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Measuring the Use of Trauma-Informed Care in Education Settings: A Scoping Review

Mia Chudzik
University of Illinois Urbana-Champaign

Emily Holden
University of Colorado, Denver

ABSTRACT

Trauma-informed care is increasingly being used in education settings. Along with an increase in the use of trauma-informed care comes a need to measure the use of trauma-informed care. We conducted a scoping literature review to explore what measures of trauma-informed care in schools are being used, with a focus on which aspects of trauma-informed care the tools are measuring. By searching the published literature, we identified 20 unique tools used to measure the use of trauma-informed care. We found that most of these tools focused on individual responses as opposed to system-level responses to trauma, and that components of trauma-informed equity-centered care were primarily not included in the tools. We discuss the implications of these findings for research and end with future directions to improve the measurement of trauma-informed care in educational settings.

Keywords: trauma, trauma-informed care, education, measurement

Trauma has been described as a public health issue (Magruder et al., 2017). Trauma can be defined as "an event, a series of events, or a set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening and has lasting adverse effects" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). By age 16, two-thirds of youth have experienced a potentially traumatic event (McLaughlin et al., 2017). The impact of trauma on students has been documented as impacting their cognitive development, physical development, and social-emotional development (Dye, 2018; National Child Traumatic Stress Network, 2008; Trickey et al., 2012).

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Understanding Trauma-Informed Care

One way to support students who have experienced trauma is through the use of trauma-informed care. While a variety of terms are used to describe this type of care (e.g., trauma-informed education, trauma-responsive teaching; Compton et al., 2023), we will use the term "trauma-informed care" in this paper. Trauma-informed care has been defined in many ways. In fact, the lack of a cohesive and consistent definition of trauma-informed care has been identified as an issue (Becker-Blease, 2017; Berliner & Kolko, 2016; Donnish et al., 2016). The National Child Traumatic Stress Network (2017) defines a trauma-informed service system as one that “recognizes and responds to the impact of traumatic stress on those who have contact with the system, including children, caregivers, staff, and service providers.” SAMHSA (2023) identified four principles of trauma-informed care, often referred to as the 4 Rs: realize the widespread impact of trauma, recognize the signs and symptoms of trauma, respond by integrating trauma-informed practices, and resist re-traumatizing. Ultimately, the goal of trauma-informed care is to respond to the already existing impacts of trauma and to prevent future trauma from happening. Research has identified that knowledge of trauma-informed care, trauma-informed attitudes, and the use of trauma-informed practices are needed for the successful use of trauma-informed care (Baker et al., 2016).

The Need for Trauma-Informed Equity-Centered Care

In recent years, several impactful critiques of the use of trauma-informed care have emerged. Alvarez (2020) identified that the research on trauma-informed care in education has mainly been race-evasive. Other scholars have noted that most research on trauma-informed care focuses on trauma occurring outside of schools and not on schools as a source of trauma, highlighting a need to explicitly address this in trauma-informed care implementation (Duane, 2023; Gorski, 2020; Petrone & Stanton, 2021). Palma and colleagues (2023) argued that using trauma-informed care in schools inadvertently perpetuates deficit-based perspectives of children from historically marginalized communities. Additionally, schools tend to focus on using trauma-informed care to ameliorate the impacts of individual-level traumas, not systemic traumas (i.e., racism, ableism) that have significant effects on students (Alvarez, 2020; Blanchard et al., 2021; Palma et al., 2023). These critiques have spurred a movement towards trauma-informed and equity-centered care that deliberately considers such critiques. Again, there is no universal list of what constitutes trauma-informed and equity-centered care, but the following components have been identified as part of this approach: not holding a savior mentality or deficit view towards students, recognizing and reconciling the role schools play in causing trauma, using culturally responsive practices, acknowledging systemic traumas that impact students, being anti-biased, and adopting a strength-based approach (Goldin et al., 2023; Palma et al., 2023; Venet, 2021).

Measuring Use of Trauma-Informed Care

Along with the absence of a singular definition for trauma-informed care, there is a lack of consensus on what trauma-informed care entails. Scholars have noted that there is no definitive checklist of components for trauma-informed care, recognizing the necessity for a non-prescriptive approach due to the individualized nature of trauma (Venet, 2021; Yatchmenoff et al., 2017). However, it remains essential to clarify what exactly being trauma-informed means in the research context, as ambiguity complicates communication, implementation, and evaluation of trauma-informed care (Becker-Blease, 2017; Hanson & Lang, 2016). This lack of clarity also raises critical questions about how we study the use of trauma-informed care in schools. With varying definitions and understandings of what it means to be trauma-informed, current tools used to measure it may be measuring very different constructs and practices. Therefore, it is imperative to explore the tools being used to measure trauma-informed care in educational settings to understand what aspects of trauma-informed care these tools are focusing on.

An existing gap in the literature is understanding what tools are available to measure trauma-informed care in educational settings and which components of trauma-informed care these tools assess. Wathen et al. (2023) conducted a literature review of trauma- and violence-informed care measures used across various sectors, focusing on studies that described the initial development and validation processes of these measures. They identified 13 measures across multiple sectors, including child welfare, education, law enforcement, mental health services, and health care. Inspired by this review, we chose to focus solely on tools used in educational settings. Additionally, we broadened our review to include literature that did not specifically discuss the initial development and validation process to gain a better understanding of the landscape of available tools. We were also interested in exploring whether and how these tools assess components of trauma-informed and equity-centered care.

Therefore, this scoping literature review aimed to explore the tools available for measuring the use of trauma-informed care in educational settings. Our research questions for this review were: (1) What tools to measure the use of trauma-informed care in educational settings are present in the literature? (2) How are the principles of trauma-informed care and equity-centered care represented in the tools? (3) What gaps exist in tools for measuring trauma-informed care in educational settings? Note that we use the word ‘measure’ to encompass a variety of terms (e.g., observe, evaluate, etc.).

METHODS

We conducted a scoping literature review following the guidelines outlined by Peters et al. (2020). We chose a scoping review because it can be used to map the existing literature on a topic, identify key concepts, and pinpoint gaps in the literature to inform future research (Grant et al., 2009; Pare et al., 2015).

Inclusion and Exclusion Criteria

We used the following criteria to select the appropriate literature for this review. First, the article must have used a tool to measure or evaluate the use of trauma-informed care among PreK-12 school staff (e.g., teachers, administrators, paraprofessionals, social workers, etc.). The tool had to have been explicitly designed to measure an aspect of trauma-informed care; tools that were used as proxies for trauma-informed care (e.g., the Classroom Assessment Scoring System [CLASS]) were excluded. We also excluded any literature that was just measuring participants' satisfaction with or experiences with a training on trauma-informed care but did not measure any of the participants' use or knowledge of trauma-informed care. Second, the literature had to be published in a peer-reviewed journal. Articles were included regardless of the year of publication to get a full view of the tools that have been used. Finally, articles had to be published in English, as that was the only language the authors could read; however, we did not limit our search to just studies conducted in the United States, as we were interested in examining the broad landscape of available tools.

Identifying Literature

We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2010) to gather and identify relevant literature for this review. The first author, along with support from a university librarian specializing in literature searches in education and social sciences, conducted the initial search in August 2024. To identify publications, we searched the ERIC and PsycINFO databases. We used a combination of the following keywords: Trauma-informed attitudes or practices or care or education AND measurement or evaluation or assessment or survey or observation or tool or questionnaire or list or checklist or scale AND schools or education. This search yielded 1,322 results. After removing duplicates, our initial review included 1,116 articles.

Then, we engaged in a two-step process to screen the articles. All articles were uploaded into Covidence, an online literature review software. First, the first author and two research assistants performed a title and abstract screening. We read the titles and abstracts of each article independently and determined whether they met the stated inclusion criteria. Then, we met as a team to discuss any discrepancies in how we screened the articles and reached consensus. Each article was reviewed by at least two members of the research team. 1,070 articles were excluded at this stage because they did not measure the use of trauma-informed care in education settings. This left 46 articles for the second round of review, in which the first and second authors conducted a full-text review. Both authors reviewed each article to determine if it met the inclusion criteria. At this stage, 12 articles were excluded, resulting in 34 articles remaining. We reviewed these articles and found 20 tools that measured the use of trauma-informed care in PreK-12 education settings. See Figure 1 for an overview of the search process.

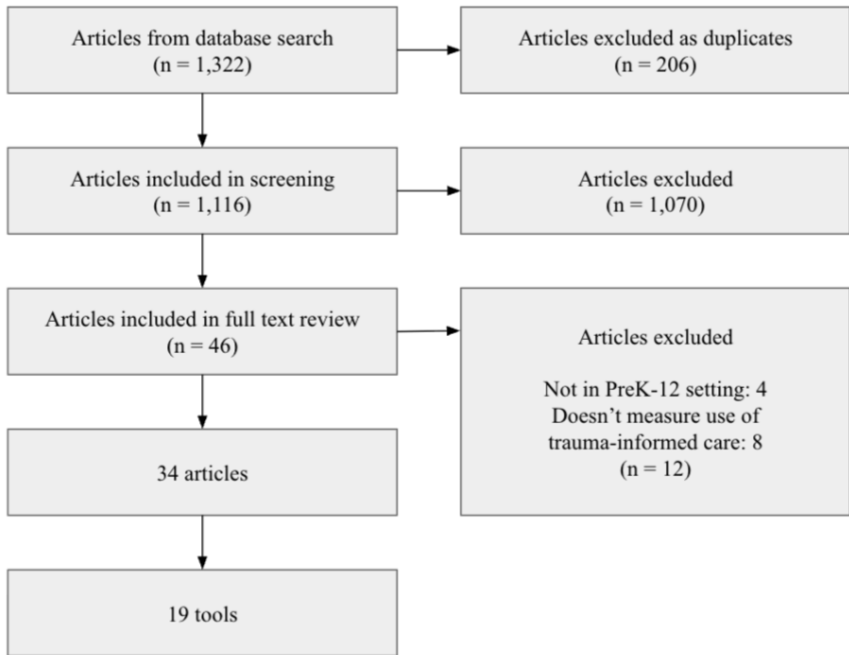

Figure 1: Summary of Article Search Process

Round 1 Coding

In the first round of coding, we created a deductive coding scheme to extract data from the articles in Covidence. The purpose of this phase was to extract contextual data about each article and tool, such as who the tool was used with and in what setting. We created codes based on the research questions and what we wanted to know about the tools. Codes included research design characteristics (e.g., type of study, setting, participants) and tool characteristics (e.g., description of tool, number of items). The first or second author coded each article. If we were unsure how to code something, it was noted and brought to the team meetings for discussion.

Round 2 Coding

In the second round, we coded each item in the identified tools. The purpose of this round of coding was to explore how trauma-informed care was being measured. Four tools did not include all or any items in the manuscript(s), which meant we could not code at least 37 additional items (the total number is unknown, as not all articles reported the number of items in a tool). There were a total of 322 unique items (i.e., items in tools that appeared more than once were not counted multiple times). To code the data, we created a spreadsheet that included the name of each tool and each item. We coded the data in multiple phases, which are detailed next. See Table 1 for an overview of the codes and example items.

Table 1: Coding Schemes for Scoping Review

Code	Definition	Example Items
	SAMHSA's 4 R's	
Realize	● Understand that trauma impacts individuals, families, groups, organizations, and communities	● Exposure to trauma is common (Trauma Informed Education Knowledge Survey) ● Staff recognize that some students' families or cultures have endured generations of violence, abuse, and other hardships (Trauma-Informed Practice Scales – School Counseling Programs Version)
Recognize	● Recognize signs, symptoms, and manifestations of trauma	● Student disruptive behaviors may be linked to physical changes related to a stressful living environment (Anderson et al., 2015) ● How traumatic stress affects the brain and body (Trauma-Informed Organizational Self-Assessment)
Respond	● Apply the principles of a trauma-informed approach ● Ensure appropriate workforce training ● Ensure a trauma-informed workforce for staff	● I can utilise strategies with the intent to create a safe environment for students (The Primary Early Childhood Educators Trauma-Informed Care Survey for Knowledge, Confidence, and Relationship Building) ● I know how to develop relationships with students with disabilities who are traumatised (Teacher Trauma Management Scale)

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Resist	● Know how policies, practices, and interventions can interfere with well-being and inadvertently trigger	● Regularly examining the enforcement of discipline policies for patterns, both in the classroom and across the school, to identify disparities by gender, race, sexual identity or orientation, or other factors (Blitz et al., 2020)
	Trauma-Informed, Equity-Centered Care	
Savior mentality	● Addresses acknowledging and rejecting holding a savior mentality with students	● N/A
Culturally responsive practices	● Addresses the use of culturally responsive practices	● Mental health services are linguistically appropriate and culturally competent (Trauma-Sensitive Schools Checklist)
Systemic trauma	● Addresses the recognition of systemic trauma as impacting students	● Staff recognize that some students' families or cultures have endured generations of violence, abuse, and other hardships (Trauma-Informed Practice Scales – School Counseling Programs Version)
Addresses school-based trauma	● Addresses schools as a source of trauma for students	● N/A
Universal use of trauma-informed care	● Addresses the need to use trauma-informed care universally with all students, regardless of known trauma background	● N/A
Anti-bias	● Addresses the need to recognize bias	● Demonstrating self-awareness and self-reflection about their

	and be anti-biased towards students	assumptions and potential biases (Blitz et al., 2020)
	Individual vs. System Level	
Individual	● Addresses individual educators' use of trauma-informed care	● I have an in-depth understanding of events that cause trauma (Teacher Trauma Identification and Management Scale) ● I generally consider my classroom or workspace to be a calm and peaceful environment (Anderson et al., 2015)
System	● Addresses program-wide use of trauma-informed care	● In this school, students have the opportunity to connect with others (Trauma-Informed Practice Scales – School Counseling Programs Version) ● Protocols exist for helping students transition back to school from other placements (Trauma-Sensitive Schools Checklist)

Note. Codes with N/A meant that no tool items addressed the component.

Phase 1: Components of Trauma-Informed Care

First, we used SAMHSA's (2023) framework of trauma-informed care to code the tools. This framework identifies four components of a trauma-informed approach: realize the impact of trauma, recognize the signs and symptoms of trauma, respond by implementing trauma-informed practices, and resist re-traumatizing. The first author read each survey item and coded it with the SAMHSA component(s) it corresponded to, or with 'N/A' if the survey items were not included. Then, the second author coded a random subset of the items and we compared codes, discussed any disagreements, refined code definitions, and updated previously coded items if needed.

Phase 2: Trauma-Informed, Equity-Centered Practices

Next, we developed a list of trauma-informed, equity-centered practices based on the literature. These terms included: savior mentality, culturally responsive practices, systemic trauma, school-based trauma, universal use of trauma-informed care, and anti-bias. The first author read each survey item again and coded items if they correlated with a listed practice. The second author reviewed the coded data, noting any items that she disagreed with or was uncertain about. We then met to discuss these items and agree on codes.

Phase 3: System vs. Individual Level

Finally, we coded for whether the tool addressed system-level factors in trauma-informed care (e.g., school's responses to trauma, school policies), individual-level factors (e.g., an educator's attitudes or knowledge), or both. The same coding process was repeated, where the first author read each tool item and coded for if it addressed systems-level or individual-level use of trauma-informed care. This was done by looking at the tool items and the description of the tool. The second author reviewed the coded data, noting any items with which she disagreed or was uncertain, which were then discussed as a team.

FINDINGS

In this section, we start by describing the tool's characteristics. We then describe what area(s) of trauma-informed care the tools were measuring. Finally, we describe whether and how the tools addressed components of trauma-informed equity-centered care.

Overview of Tools

Overall, we identified 20 unique tools that measure the use of trauma-informed care in educational settings. Table 2 provides an overview of each tool, including a

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description, the number of items, the population with which it was used, and whether it has been psychometrically validated. Note that when the tool was not given a specific name, we used the author's name in its place. The tools were published and used between 2012 and 2024, with most being published after 2020.

The tools broadly focused on three areas of trauma-informed care: attitudes, practices/skills, and knowledge. Tools were able to fall under multiple areas. Four tools measured attitudes, meaning they addressed perceptions of or beliefs towards trauma-informed care. For example, the Attitudes Related to Trauma-Informed Care (ARTIC) scale measures attitudes related to five areas of trauma-informed care: (a) Underlying causes of Problem Behavior and Symptoms, (b) Responses to (c) Problem Behavior and Symptoms, (d) On-The-Job Behavior, (e) Self-Efficacy at Work, and (f) Reactions to the Work. Twelve tools focused on knowledge of trauma-informed care, such as the Trauma-Informed Education Knowledge Survey. This survey includes 13 items and asks participants to rate on a scale of one to six (1 = disagree very much, 6 = agree very much) where they fall on items such as "Students who have experienced trauma can become triggered in the classroom." Nine tools focused on skills/practices related to trauma-informed care use. For example, the Teacher Trauma Identification and Management Scale (TTIMS) is a self-assessment that measures teachers' perceived competence in identifying trauma and implementing trauma-informed practices.

All the tools were self-report tools, meaning that participants rated their own use of, knowledge about, or beliefs towards trauma-informed care. Most tools (n = 15) were scales (e.g., rating statements on a 6-point Likert scale, where 1 = not difficult at all to 6 = extremely difficult). A few tools (n = 3) were multiple choice. The number of items on the measures ranged from nine to 60. Thirteen tools had accompanying information about psychometric validation.

Some articles did not specify who the tool was used with, instead just describing participants as "school staff." However, of the articles that did report participants in more detail, we found that most tools (n = 14) were used with teachers. Seven tools were used with administrators, four with school-based mental health providers, three with classroom aides/paraprofessionals, and two with other school staff (i.e., speech-language pathologists, school security officers). Some of the tools were designed for use by education professionals who work with specific groups of students. For example, the Primary Early Childhood Educators Trauma-Informed Care Survey for Knowledge, Confidence, and Relationship Building (PECE-TICKCR) scale was designed for use with preschool through third-grade teachers. Seven articles did not specify the grade level at which the participants who completed the tool worked. Additionally, many articles did not specify the type of school in which the tool was used (e.g., public or private setting). Of those that did, most were used in public school settings and a few in private settings. The tools were used mainly in the United States, with other countries including Canada, Egypt, Ireland, Ghana, the United Arab Emirates, Australia, and the United Kingdom. Additionally, just over half of the articles did not include information about participants' race/ethnicity or gender.

Table 2: Overview of Tools used for Measuring Trauma-Informed Care in Educational Settings

Tool name	Description	Focus of Tool	Number of Items	Population Used With	Information About Psychometric Validation?
Attitudes Related to Trauma-Informed Care (ARTIC) Scale (Baker et al., 2016)	Measures trauma-informed attitudes in 5 or 7 subscales: (a) Underlying causes of Problem Behavior and Symptoms, (b) Responses to (c) Problem Behavior and Symptoms, (d) On-The-Job Behavior, (e) Self-Efficacy at Work, (f) Reactions to the Work, (g) Personal Support of Trauma-Informed Care, (h) System-Wide Support of Trauma-Informed Care. From the Traumatic Stress Institute	Attitudes	10, 35, or 45 items on a 7-point scale	School staff	Yes
Trauma-Sensitive School Checklist	Evaluates five components involved in creating a trauma-informed school: (a) school-wide policies and practices, (b) classroom strategies and techniques, (c) collaborations and linkages with mental health, (d)	Practices/Skills	26 items on a 4-point scale	Teachers, administrators, and classroom support staff	Yes

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	family partnerships, and (e) community linkages. From the Trauma and Learning Policy Initiative (2012)				
Trauma-Informed Practice Scales -- School Counseling Programs Version (Fye et al., 2024)	A brief instrument to provide school counselors with a self-assessment of their trauma-informed practices	Practices/Skills	28 items on a 0-3 scale	School counselors	Yes
Teachers' Difficulties Helping Children After Traumatic Exposure Scale (Alisic et al., 2012)	Measures various aspects of assisting children after being exposed to trauma	Practices/Skills	9 items on a 6-point scale	K-12 teachers	Yes
Knowledge About Trauma-Informed Approaches Measure (Baker et al., 2021)	Quiz-like measure that evaluates knowledge of trauma-informed care	Knowledge	11-14 multiple-choice questions	Teachers, administrators, and classroom support staff	No
The Trauma-Informed Skills Survey (Barnett et al., 2018)	A modified version of the Trauma-Informed Self-Assessment included in the National Child Traumatic Stress Network that measures sense of competence in delivering TIC	Practices/Skills	13 items on a 5-point scale	Teachers, paraprofessionals, and administrators	No

The Primary Early Childhood Educators Trauma-Informed Care Survey for Knowledge, Confidence, and Relationship Building (PECE-TICKCR) (Bilbrey et al., 2021)	Assesses perceptions of benefits/effectiveness of TIC for teachers and students. Adapted from the Trauma-Informed Care Dispositions Survey.	Knowledge, Practices/Skills	14 items on a 5-point scale	PreK-3 teachers	Yes
HEARTS Program Evaluation Survey (Dorado et al., 2016)	Measure staff's perception of changes in their knowledge, skills, and use of trauma-sensitive practices.	Knowledge	9 items on a 5-point scale	K-8 teachers, administrators, and other school staff	No
Trauma-Informed Organizational Self-Assessment (Fallot & Harris, 2009)	Assesses general knowledge of trauma and trauma-informed practices.	Knowledge	17 items on a 4-point scale	K-12 school security professionals	Yes
The Trauma-Informed Climate Scale-10 (TICS-10) (Hales et al., 2019)	Measures staff perceptions of the service environment along Harris and Fallot's (2001) five values of TIC: safety, trustworthiness, choice, collaboration, and empowerment. Adapted from the 34-item Trauma-Informed Climate Scale (Kusmaul et al., 2015)	Attitudes	10 items on a 5-point Likert scale	Education professionals	Yes

Trauma-Informed Education Knowledge Survey (IIchena et al., 2024)	Designed to evaluate educators' knowledge about the impact of trauma and trauma-informed approaches	Knowledge	13 items on a 6-point scale	K-12 teachers	Yes
Knowledge of Trauma-Informed Approaches (McIntyre et al., 2019)	Assesses teacher knowledge of the prevalence of trauma, impact of trauma, the need for behavioral and learning supports for students, the key principles of a trauma-informed approach as laid out by SAMHSA, and addressing secondary traumatic stress in educators. Adapted from Brown et al., 2012	Knowledge	14 multiple choice questions	K-12 teachers	Yes
Usage Rating Profile-Intervention Revised (URP-IR) (Briesch et al., 2013)	Comprised of six subscales that represent factors that might influence whether a teacher uses trauma-informed care	Attitudes, Knowledge	9 questions on a 6-point scale	Primary and secondary teachers	Yes
Teacher Trauma Management Scale (Opoku et al., 2023)	Measures teachers' perceived competence in trauma identification and the use of trauma-informed practices	Knowledge, Practices/Skills	53 questions on a 5-point scale	Used with early childhood-12th grade teachers	Yes

Teacher Trauma Identification and Management Scale (TTIMS) (Opoku et al., 2025)	Measures teachers' perceived competence in trauma identification and the use of trauma-informed practices	Knowledge, Practices/Skills	33 questions on a 5-point scale	Primary and secondary teachers	Yes
Teaching Traumatized Students (TTS) Scale (Crosby et al., 2016)	Measure teachers' knowledge of working with students who have experienced trauma	Knowledge, Practices/Skills	9 items on a 5-point scale	K-12 teachers	Yes
Orapallo et al., 2021	Measures knowledge of core trauma-informed care content	Knowledge	Multiple choice questions (number of items missing)	Preschool and elementary school teachers, staff, and administrators	No
Sharkey et al., 2024	Measures knowledge of trauma	Knowledge	3 questions on a scale of 1-5	K-12 administrators	No
Anderson et al., 2015	Explores perceptions related to trauma-informed practices and school/workplace climate	Attitudes	11 questions on a 4-point scale	Elementary school classroom aides and paraprofessionals	No

Blitz et al., 2020	Measures use of trauma-informed practices in six principles: (a) adopt a social-emotional lens, (b) know the students and continually develop cultural responsiveness, (c) move the discipline paradigm from “punishment” to “opportunities to teach desired behavior,” (d) resist the criminalization of school behavior, (e) maintain an inclusive, cohesive, and nurturing professional work environment, and (f) address culture in the school	Practices/Skills	60 questions on a 5-point scale	K-5 school staff	No

Note. TIC = trauma-informed care.

Measurements of Trauma-Informed Care

In the following section, we describe how components of trauma-informed care, trauma-informed equity-centered practices, and system versus individual level responses were represented in the tools. This information is presented in Table 3.

Trauma-Informed Care Components

Regarding SAMHSA's components of trauma-informed care, most items (83%, n = 267) mapped on to the *respond* component. Items were coded as *respond* when they focused on applying the principles of trauma-informed care, ensuring appropriate workforce training, and ensuring a trauma-informed workforce for staff (SAMHSA, 2023). These included items such as "I am knowledgeable about the steps to take once a student has been identified as experiencing a traumatic event," and "Staff understand that students know what's best for them." 14% (n = 45) of items mapped on to the *recognize* component; these were items that focused on recognizing the signs, symptoms, and manifestations of trauma in students. Example items included "How trauma affects a child's development" and "General and special educators consider the role that trauma may be playing in learning difficulties at school." 2% (n = 6) of items mapped onto the *realize* component, meaning they addressed if and how the person completing the tool realizes that trauma impacts individuals, families, groups, organizations, and communities. Some of the items were "I have an in-depth understanding of events that cause trauma" and "The definition of traumatic stress." Finally, less than 1%, only one item, addressed the *resist retraumatizing* component. This item was "Regularly examining the enforcement of discipline policies for patterns, both in the classroom and across the school, to identify disparities by gender, race, sexual identity or orientation, or other factors." Overall, most of the tools included more than one component. The most frequently represented component for the tools as a whole was *respond* (n = 15), followed by *recognize* (n = 12), *realize* (n = 5), and *resist re-traumatization* (n = 1).

Trauma-Informed and Equity-Centered Care

Overall, we found that few components of trauma-informed and equity-centered care were included in the tools. Table 3 indicates which tools include these components. We found eight items across six different tools that discussed being strengths-based (e.g., "Knowing the strengths of each student and affirming these with them regularly"). Five items in four different tools addressed the use of culturally responsive practices (e.g., "Staff respect the strengths they get from their culture or family ties"). Two items in two tools addressed systemic trauma (e.g., "Talking about how members of marginalized groups are affected by oppression and bias in their lives outside of the school environment"), and two items in one tool addressed being

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Table 3: Representation of Trauma-Informed Care, Equity-Centered Practices, and System Level Responses in Measurements

Tool	SAMHSA Component	Trauma-Informed Equity-Centered Practices?	System or Individual Level
Attitudes Related to Trauma-Informed Care (ARTIC) Scale	Recognize Respond	Being strengths-based	Individual
Trauma-Sensitive School Checklist	Recognize Respond	Being strengths-based Culturally-responsive practices	System
Trauma-Informed Practice Scales -- School Counseling Programs Version	Realize Respond	Being strengths-based Culturally-responsive practices Systemic trauma	System Individual
Teachers' Difficulties Helping Children After Traumatic Exposure Scale	Respond		Individual
Knowledge About Trauma-Informed Approaches Measure	NA		NA
The Trauma-Informed Skills Survey	NA		Individual

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The Primary Early Childhood Educators Trauma-Informed Care Survey for Knowledge, Confidence, and Relationship Building (PECE-TICKCR)	Recognize Respond		Individual
HEARTS Program Evaluation Survey	Recognize Respond		Individual
The Trauma-Informed Climate Scale-10 (TICS-10)	Respond		System
Trauma-Informed Organizational Self-Assessment	Realize Recognize Respond		Individual
Trauma-Informed Education Knowledge Survey	Realize Recognize Respond	Being strengths-based	Individual
Knowledge of Trauma-Informed Approaches	Realize Recognize Respond		Individual
Usage Rating Profile-Intervention Revised (URP-IR)	NA		Individual
Teacher Trauma Management Scale	Recognize Respond	Culturally-responsive practices	System Individual

Teacher Trauma Identification and Management Scale (TTIMS)	Realize Recognize Respond		Individual
Teaching Traumatized Students (TTS) Scale	Recognize Respond		Individual
Orapallo et al., 2021	NA		Individual
Sharkey et al., 2024	Recognize Respond		Individual
Anderson et al., 2015	Recognize Respond	Being strengths-based	Individual
Blitz et al., 2020	Resist Respond	Anti-bias Being strengths-based Culturally-responsive practices Systemic trauma	Individual

Note. NA = Not applicable to be coded because the items were not included.

anti-biased (e.g., "Demonstrating self-awareness and self-reflection about their assumptions and potential biases"). We found no items that addressed the universal use of trauma-informed care, addressing school-based trauma, or addressing holding a savior mentality.

Systems vs. Individual Level

We also coded for whether the tool was designed to assess individual-level factors (e.g., individual attitudes, individual knowledge), system-level factors (e.g., school's responses to trauma, school policies), or both. Sixteen tools focused solely on the individual level, with items such as "I am knowledgeable about different types of trauma" and "I can treat students with dignity and respect at all times." Two tools, the Trauma-Sensitive Schools Checklist and the Trauma-Informed Climate Scale-10, focused just on the systems level with items such as "Policies describe how, when, and where to refer families for mental health supports" and "When possible, school and community agencies leverage funding to increase the array of supports available." Finally, two tools (Trauma-Informed Practice Scales–School Counseling Programs Version [TIPS- SCP] and the Teacher Trauma Management Scale) included items that focused on the individual and system level.

DISCUSSION

In this literature review, we aimed to explore the tools available in the published literature for measuring the use of trauma-informed care in educational settings. Additionally, we were interested in whether and to what extent the tools included components of equity-centered, trauma-informed care. We found 20 tools, most of which were published and used within the last five years, speaking to the recent increase in trauma-informed care research (Compton et al., 2023).

Our coding of the tools based on SAMHSA's four components of trauma-informed care indicated that most of the tools focused on responding by implementing trauma-informed practices. Notably, recognizing the signs and symptoms of trauma was also widely present, appearing in 12 tools. A recent discussion in the field of trauma-informed care is the use of a targeted and reactive approach versus a universal approach. In a targeted approach, educators use trauma-informed care after identifying a student as having experienced trauma; a universal approach looks like using TIC with all students, regardless of whether they are showing signs of trauma or if their trauma background is known (Venet, 2021). Considering that no tools included items that addressed using a universal approach to trauma-informed care, we believe that this is an area trauma-informed care researchers will have to navigate when designing tools, ensuring that education professionals recognize how trauma can impact students, but still using a universal approach to trauma-informed care.

Another notable finding is the inconsistent reporting of who was using these tools. When coding for research design characteristics (e.g., type of education

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professional, grade level(s) they worked with, type of setting), we noticed much of this data was missing from the description of participants, such as saying the tool was used with school counselors and not stating the grade level, not sharing if the teachers worked in a public or private setting, or referring to participants as simply “school staff” without describing their role. Additionally, some studies did not report the race or gender of participants who used the tool. Given the unique circumstances of each school that may impact the use of trauma-informed care, we urge researchers to include detailed demographic information in their research study descriptions when using tools that measure trauma-informed care.

Based on the findings from this study, we identified three main gaps in the literature. First, the measures we found were largely missing components of an equity-oriented approach to trauma-informed care. When an equity-oriented approach to trauma-informed care was included in tools, it was often represented in just one or two items and not widely incorporated throughout the tool. Considering the increasing calls for the use of equity-centered trauma-informed care (Palma et al., 2023; Venet, 2021), this highlights the need to develop tools with a specific attention on this. We recognize the varying definitions and components of equity-centered trauma-informed care, and that being equitable and trauma-informed cannot be condensed into a single checklist. However, if the field of education is to continue measuring trauma-informed care, there is a need to ensure that this perspective is represented and included. To assist with this, future research can work towards consensus-building on what it means to be trauma-informed and equity-centered in education, building off of previous work in the area (Alvarez & Farinde-Wu, 2022; Haynes et al., 2025; Venet, 2021). Additionally, there may be ways to adapt existing tools by adding or adjusting questions to include a focus on equity.

Second, all identified tools relied on self-report measures, regardless of whether they focused on attitudes, knowledge, or practices. While self-report may be an effective strategy for assessing attitudes and knowledge, this approach may be less appropriate when considering teaching practices. Teachers’ self-reports of contextually driven practices (e.g., culturally responsive teaching) are not always aligned with observational measures of those practices, potentially due to the impact of social desirability or to different understandings of trauma-informed care (Debnam et al., 2015). Similar to culturally responsive teaching, trauma-informed care is highly individualized and context-driven, which may contribute to the difficulty in creating a reliable observational tool. During the screening phase of this review, several studies were identified that used other classroom observational tools focused on educator-student interactions (e.g., CLASS) as proxies for trauma-informed care. These proxies may capture some elements of trauma-informed care but also may miss critical practices due to their lack of focus on trauma-informed care. Therefore, there is a need for the development of observational measures of trauma-informed care in education settings, which previous researchers have also called for (Loomis et al., 2025).

Finally, we noticed that there was a heavy focus on individual beliefs and practices rather than systems-level adoption of trauma-informed care. This is in contrast to how SAMHSA (2023) and other scholars (Champine et al., 2019; Howard, 2019) define trauma-informed care, which focuses on a holistic, organizational

adoption of trauma-informed principles by all personnel. While individual staff practices may benefit students, these benefits will likely be limited when such practices occur within a system that has not adopted a trauma-informed approach. A few tools have emerged that focus on more organizational trauma-informed practices (e.g., Trauma Sensitive Schools Checklist, Trauma-Informed Climate Scale). However, there remains a notable lack of research in which those tools are used to evaluate trauma-informed care in educational settings. Future research could explore the differential impact of individual versus systems-level adoption of a trauma-informed approach.

Limitations

There are a few limitations to this literature review. First, we used the term "trauma-informed" to identify tools in the literature; therefore, we might be missing tools that used different but related terms (e.g., adversity-informed, trauma-responsive). Second, due to time and resource constraints, we only included published literature and did not search dissertations. Additionally, our decision to use SAMHSA's four principles to frame trauma-informed care, rather than other frameworks of trauma-informed care (e.g., The National Child Traumatic Stress Network's Elements of a Trauma-Informed School System), means that reviews using other frameworks/conceptualizations might yield different findings. Finally, we did not assess the methodological rigor of each study, and the results should be considered within this context.

CONCLUSION

This scoping literature review highlights the current landscape of tools used to measure trauma-informed care in educational settings. Our analysis reveals that while a growing number of tools have emerged in recent years, most emphasize individual-level practices, focus predominantly on the "respond" component of trauma-informed care, and rely exclusively on self-report data. Critically, components essential to equity-centered trauma-informed care such as recognizing systemic trauma, using culturally responsive practices, and being anti-biased, are largely absent or minimally represented. Moving forward, there is a need to develop more comprehensive tools that capture both individual and systemic dimensions of TIC, integrate equity-centered principles, and utilize multiple forms of measurement beyond self-report, such as observation tools. In doing so, researchers and educators alike can work towards a more inclusive, responsive, and effective implementation of trauma-informed care in schools.

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MIA CHUDZIK, PhD, is a postdoctoral research associate at the University of Illinois in the departments of Curriculum and Instruction and Special Education. Her research focuses on the use of trauma-informed care in early childhood and special education settings. Email: miatc2@illinois.edu

EMILY HOLDEN, EdS, is a doctoral candidate in the Department of Education and Human Development at University of Colorado, Denver. Her research interests center around trauma-informed care, secondary traumatic stress, and mental health in early childhood care and education contexts. Email: emily.holden@ucdenver.edu