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Identifying Dual Status Youth with Trauma-Related Problems

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Imagine that a clinician or agency has decided to put in place a way to identify dual status youths' trauma-related needs. How should they go about it? That is the question addressed in this second brief in a series on trauma-related procedures for use with dual status young people—children and adolescents who are being served by both child welfare and juvenile justice systems.

The first brief, *Trauma in Dual Status Youth: Putting Things in Perspective*, described the prevalence of trauma-based behavior problems among dual status youth and introduced the need to improve our ability to identify those problems so that we can offer those youth proper interventions.[1] Here we examine how to go about setting up a system for identifying trauma-related problems.

We propose a three-step process:

(a) developing a clear understanding of your *purpose and context* for identification of trauma-related problems;

(b) selecting a *method*; and

(c) dealing with matters of *implementation*.

The first step—understanding your service's purpose and context—requires giving some thought to your specific reason for wanting a method to identify youths' trauma-based disorders, as well as the operations and capacities of your service. Why is understanding your purpose important?

[1]Recall, in the first brief in this series, it was asserted that, "Promoting trauma-informed care does not mean providing trauma-based treatment to every youth who has been exposed to something that may or may not have been traumatic. It means recognizing the role of trauma in most youth's lives and applying trauma-based treatment in cases in which it is needed. Effective and efficient use of resources involves targeting specific approaches for specific youths, avoiding their application indiscriminately." (Grisso, T. & Vincent, G. *Trauma in Dual Status Youth.* Robert F. Kennedy National Resource Center for Juvenile Justice. *2014.)*

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The Robert F. Kennedy National Resource Center for Juvenile Justice, led by Robert F. Kennedy Children's Action Corps, provides consultation, technical assistance, and training to enhance the performance of youth-serving systems and improve outcomes for youth and families touched by the juvenile justice system. The array of services and resources delivered by the RFK National Resource Center addresses: (1) youth with prior or current involvement in both the child welfare and juvenile justice systems, known as dual status youth, (2) the review and improvement of juvenile probation systems, and (3) the use of a model framework to address the state and national laws and policies governing the exchange and sharing of data, information, and records for youth and families.

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Imagine that a friend says to you, "I've been thinking about buying a new car. Tell me, what do you think is the best car for me to buy?" You might simply recommend your favorite automobile. But if you take the question seriously, you will focus on that word "best." You will think of the dozens of makes of cars with their hundreds of variations, each designed to do somewhat different things—good gas mileage, speed, passenger volume, and a host of other factors. But none of them will be "best" in all of those ways. In the end, you will conclude that what is "best" can only be defined as a match between a type of car and your friend's own particular needs and purposes. Similarly, when considering various strategies for identifying youth exposed to trauma or who may be experiencing a trauma-related disorder, you must understand the purpose for asking the question before you can determine which strategy is "best."

The second step, choosing a method to identify youths' trauma-related problems, depends in part on that first step. Structured tools for this task are numerous, having been designed to arrive at different types of information to address different types of trauma-related questions. The tools also vary considerably in their qualities, costs, and appropriateness for various settings. Once you have taken a close look at your "purposes and context," you are less likely to be bewildered when you try to choose among the array of available methods. Our later discussion of screening and assessment methods for identifying trauma-related problems in dual status youth will point out ways in which those tools will be a better or poorer match for your own service's needs.

Finally, in the first brief we explained that efforts to identify trauma-related problems in dual status youth must attend not only to using good methods, but also implementing them properly. Using our earlier analogy, getting the best automobile for your friend's needs will be of little value if your friend drives poorly, fails to keep the auto serviced, and tries to make it do things it was never designed to do. This holds as well for implementation of methods to identify trauma-related problems. We will conclude this brief with a discussion of implementation—putting trauma-identification methods in place in ways that allow them to do the job they were intended to do.

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Purposes and Context: Understanding What We Want to Know and Why

Our broad objective is to identify trauma-related problems in dual status youth so that we can better serve those youths' needs. But how we identify those youths will vary depending on what we want to know to achieve that objective.

Three Possible Purposes

In the first brief, we identified three purposes for obtaining information about trauma-related problems.[2] We may want to know about:

- *Exposure*—whether a youth has been exposed to traumatic events
- *PTSD*—whether that exposure has led to a specific trauma-relevant disorder, Posttraumatic Stress Disorder (PTSD)
- *Trauma-related Symptoms*—whether the youth might have any of a variety of psychological symptoms often related to previous traumatic experiences

Regarding the first, some clinical services that work with dual status youths might want to know whether each youth it sees has ever been exposed to early experiences that may have been traumatizing. For those who have, the service can then refer each of them for further examination to determine whether that exposure has resulted in trauma-related problems. Other services, though, may find the question of "ever exposed" less relevant. For example, almost all youth encountered in juvenile justice detention centers have had at least

[2] "We know that for youth in child welfare and in delinquency populations, the prevalence of potential traumatizing experiences, as well as symptoms that could be caused by those experiences, are both extremely high. We know that for a significant proportion of them—those who have PTSD—exposure to traumatizing experiences are the cause of their behavior problems. We also have good evidence that for many other young people who do not meet PTSD criteria, trauma is at the root of their behavior problems and psychiatric symptoms, although we are less certain about their prevalence." (Grisso, T. & Vincent, G. *Trauma in Dual Status Youth.* Robert F. Kennedy National Resource Center for Juvenile Justice. *2014.*)

some early traumatizing experience (see our first brief). For youth encountered in this setting, the more important goal might be to identify those who have been *polyvictimized*.[3] This term refers to the frequency and range of *types* of traumatizing experiences in a youth's past. They might also want to know whether traumatizing experiences have persistently occurred, and whether they occurred in early childhood or more recently. These two services, therefore, might need different tools, given that not all trauma exposure tools can provide nuanced information about traumatic event exposure.

Second, some services might focus on identifying those youth who are most likely to have developed specific symptoms of PTSD as a result of their exposure to traumatizing experiences. That will require a tool that has been designed for that specific purpose, not merely to identify prior traumatic experiences or "trauma-related problems" in general.

Other services might want to address the broader third question. Traumatic experiences can lead to many psychological symptoms or disorders other than PTSD. Some of those cases involve *complex trauma*.[4] This term refers not only to multiple and persistent traumatic event exposures but also to the invasiveness of their impact, having effected the youth's development and identity formation in a way that results in chronic and serious psychiatric symptoms, that include but extend beyond PTSD, and that may vary across such cases.

The three questions raised above will require somewhat different trauma-based tools based on what they measure. Another way to think about trauma-based tools, however, is with regard to their strategic use. Does one want a trauma *screening* tool or a trauma *assessment* tool?

Screening versus Assessment

Some services wish to identify the presence or absence of trauma-related problems for every youth with whom it comes in contact. If so, *trauma screening tools* will serve that purpose well. Their brevity makes it feasible for them to be given to every youth entering a program. Trauma screening tools, though, do not provide definitive diagnoses. Instead, they serve a triage function to determine the need for more detailed information to answer those questions.

In contrast to screening tools, *trauma assessment tools* are designed to assist in arriving at a more definitive, comprehensive, and individualized picture of a youth that will be useful in developing an intervention plan. That is, they often offer a clearer picture of the specific nature of a youth's individual needs. Services using these tools must have qualified mental health professionals on staff to administer and interpret them, so they might require more effort than the service can afford in every case that it sees. For this reason, our later review in this article will focus primarily on screening tools.

Considering the Context

Beyond purpose, one needs to consider various matters of *context* related to the service's population and resources. What are the ages of the dual status youth seen in your service? Tools vary in the ages for which they have been designed and validated. Is it likely that their parents or guardians will be available at the time of screening, or will the youth be alone? There are both child and family forms for some trauma-related screening tools. Will the person giving the tool be a health professional, or does the tool have to be designed for use by persons without specialized health or mental health training? Some tools require more or less specialized professional training.

Trauma-related screening and assessment tools also vary in their financial cost, as well as the amount of time required to administer and score them. So your service's resources need to be taken into account. Finally, what is the evidence for the validity of the tools, based on past research? Do they measure what they claim to measure? Many programs serving dual status youth have committed to using "evidence-based methods," offering some assurance that the tools actually measure what is intended.

Selecting a Method

What do trauma-related screening tools look like? Users can select from many tools and, as noted earlier, they are not interchangeable. The three basic types of trauma-related tools mentioned earlier in this brief have different purposes, and tools within those types vary in their formats and quality. Here we provide a couple of examples in each category.

[3] Finkelhor, Turner, Hamby & Ormrod, 2011
[4] Courtois, 2004

Exposure Screening Measures

These are tools that screen for a history of exposure to one or more traumatic events. According to the DSM-5,[5] a traumatic event involves exposure to, witnessing of, or learning of actual or threatened death, serious injury or physical violence toward one's self or a loved one. Tools in this category typically present youth with a list of traumatic events and ask them to endorse those to which they have been exposed or experienced at any point in their lifetime.

Three types of screening tools:

- Exposure Screening Measures
- PTSD Symptom Screening Measures
- Trauma Related Symptom Measures

These tools can be useful if a service's goal includes identifying youth who are at risk of having a trauma-related disorder or developing one in the future. Some of the tools in this category also offer information about specific features of exposure, such as recency, frequency and whether there has been exposure to multiple types of traumatic event exposures (i.e., polyvictimization). However, one must be clear about their limits. They will not indicate whether youths have developed trauma-related symptoms or a trauma-related disorder.[6] So they are of value in raising a flag for further assessment, but do not offer a basis for deciding on application of a trauma-based intervention. Here are some examples of trauma-exposure screening tools.

Example 1: The TESI

A well-known trauma exposure tool is the Traumatic Events Screening Inventory (TESI).[7] The TESI is available in parent- and youth-report forms that can be administered as semi-structured interviews or paper-and-pencil questionnaires. The TESI covers a wide range of traumatic events, such as exposure to accidents, natural disasters, serious injury or illness, interpersonal losses, physical and emotional abuse, domestic violence, community violence and sexual abuse. This makes the tool more relevant to dual status youth as it matches the types and range of exposures commonly found in this group. All endorsed items are followed up with questions allowing for the gathering of details regarding a youth's exposure, including the age at the time of the event, frequency of exposure, relationship between victim and perpetrator, consequences of the event and the youth's appraisal of event severity. The TESI takes about 10-30 minutes to complete, is free of charge, and can be administered by people with some training in child mental health and trauma assessment. There has been sufficient research to provide confidence in the TESI's ability to signal whether youth are at greater or lesser risk of trauma-related disorders, but of course results do not actually predict that a youth will or will not have a trauma-based disorder.

Example 2: The JVQ

The Juvenile Victimization Questionnaire (JVQ)[8] offers a contrast to the TESI insofar as the developers created several versions of the tool that vary based on the depth of information they elicit from youth. All versions of the JVQ address youths' exposure to a range of traumatic experiences, including crime, maltreatment, peer and sibling victimization, sexual victimization and witnessing violence/indirect victimization. But the more comprehensive versions include follow-up questions that allow interviewers to gather information about the nature of a youth's exposure. These questions are tailored to the experience endorsed (whereas such questions on the TESI are identical for all experiences). The JVQ typically takes less than 20 minutes to administer but varies based on the version used. It may be administered by non-clinical staff under the supervision of a clinician. Studies have shown that youth who report exposure to more events on the JVQ tend to exhibit more mental health problems, including trauma-related symptoms.[9] Some research also suggests the JVQ may be useful in identifying youth at risk for serious delinquency.[10]

PTSD Symptom Screening Measures

These tools typically present youth with a list of symptoms consistent with DSM-5 criteria for Posttraumatic Stress Disorder and ask youth to indicate which symptoms they have experienced during a given time period. Scoring rules built into the tool or identified by prior research with the

[5] American Psychiatric Association, 2013
[6] D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012
[7] National Center for PTSD & Dartmouth Child Trauma Research Center, 2011; Ribbe, 1996
[8] Hamby, Finkelhor, Turner, Kracke, 2011
[9] Finkelhor, Ormrod & Turner, 2007
[10] Cuevas, Finkelhor, Turner & Ormrod, 2007

tool then allows one to identify the likelihood that the youth will be found to have PTSD if given a more thorough assessment. They are useful, therefore for deciding which youth should be referred for actual diagnostic assessment specifically for PTSD, in contrast to youth who have been exposed but are less likely to have developed PTSD as a consequence. Even when the youth does not reach the criterion for "likely" PTSD, examining PTSD-like symptoms that the youth displays can be helpful in considering referral for a diagnostic assessment and thinking about a youth's treatment needs.

Example 1: The UCLA PTSD-RI

The UCLA Posttraumatic Stress Disorder Reaction Index (UCLA PTSD-RI) has become one of the most widely used and extensively studied measures of PTSD symptoms in youth in juvenile justice and child welfare settings. The PTSD-RI has the benefit of assessing both exposure and related PTSD symptoms, although one would not want to use it routinely if exposure screening was the only goal, as the additional time and information that it requires would be inefficient.

The PTSD-RI is typically administered in an interview format and includes forms for children, adolescents, and parents. There is also an abbreviated version for rapid screening. The first section of the tool assesses youths' history of exposure, and then they are asked about the presence of trauma-related symptoms. Items are keyed to DSM-5 diagnostic criteria. Researchers have developed cutoff scores to indicate the likelihood of PTSD following a single incident traumatic event.[11]

The PTSD-RI must be purchased and requires training in psychological assessment to administer and interpret. The tool is supported by excellent research, including the relation of its screening scores to more comprehensive PTSD assessment tools,[12] and its use in the assessment of complex trauma.[13]

To learn more about trauma screening methods, including the examples described in this brief, visit:
www.nysap.us/Products.html

Example 2: The CPSS

The Child PTSD Symptom Scale (CPSS)[14] is another example of a PTSD symptom screening measure. It is typically administered as a paper-and-pencil questionnaire, though adapted parent-report and interview forms are available. Like the PTSD-RI, it screens for both the presence and frequency of PTSD symptoms, but it differs from the PTSD-RI in several ways. It does not include a measure of exposure, and the symptom frequency rating scale is less detailed. But its additional benefit is that it examines the degree to which youths' symptoms are impairing their functioning in everyday life. Also it is available at no cost and requires less time to administer. Cut-off scores indicate a probable PTSD diagnosis and flag those youth for further assessment. It was designed for use by persons with some mental health experience and training. Studies have shown strong relationships between CPSS scores and a history of trauma exposure, functional impairment and PTSD diagnostic status.[15]

Trauma-Related Symptom Measures

These tools screen for the presence of mental health symptoms that may be caused by or related to trauma, but which are not captured by measures focused solely on PTSD. These may include, for example, depression, problems with anger, and difficulties in relationships. Therefore, tools in this category may be useful to services interested in understanding the potential range of mental health problems faced by youth who have experienced trauma. Given their diverse focus, the structure of these tools can vary greatly. However, one of their primary benefits lies in their ability to screen for complex trauma reactions such as difficulties across multiple areas (e.g., significant problems regulating emotions, disrupted attachments). These youth may also present with an altered sense of self and future, physical distress and an overdeveloped avoidance response that might lead to dissociation, substance abuse, or self-injurious behavior.[16] Therefore, tools that screen for a range of symptoms (not just those associated with PTSD), may provide a more complete picture of the difficulties experienced by some traumatized youth.

[11] Steinberg & Beyerlein, 2014
[12] Steinberg, Brymer, Kim, Briggs, Ippen, Ostrowski, & Pynoos, 2013
[13] Ford, Chapman, Connor, & Cruise, 2012
[14] Foa, Johnson, Feeny & Treadwell, 2001
[15] Havens et al., 2012; Nixon et al., 2013
[16] Briere & Spinazzola, 2005

Example 1: The TSCC

The Trauma Symptom Checklist for Children (TSCC)[17] is a widely-used tool that assesses a range of emotional, behavioral and cognitive symptoms related to trauma exposure. This paper-and-pencil self-report tool asks youth questions about how often they experience various thoughts, feelings, and behaviors. Although a mental health background is required to interpret results, individuals without mental health experience may administer it.

The TSCC contains six subscales that screen for symptoms related to anxiety, depression, anger, posttraumatic stress, dissociation and, in one version, sexual concerns. The tool includes several critical items that, when endorsed, signal the need for immediate intervention. Unique to the TSCC are validity scales that assess over- and under-reporting of symptoms and help administrators determine when youth may have misrepresented their symptoms. There are separate scoring norms for boys and girls of various ages.

Of special importance for use with dual status youth, the TSCC has been studied for use with youth both in juvenile justice and child welfare agencies.[18] Recent work has provided suggestions for new methods of interpreting TSCC scores specific to juvenile-justice-involved youth.[19]

Example 2: The A-DES

While the TCSS has six different symptom scales, the Adolescent Dissociative Experiences Scale (A-DES)[20] examines just one symptom—dissociation—seen in some youth exposed to trauma. Dissociation involves an altered state of consciousness that distorts one's thinking, awareness and memory, often occurring because the person is trying (consciously or unconsciously) to manage feelings of trauma-related stress by repressing, avoiding or minimizing them. The A-DES asks youth to indicate the frequency with which they experience 30 thoughts, behaviors and feelings that indicate potential dissociation. Using recommended cut scores, services can classify youths into groups of those endorsing indicators of normal dissociation (e.g., day dreaming, fantasizing), and those who may be exhibiting pathological types or levels of dissociation; although distinction in the clinical group does not infer the presence of a specific mental health disorder. The A-DES can be obtained and used without charge and can be used by non-clinicians. The A-DES's focus on dissociation alone makes it a good screening tool for this purpose, but less appropriate than the TSCC for obtaining a broader picture of trauma-related symptoms.

Thinking through Implementation

After a service has developed a clear understanding of its purpose for identifying trauma-related problems, and after selecting an appropriate tool to identify youths' trauma-related needs, the last step is outlining a plan for putting the tool in place. This step—called implementation—might seem straight-forward, but it requires careful consideration and planning. Implementation steps will vary depending on a number of agency-specific characteristics and the specific method that has been selected. But whatever a local agency's specific needs, we suggest that an implementation plan should proceed in four steps:

1. Examining system readiness and resources;
2. Reviewing and updating relevant policies and procedures;
3. Monitoring how staff are using results in case planning; and,
4. Tracking outcomes at the agency level.

System Readiness

Human Resources and Training

This involves two broad considerations. First, is the agency prepared by way of staff and resources to put the identification method in place? By definition, screening tools are designed to be administered by non-clinical staff[21] or staff with minimal mental health training. However, trauma assessment tools must be administered by qualified mental health professionals. In either case, agencies must devise a training strategy that matches the educational qualifications associated with specific trauma screening tools. Different tools may also require specific training needs based on their format (e.g., interview; self-report).

[17] Briere, 1996; National Child Traumatic Stress Network 2012
[18] e.g., Elliott & Briere, 1994; Leibowitz, Laser & Burton, 2011; van Vugt, Lanctôt, Paquette, Collin-Vézina & Lemieux, 2014; Wolpaw, Ford, Newman, Davis & Briere, 2005
[19] Butcher, Kretschmar, Singer & Flannery, 2015
[20] Armstrong, Putnam, Carlson, Libero & Smith, 1997
[21] Williams, 2007

Available Services and Interventions

"System readiness" also means that the agency must have available the resources to respond to the results of the identification methods. For example, if a youth "screens in," where will the youth be sent for a more individualized assessment? And what if the screen raises the need for immediate intervention? For example, implementing the TESI can reveal recent experiences of physical abuse by a caregiver. Such responses could signal the need for either child welfare or juvenile justice staff to consider the youth's immediate safety needs, particularly if the youth has ongoing contact with individuals suspected to be perpetrators of the abuse. Such information could trigger the need for an immediate review of safety and risk factors for child maltreatment.[22]

If a follow-up assessment verifies a trauma-related need, the agency should be prepared to make decisions about how to provide an intervention.[23] Agencies will need to determine what treatment resources are available within structured residential settings (e.g., detention centers, residential facilities) and the availability of either trauma-informed or trauma-specific interventions in the community. The third brief in this series will address trauma-specific interventions.

Policies and procedures should describe **when**, **where**, **how** *and by* **whom** *the tool will be administered, as well as policies for responding to the results of the screening or assessment.*

Reviewing Policies and Procedures

Most child welfare and juvenile justice agencies have formal documentation of their policies and procedures. Many of them already have policies for screening and assessment, and typically they can be modified to accommodate a new method for identifying trauma-relevant needs. Policies and procedures should describe *when, where, how* and by *whom* the tool will be administered, as well as policies for responding to the results of the screening or assessment.

Informed Consent

Special attention should be given to developing policies and procedures for informing youth and caregivers. When research is done to examine the validity of trauma-relevant tools, the tools are given with specific instructions to youth. If those instructions are not provided when the tool is used in the agency, then the results cannot be trusted to have the validity suggested by the supporting research.

Generally, instructions to youth should (a) inform them why they are being asked to complete the screening tool, (b) explain who will see the results of the tool, and (c) describe how the information will be used.[24] This is particularly relevant for youth exposed to traumatic events involving betrayal by those responsible for their care[25] and among youth who have experienced heightened sense of distrust and suspicion typically associated with prolonged trauma exposures or complex trauma[26]. Research studies have found that trauma screening does not directly induce or heighten distress in the great majority of parents or youth who have histories of trauma exposure.[27] Nevertheless, policies and procedures should address how staff can access and implement crisis response services for any youth who verbalize or exhibit signs of distress.

Information Sharing

How much of the information should be shared with others and, if so, with whom? Especially in the context of dual status youth, a strong argument can be made for sharing information across agencies and services that are involved with the youth, to avoid duplication of assessment services and fragmented case planning or service delivery across systems. Yet in some jurisdictions, information sharing may be restricted by agency-specific policies protecting confidentiality of assessment results from potential misuse in other contexts (for example, using child welfare assessment results in a youth's juvenile court adjudication hearing). Sometimes it is helpful to construct an "MOU" (Memorandum of Understanding) within and between child welfare and juvenile justice systems to make clear what information will and will not be shared. Specific MOUs may need to be drafted to accommodate how and when trauma-specific information can be shared. The "Models for Change Information Sharing Tool Kit," an online resource, (www.infosharetoolkit.org) describes these issues, and many others, related to cross-agency communications about youths' screening and assessment information.

[22] Orsi, Drury & Mackert, 2014 offers a review of risk and safety assessment instruments in the child welfare context
[23] Ford, Kerig, & Olafson, 2014
[24] Williams, 2007
[25] Kerig, Bennett, Thompson, & Becker, 2012
[26] see Cook et al., 2005; Ford, Chapman, Conner, & Cruise, 2012
[27] Dean, Stein, Jaycox, Kataoka, Wong, Pincus, & Tanielian, 2004; Zajac, Ruggiero, Smith, Saunders, & Kilpatrick, 2011

Monitoring Case Planning

Agencies should establish a plan for monitoring how agency staff are integrating the results of trauma screens or assessments into case plans. While most agencies likely have dedicated staff responsible for monitoring quality assurance, there are specific challenges that can arise in the trauma screening. For example, even though "screen" is included in the name of numerous trauma measures (e.g., TESI), not all such tools provide a specific score or decision rule about when a youth "screens in" or "screens out." PTSD symptom measures, such as the PTSD-RI, offer a range of scoring options including symptom counts, severity scores, and indicators of whether a youth meets partial or full diagnostic criteria for PTSD. The available research suggests more than one way to use scores on such tools. For example, tools that identify youth meeting the overall diagnostic criteria for PTSD are helpful in deciding on further assessment or immediate intervention. But elevations on certain parts of the tool (e.g., Criterion E symptom count score) can have further meanings for dual status youth—for example, signaling risk of aggression[28] or substance use[29].

Sorting out the ways to use scores on such tools can be complicated, and we encourage agencies to partner with local researchers on these matters. Clear guidance and training of staff will be needed to support how follow-up decisions are guided by screening results and how these decisions are documented and followed-up on via a youth's case plan.

Tracking Outcomes

Agencies should develop a system for tracking outcomes of trauma screening and assessment procedures at the system level. Once a tool has been implemented, child welfare and juvenile justice systems can put together the results across all youth who complete the measure, providing valuable information about trauma-specific needs of their own youth. These can be compared to published reports that offer similar information on a nationwide basis. Agencies can use these reports as guiding benchmarks to evaluate whether or not their adopted screening and assessment procedures are producing similar results.

Adopting a two-step process that involves both trauma screening and trauma assessment can comprehensively identify both level of need and determine to what extent there are service gaps and intervention resources that need to be targeted for further service development. For example, the rate of traumatic loss of close friends or family members identified among youth within the service can be mapped onto the availability of trauma-specific interventions that specifically target grief and loss as a key program component. In this way, system-level results can be very helpful in evaluating the overall success of the trauma screening and assessment process and provide valuable information about the type and range of trauma-specific services that an agency needs in response to the level of need identified for dual status youth.

Conclusion

This brief described the several steps in the process of developing an agency's capacity to identify trauma-related problems among dual status youth. The following points summarize the process:

- Clarifying the agency's purpose for identifying trauma-related conditions and symptoms of youth.
- Selecting screening tools that will identify youths who need further assessment.
- Implementing those tools in ways that allow them to fulfill their potential, leading to appropriate interventions to meet their needs.

In the third brief in this series, we will describe therapeutic interventions that have shown promise for responding to the trauma-related needs of dual status youth and their families.

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[28] Stimmel, Cruise, Ford, & Weiss, 2014
[29] Donbaek, Elkit, & Pederson, 2014

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