different and their cognitive abilities can vary widely. Nonetheless, it is universally true that a 4-month-old will not be able to respond to a questionnaire about existing or potential traumatic events. As such, a multigenerational approach is necessary for very young children. Screening parents with young children for adverse experiences can give providers an understanding of any potential traumas the adults carry with them into their parenting practices. Providers can support parents who may be struggling with unaddressed trauma in their own life with strategies and resources to heal, bond with their child, and best promote his or her healthy growth and development.³⁵

In 2015, the Children’s Clinic in Portland, Oregon began asking parents who brought their 4-month-old babies in for well-baby check-ups to answer a few questions about their own childhood trauma. The answers provided insight to how these individuals might parent. Clinicians at the Children’s Clinic believed it was the best way to help prevent the children of these parents from experiencing trauma.³⁶

Recommendation for Providers: Trauma screening of young children should involve parents/caregivers, both to inquire about the parent’s/caregiver’s trauma in their own childhood, and to ask about potentially traumatizing events for their child. Pediatricians must work closely with adult primary care providers in the event they need to refer parents for any clinical issues that arise due to the impact of trauma.



6. Resiliency should be intentionally fostered

The ultimate goal of any trauma screening should not be just to heal from past trauma and prevent future trauma, but also to connect children to resources that can help them develop resiliency. While practitioners may not be able to prevent traumatic events from happening, they can help build the necessary social-emotional skills in children to help them cope and live productive lives. Resilience is “the process of, or the capacity for, successful adaptation despite challenging or threatening circumstances.”³⁷

Physically, resilience has a protective effect against the pitfalls of trauma—depression, anxiety and PTSD.³⁸ One study found that resilience not only was negatively associated with anxiety symptoms in women surviving breast cancer, but may have a “vaccination effect” through hardening individuals against future adverse life experiences³⁹.

Children need adults who know how to promote resilience and are becoming more resilient themselves. For very young children, it is important that a caring adult is available to them, ideally someone they have a strong attachment with, who can meet their needs and help provide structure and consistency. For elementary-school-aged children, it is helpful for them to feel that they have some ability to do things on their own; especially things they feel they do well, which can vary from being helpful in the classroom or at home to being recognized for their athletic or creative abilities. As children grow into adolescents, it is especially important that they feel a sense of personal responsibility in their decision-making and are able to feel that they can exert control over at least some aspects of their lives. This continues to be true as adolescents grow into adults, and a strong sense of self-efficacy and self-control, as well as encouraging individuals to recognize their accomplishments, helps foster resiliency in the face of trauma.⁴⁰

Recommendation: Both the state and providers need to ensure the local resources that exist include those organizations that encourage resilience. Resilience-building organizations will focus on providing support to help build the social-emotional skills of young children and their families. In addition, the state and providers should further investigate whether and how to screen for strengths and protective factors as well as adversity and trauma.

Conclusion

These recommendations suggest a broader strategy aimed at preventing and treating childhood trauma that can be endorsed by the Administration and guided by CHHS. California’s new gubernatorial administration provides an opportunity to strengthen existing trauma screening efforts. In addition to fiscal and administrative considerations, CHHS can provide policy guidance, coordination, and oversight on how health and human service programs and pediatricians can best implement trauma-related care.

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Children Now is on a mission to build power for kids. The organization conducts non-partisan research, policy development, and advocacy reflecting a whole-child approach to improving the lives of kids, especially kids of color and kids living in poverty, from prenatal through age 26.

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Endnotes

- 1 Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. Felitti, Vincent J et al. American Journal of Preventive Medicine , Volume 14 , Issue 4 , 245 - 258 Retrieved from [https://www.ajpmonline.org/article/S0749-3797\(98\)00017-8/abstract](https://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract)
- 2 Robert Anda, MD, MS Fayetteville, GA July 2, 2010 Retrieved from <http://www.theannainstitute.org/ACE%20folder%20for%20website/44%20Exec%20Summary%20WA%20ACE%20Rpt.pdf>
- 3 Maul, Alexandra and Menschner, Christopher. Issue Brief: Key Ingredients for Successful Trauma-Informed Care Implementation. Center for Health Strategies. April 2016. Retrieved from <https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/>
- 4 California Children's Report Card 2018. Children Now. Retrieved from https://www.childrennow.org/files/7715/1613/3234/Children_Now_2018_Report_Card.pdf
- 5 In Brief: The Impact of Early Adversity on Children's Development. Center on the Developing Child. Harvard University. Retrieved from <https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2015/05/inbrief-adversity-1.pdf>
- 6 In Brief: The Impact of Early Adversity on Children's Development. Center on the Developing Child. Harvard University. Retrieved from <https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2015/05/inbrief-adversity-1.pdf>
- 7 Trauma. SAMSHA HRSA Center for Integrated Solutions. Retrieved from <https://www.integration.samhsa.gov/clinical-practice/trauma>
- 8 Trauma. American Psychological Association. Retrieved from <http://www.apa.org/topics/trauma/>
- 9 Screening and Assessment. The National Child Traumatic Stress Network. Retrieved from <https://www.nctsn.org/treatments-and-practices/screening-and-assessment>
- 10 Stevens, Ellen Jane. Pediatricians screen parents for ACEs to improve health of Babies. Aces too High. August 2015. Retrieved from <https://acestoohigh.com/2015/08/03/pediatricians-screen-parents-for-aces-to-improve-health-of-babies/>
- 11 SB0565. Illinois General Assembly. Effective June 1, 2017. Retrieved from <http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0927>
- 12 New York ACEs Initiatives and Actions. Aces Connection. Retrieved from <https://www.acesconnection.com/g/state-aces-action-group/fileSendAction/fcType/0/fcOid/473769386031145707/filePointer/473769386031145722/fodoid/473769386031145718/2018%20-%20New%20York.pdf>
- 13 Senate Bill 1356. Relating to human trafficking and its victims and the care of juveniles who have experienced traumatic events. Effective September 1 2013. Texas Legislature. Retrieved from <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=83R&Bill=SB1356>
- 14 General Assembly of Vermont. Act 43. H. 508. Effective July 1 2017. Retrieved from <https://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT043/ACT043%20As%20Enacted.pdf>
- 15 EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. Center for Medicaid and Medicaid Services. June 2014. Retrieved from https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

Endnotes Continued

- 16 California Assembly Bill-340 (Arambula) Early and Periodic Screening, Diagnosis, and Treatment Program: trauma screening. 2017-2018. Retrieved from https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB340
- 17 Michael Scheeringa, MD, MPH. (2012). Young Child PTSD Screen. Measurement Instrument Database for the Social Science. Retrieved from <http://www.midss.org/sites/default/files/ycps.pdf>
- 18 Michael Scheeringa, MD, MPH. (2012). Young Child PTSD Screen. Measurement Instrument Database for the Social Science. Retrieved from <http://www.midss.org/sites/default/files/ycps.pdf>
- 19 Mazefsky, Carla A et al. "Child Behavior Checklist Scores for School-Aged Children with Autism: Preliminary Evidence of Patterns Suggesting the Need for Referral" Journal of psychopathology and behavioral assessment vol. 33,1 (2011): 31-37. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3362998/>
- 20 Trauma Screening. Children's Trauma Assessment Center. Western Michigan University. Retrieved from <https://wmich.edu/traumacenter/grants>
- 21 Ages 0–5 CTAC Trauma Screening Checklist: Identifying Children at Risk. Southwest Michigan Children's Trauma Assessment Center. The National Child Traumatic Stress Network. Retrieved from <https://wmich.edu/sites/default/files/attachments/u354/2016/Trauma%20Screening%20Checklist%200-5%20Revised%203-2016-JF.pdf>
- 22 Traumatic Events Screening Inventory for Children (TESI-C). PTSD: National Center for PTSD. Retrieved from <https://www.ptsd.va.gov/professional/assessment/child/tesi.asp>
- 23 Bethell, CD et al., Methods to Assess Adverse Childhood Experiences of Children and Families: Toward Approaches to Promote Child Well-being in Policy and Practice. Academy Pediatrics. 2017 Sep - Oct;17. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/28865661>
- 24 Maul, Alexandra and Menschner, Christopher. Issue Brief: Key Ingredients for Successful Trauma-Informed Care Implementation. Center for Health Strategies. April 2016. Retrieved from <https://www.chcs.org/media/ATC-whitepaper-040616-rev.pdf>
- 25 The Trauma Informed Care Project. Retrieved from <http://www.traumainformedcareproject.org/>
- 26 FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics. 2017;18(1):19. Published 2017 Mar 1. doi:10.1186/s12910-017-0179-8 Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5333436/>
- 27 Maul, Alexandra and Menschner, Christopher. Issue Brief: Key Ingredients for Successful Trauma-Informed Care Implementation. Center for Health Strategies. April 2016. Retrieved from <https://www.chcs.org/media/ATC-whitepaper-040616-rev.pdf>
- 28 Core Curriculum on Childhood Trauma. The National Child Traumatic Stress Network. Retrieved from <https://www.nctsn.org/treatments-and-practices/core-curriculum-childhood-trauma>
- 29 Maul, Alexandra and Menschner, Christopher. Issue Brief: Key Ingredients for Successful Trauma-Informed Care Implementation. Center for Health Strategies. April 2016. Retrieved from <https://www.chcs.org/media/ATC-whitepaper-040616-rev.pdf>

Endnotes Continued

- 30 Individuals with Disabilities Education Act, Part C. U. S. Department of Education. Retrieved from <https://sites.ed.gov/idea/regs/c>
- 31 Melnick, Hanna et al., Understanding California's Early Care and Education System. Learning Policy Institute. Retrieved from https://learningpolicyinstitute.org/sites/default/files/product-files/Understanding_CA_Early_Care_Education_System_REPORT.pdf
- 32 Recommendations for Preventative Pediatric Health Care. American Academy of Pediatrics/Bright Futures. Periodicity Schedule. Retrieved from https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
- 33 Maul, Alexandra and Menschner, Christopher. Issue Brief: Key Ingredients for Successful Trauma-Informed Care Implementation. Center for Health Strategies. April 2016. Retrieved from <https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/>
- 34 Shahinfar, A., Fox, N., & Leavitt, L. (2000). Preschool children's exposure to violence: Relation of behavior problems to parent and child reports. *American Journal of Orthopsychiatry*, 70(1), 115–125. Retrieved from <http://psycnet.apa.org/record/2000-13882-012>
- 35 Stevens, Ellen Jane. Pediatricians screen parents for ACEs to improve health of Babies. *Aces too High*. August 2015. Retrieved from <https://acestoohigh.com/2015/08/03/pediatricians-screen-parents-for-aces-to-improve-health-of-babies/r>
- 36 Stevens, Ellen Jane. Pediatricians screen parents for ACEs to improve health of Babies. *Aces too High*. August 2015. Retrieved from <https://acestoohigh.com/2015/08/03/pediatricians-screen-parents-for-aces-to-improve-health-of-babies/>
- 37 Burton, M. S., Cooper, A. A., Feeny, N. C., & Zoellner, L. A. (2015). The Enhancement of Natural Resilience in Trauma Interventions. *Journal of Contemporary Psychotherapy*, 1-12. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4689312/>
- 38 Sexton MB, Hamilton L, McGinnis EW, Rosenblum KL, Muzik M. The roles of resilience and childhood trauma history: main and moderating effects on postpartum maternal mental health and functioning. *J Affect Disord*. 2014;174:562-8.
- 39 Scali, J., Gandubert, C., Ritchie, K., Soulier, M., Ancelin, M.-L., & Chaudieu, I. (2012). Measuring Resilience in Adult Women Using the 10-Items Connor-Davidson Resilience Scale (CD-RISC). Role of Trauma Exposure and Anxiety Disorders. *PLoS ONE*, 7(6). Retrieved from <http://doi.org/10.1371/journal.pone.0039879>
- 40 Byrns, Heather., James., William., Hargitay , Miklos. Trauma and Resiliency. William James College. Retrieved from <https://interface.williamjames.edu/topic/trauma-resiliency>