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Trauma-Informed Screening & Assessment

Trauma Screening

Trauma Screening refers to a tool or process that is a brief, focused inquiry to determine whether an individual has experienced one or more traumatic events, has reactions to such events, has specific mental or behavioral health needs, and/or needs a referral for a comprehensive trauma-informed mental health assessment.

Trauma-Informed Mental Health Assessment

Trauma-Informed Mental Health Assessment refers to a process that includes a clinical interview, standardized measures, and/or 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 functional impairment(s). Clinicians use this to understand a child's trauma history and symptom profile; to determine whether a child is developmentally on target in the social, emotional, and behavioral domains; to inform case conceptualization and drive treatment planning; and to monitor progress over time.

Links:
[1] http://www.nctsn.org/resources/topics/trauma-informed-screening-assessment/general-info
[2] http://www.nctsn.org/resources/topics/trauma-informed-screening-assessment/engaging
[3] http://www.nctsn.org/resources/topics/trauma-informed-screening-assessment/trauma-screening

[4] http://www.nctsn.org/resources/topics/trauma-informed-screening-assessment/implementation
[5] http://www.nctsn.org/resources/topics/trauma-informed-screening-assessment/resources

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Trauma Screening

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What is a Trauma Screening Tool or Process?
Trauma screening is designed to be able to be administered to every child within a given system (such as child welfare) to determine whether he or she has experienced trauma, displays symptoms related to trauma exposure, and/or should be referred for a comprehensive trauma-informed mental health assessment. Trauma screening can include a particular tool or a more formalized process. Trauma screening should evaluate the presence of two critical elements:
(1) Exposure to potentially traumatic events/experiences, including traumatic loss
(2) Traumatic stress symptoms/reactions
Not all children who experience negative events suffer posttraumatic or trauma-specific reactions as a result. Trauma screening should measure a wide range of experiences, identify common reactions and symptoms of trauma (e.g., PTSD, dissociation), as well as other commonly reported difficulties (e.g., anger, behavior problems, depression, anxiety). With proper training, professionals or paraprofessionals from various child-serving systems—pediatric/medical settings, schools, home visiting programs, and domestic violence programs/shelters—can administer the screening.
Screening typically covers the following types of traumatic stress symptoms/reactions:

- Avoidance of trauma-related thoughts or feelings
- Intrusive memories of the event or nightmares about the event
- Hyper-arousal or exaggerated startle response
- Irritable or aggressive behavior
- Behavioral problems
- Interpersonal problems
- Other problems based on the developmental needs and age of the child

The following case example highlights the role trauma screening plays in understanding a child's history of trauma and its role in subsequent behaviors.

CASE EXAMPLE Joshua: Screening Process

Joshua is a 12-year-old Caucasian boy whom child welfare placed with his grandmother several months ago. His behavior has declined since his middle sibling was placed in the same home. He reacts strongly when his sister gets more attention than he gets. In therapy, Joshua says that he gets angry with her easily and that being around her is "like all this old stuff coming back again." His moods shift from flat to volatile with frequent angry outbursts, verbal and physical aggression toward family members, and multiple signs of physiological arousal (e.g., difficulty sleeping, trouble concentrating, edginess, and irritability). He was recently diagnosed with Oppositional Defiant Disorder and ADHD.

Joshua's grandmother, who has a history of childhood trauma, has become increasingly depressed and overwhelmed

by his emotional outbursts and has difficulty consistently caring for the children. Child Protective Services (CPS) has become re-involved and is considering a more intensive level of care for Joshua.

What additional information do you need to develop a case management plan for Joshua? What events in Joshua's current situation concern you? What other services might he need? If you would consider further screening or assessment, what questions about Joshua would you hope to answer?

You may wonder how Joshua's experiences have affected him. He has been exposed to several potentially traumatizing events, but not all of these events may have had a harmful effect.

A trauma screening reveals that Joshua has suffered multiple traumatic events, including being locked in dark closets for hours at a time, being forced to watch his biological father fondle his youngest sibling, being isolated and denied food and water for more than a day at a time, unpredictable violence by his father, and ongoing substance use by both parents. As his sister was present during the abuse, she serves as a powerful reminder to Joshua. His trauma symptoms include irritability, difficulty concentrating, avoidance of discussing the abuse, being on "hyper alert," and having nightmares.

Given the results of this screening, the case management plan should include referring Joshua to a trained provider for a more comprehensive trauma-focused mental health assessment of the accuracy of the diagnoses and his current treatment needs.

*Adapted from the Child Welfare Trauma Training Toolkit.

Types of Screening Tools

Clinicians may administer the trauma screening in a number of ways depending on the age and developmental stage of the child and on the child's relationship with the caregiver and other collateral informants in his or her life. For example, in very young children, it is difficult to screen specifically for "trauma symptoms." Rather, a provider may screen for exposure to traumatic events and social and emotional difficulties, such as attachment difficulties or mood dysregulation. As the child gets older, it may be more appropriate to screen specifically for trauma symptoms.

Most screening tools are for use by professionals with a range of training and experience. However, providers using a screening tool should consider (1) factors such as age, race, linguistic skills, and cognitive/developmental capabilities; (2) whether the client is among the populations for which the tool has been validated and normed; and (3) if there are factors which might affect the reliability and validity of the tool for this particular client.

- Child-Completed Tool (Self-Report)—Child-completed tools are appropriate for children, typically ages eight and above, who are able to read and complete the questions. These measures provide the child with an opportunity to verbalize his or her responses aloud or in writing.
- Caregiver-Completed Tool—For infants, toddlers, young children (ages 0-8), or children with developmental delays, it is more appropriate to have a caregiver complete the trauma screening either by providing written responses to the questions/items or through an interview by the provider.
- Provider-Completed—The caseworker, clinician, or other professional can administer certain tools as he/she reviews and integrates available information on a child (e.g., court reports, interviews with caregivers and teachers, other questionnaires, and behavioral observations). These tools can be useful in consolidating a range of information in one place so that it is readily accessible.

Engaging Families in the Screening Process

To engage families in the screening process, the individual administering the tool should consider the following:

- Explain the purpose and use of the screening tool and process. Say why you need to know this information, how you will use what you gather, how it may benefit the child/family, and who will have access to the information in the future. Emphasize that the information is confidential in most cases, unless the child endorses harm to self or others or the clinician has concerns regarding child abuse.
- After the client/family has completed the trauma screening, share the results and show how you are using the information. For example, "It's clear from the forms that you filled out that your daughter is having a really hard time with nightmares and fear of things that remind her of her brother getting hurt. We call this 'Post-Traumatic Stress.' To help her, I would like to refer you to a therapist who specializes in treating children with these problems."
- Make sure to thank the child for completing the tool or process, particularly if he or she disclosed a new trauma. Explain that the child's feelings and trauma reactions are normal and expected, given what he or she has lived

through.

- Consider the potential burden of the trauma screening to family members in terms of time and effort, and highlight the potential benefits, such as helping to link them to appropriate providers and services. Some families may be discouraged by the process; others may be comfortable with it. When clinicians explain the purpose and use of the screening tools and share the results, they enhance the benefits to families.

NEXT PAGE [2] MAIN PAGE [1]

Links:
[1] http://www.nctsn.org/resources/topics/trauma-informed-screening-assessment
[2] http://www.nctsn.org/resources/topics/trauma-informed-screening-assessment/resources

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Trauma-Informed Mental Health Assessment Resources

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What is a Trauma-Informed Mental Health Assessment and Why is it Important?
Trauma-informed mental health assessment offers a structured framework for (1) gathering information across several key domains of functioning, (2) identifying and addressing the needs of children and families exposed to traumatic events, and (3) coding and summarizing this information, so that it can be communicated to with families and other providers (Kisiel, Conradi, Fehrenbach, Torgerson, & Briggs; 2014). The following models highlighted below offer trauma assessment strategies (Kisiel, Fehrenbach, et al., 2009; Spaccarelli, 1994; Chadwick Center for Children and Families, 2009).

Examples of Trauma-Focused Mental Health Assessment Tools and/or Processes

- Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway (TAP) Model—Developed by the Chadwick Center for Children and Families (2009), with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Trauma Assessment Pathway (TAP) was designed for children 0 to 18 years of age who have experienced any type of trauma and who may or may not be in the Child Welfare (CW) system. TAP is a multifaceted assessment process enabling clinicians to screen clients and, if appropriate for the treatment setting, to gain an in-depth understanding of the child, developmental level, traumatic experience, and the child's family, community, and cultural systems.
- Child and Adolescent Needs and Strengths (CANS)—Trauma Comprehensive Version—"CANS-Trauma" is a flexible, multi-purpose tool utilized in different capacities depending on the needs of a particular child-serving system (Kisiel, Lyons, et al., 2010). The CANS methodology is intended to gather information on a range of domains relevant to the functioning of the child and caregiving system (e.g., trauma experiences, traumatic stress symptoms, emotional/ behavioral needs, risk behaviors, life domain functioning, strengths, and caregiver needs and strengths) and incorporate this information directly into individualized plans of care (Lyons, 2004; Lyons & Weiner, 2009).
- Transactional Model—Spaccarelli (1994) proposed a transactional or interactive model for understanding the effects of child abuse (and its associated events) on the presentation of symptoms. This model examines factors related to the abuse of the child, as well as those associated with the investigation (i.e., disclosure events) and related events that may occur subsequent to, and/or due to, the investigation (e.g., placement outside the home and court hearings). Age, sex, and personality factors are identified as possible moderating variables that have the potential to effect the expression of a child's symptomatology. Social support, as well, plays an important role in recovery (Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989). Finally, this model recognizes previous coping styles and cognitive appraisal schemes (i.e., the way a child organizes and understands events in his or her world) in terms of self-talk strategies and symptom maintenance. Individually and collectively, these factors influence expression of abuse/traumatic stress symptoms.

NEXT PAGE [2] MAIN PAGE [1]

Links:
[1] http://www.nctsn.org/resources/topics/trauma-informed-screening-assessment
[2] http://www.nctsn.org/resources/topics/trauma-informed-screening-assessment/engaging

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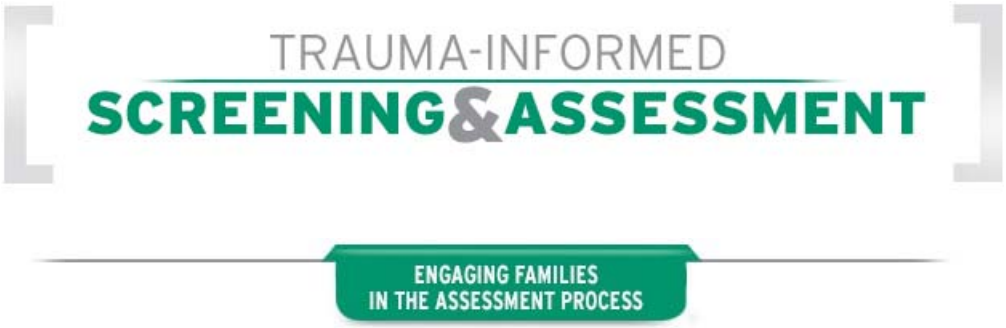
Engaging Families in The Assessment Process



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Following are practical ideas that clinicians can use to engage families in the assessment process (adapted from www.taptraining.net [2]). Of course, clinicians will facilitate child and family engagement in the process by addressing their concerns, answering their questions, validating their observations, and demystifying the process:
Administering Measures
Describe for caregivers (and youth as appropriate), the purpose and importance of the assessment process and various tools used to gather information across areas of functioning, given children's range of reactions to trauma.

- Make time in the therapy session to complete measures with caregivers/family members by putting it on the session agenda and explaining to caregivers how the measures can aid the treatment process and support the development of treatment goals and plans.
- Allow the parent and child to choose the language in which they will complete the measures.
- Describe the measures as a way you gather information on child and family functioning in order to help them as much as possible, not just more paperwork to complete.
- Use developmentally appropriate strategies when completing measures with youth, including the following:
  - Have a dry erase board/chalk board, as an alternative to pencil/paper, for marking answers
  - Let them decide the order in which they complete measures, if/when possible
  - Select a fun pen or pencil to use when marking items
  - Use visuals to clarify constructs such as frequency (e.g., calendar)
  - If the child opposes doing the measures, read aloud the items to him or her. This interviewing will allow you to collect additional "data," such as affective and physiological responses (Is he nervous completing the measure? Is she indecisive in responding? Does he fully understand the question?)
  - For youth, ask follow-up questions to probe more deeply after you have completed the measure.

- Offer to complete the assessment over 1-3 sessions and give the child and caregiver some choice in this (e.g., complete all today or one today and one next week?).
- Praise all children (and parents) for their "hard work" and patience completing questions.
- Check the endorsement of critical items (e.g., hurting oneself) and develop a safety plan.
- Take time to explain what will happen next (i.e., how the measures will be scored and how you will review the results with the youth and caregiver).
- Clarify that you will re-administer the measures on an ongoing basis, share the results, and use those results as you develop and monitor the treatment plan.

Providing Feedback

- Review the purpose of the measures with the child and caregiver.
- When applicable, explain that the measures provide information on how the child is doing related to other children.
- Highlight the strengths the child exhibits, whether indicated by a measure or domain related to resiliency, or strengths revealed as they were NOT identified as problematic (i.e., doing well in school). Explain to family members how you

will integrate these strengths into the treatment plan to support recovery from trauma.

- Assess the child and caregiver's level of interest in the feedback to decide; you may want to provide more or less detailed information and assessment data.
- Consider drawing diagrams or pictures to explain results on some measures (e.g., using bar graphs to indicate progress).
- Highlight areas where the caregiver and child were consistent in their report on the measures (i.e., both agree the youth client is experiencing problems in school). If they are very consistent, this is a potential strength, indicating that they are "on the same page."
- Highlight discrepancies between the child and caregiver report; explain that this suggests child and caregiver experience the same symptom very differently.
- Ask the caregiver and child if the results are consistent with their experiences (Does this seem accurate? Does it provide any new information? If they disagree, why?). This helps reconcile differences between caregiver and youth responses or varying responses on different measures.
- Share initial assessment results and use this information to engage in collaborative treatment planning with caregivers and youth as appropriate. Summarize the findings, noting two or three main points.
- Use the feedback process to provide psychoeducation about trauma reactions with the child and caregivers (e.g., noting common responses to trauma or areas of need that are related to each other) and tie this information to the treatment selected (e.g., "This treatment can help reduce those physical reactions and improve your sleep.").
- Remind the caregiver and child that you will re-administer the measures in the future, and that the results will show the progress of therapy, the areas where you may want to continue work, and how helpful the treatment has been for the child and family.

NEXT PAGE [3] MAIN PAGE [1]

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Considerations for Implementation

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Clinicians should consider the following when selecting trauma screening or assessment tools to implement in a given system:

- Considering the number of items/length of administration—The shorter the tool, the more likely you will use it.
- Cost—Systems are more likely to use free or low-cost tools.
- Child age range targeted with the instrument—Many prefer tools that apply to a range of ages or have age-defined versions.
- Method of administration—Tools that you can administer quickly and easily in a paper and pencil or interview format gather more comprehensive and accurate information.
- Respondent—What is the feasibility of having a particular respondent (child, caregiver or caseworker) complete a specific tool (e.g., availability)?
- Translations and available languages—For tools to be relevant and accurate, they should be available in the family's language.
- Accessibility & Mobility—As tools are developed that include on-line administration, real-time scoring and reporting features, and mobile access, you will need to consider feasibility, organizational readiness, costs, and security of these products.

  Empirical support—You should use tools that have empirical support. Here are some key empirical concepts to consider:
  1. **Reliability**: The extent to which a measurement instrument yields consistent, stable, and uniform results over repeated observations or measurements when administered under the same testing conditions.
  2. **Validity**: The degree to which a measure actually measures what is intended, rather than something else. An IQ test has validity if it measures IQ and not IQ plus achievement in reading. A measure of depression has validity if it measures depression and not both depression and anxiety.
  3. **Standardization of Norms**: Standardization is the process of testing a group of people to ascertain their typical scores on a construct. For example, the presence of specific trauma symptoms within a population of children who have experienced physical abuse. With a standardized test, the participant can compare where his or her score falls compared to the standardization group's performance.
  4. **Specificity and sensitivity**: These metrics/statistics are important when trying to determine if a characteristic or diagnosis is truly present or absent. A measure is specific when it accurately identifies a construct that is present. A measure is sensitive when it accurately identifies the construct as absent. For example, many researchers have tried to use existing measures to screen for PTSD symptoms and their efforts illustrate the difficulty in achieving both specificity and sensitivity. Specific items on the Child Behavior Checklist identify children likely to have the diagnosis of PTSD. However, because certain items assessing some aspects of PTSD were not included in the original version of the CBCL, the existing items are not sensitive which may lead to false positives, and thus do not accurately identify those who should not be considered to have PTSD (i.e., those where PTSD is truly absent).

Implementing a Trauma Screening Process or Tool
Prior to implementing a trauma screening or assessment process into a child serving system, take these important steps

to facilitate seamless implementation and to support the workforce throughout the process. The Chadwick Trauma-Informed Systems Dissemination and Implementation Project (CTISP-DI; www.ctisp.org) makes the following suggestions:

1. Pull together an "Implementation Team" that includes an expert in research and psychometrics.
2. Become familiar with some of the common concerns that may arise prior to the implementation of a screening process.

    a. Professionals or paraprofessionals may express concern that the process of asking questions about a child's trauma history or symptoms may potentially distress the child. Multiple research studies have explored this topic and none has found any evidence that asking questions regarding trauma exposure and symptoms increases a child's level of distress (Finkelhor, Turner, Shattuck, and Hamby, 2013).
    b. Professionals often question whether the screening or assessment tool or process will provide additional information not previously collected in the interview process. Numerous research studies have explored this issue over the last half century and have consistently found that the use of measures outperforms clinical judgment, suggesting that both forms of information gathering are essential (Grove & Lloyd, 2006).
    c. A further concern of professionals is the time it may take to implement, evaluate, and re-assess the selected processes and protocols over the period working with the child and family. While this concern is valid, the amount of information gathered through the process can help clinicians provide the best care to the child and family.

3. Child-serving systems should provide broad training on child traumatic stress to the entire workforce, including training on different trauma types (e.g., sexual abuse, physical abuse, neglect, exposure to domestic violence) and various traumatic stress reactions that children may exhibit, including internalizing and externalizing problems. Through training, the workforce should acquire a core knowledge base of how child traumatic stress reactions may manifest, the trauma reminders typical in their populations, and concrete strategies to address child traumatic stress reactions. The NCTSN has developed resources that provide broad training on child traumatic stress, including the Child Welfare Trauma Training Toolkit (for child welfare), Think Trauma (for juvenile justice), and the Core Curriculum on Childhood Trauma (for clinicians and other professionals).
4. Child-serving systems should establish an ongoing relationship with a mental health provider so that if a screening process determines that a child would benefit from a trauma-focused mental health assessment, there is a clear linkage to a provider trained in providing such an assessment.
5. Identify the informants for the screening or assessment tool. Determine during initial contacts if it is more appropriate to administer the assessment tool to the child or to ask the caregiver to answer the questions about the child. Determine this by considering the age of the child, the caregiver's knowledge of the child's symptoms, and the willingness of either to give the information. Screening and assessment tools are not interchangeable, meaning that you cannot administer a tool intended for a child to an adult and vice-versa.
6. Pilot test the screening or assessment process within the system prior to implementation. Asking questions about trauma exposure and symptoms may be uncomfortable, and providers who practice with a colleague become more comfortable with the language and managing various responses.
7. Initiate a system for addressing secondary traumatic stress. Service providers should have an organizational policy in place to address secondary/vicarious trauma. Find more information on addressing this here [2].

MAIN PAGE [1]

Links:
[1] http://www.nctsn.org/resources/topics/trauma-informed-screening-assessment
[2] http://www.nctsn.org/resources/topics/secondary-traumatic-stress