Identifying Childhood Trauma

RECOMMENDATIONS ON TRAUMA IDENTIFICATION PRACTICES IN CHILD-SERVING ORGANIZATIONS

A Report of the Childhood Trauma Task Force

NOVEMBER 2022 | https://www.mass.gov/lists/childhood-trauma-task-force-cttf

About the Childhood Trauma Task Force

The Childhood Trauma Task Force (CTTF) was established by *An Act Relative to Criminal Justice Reform* (2018) in M.G.L. Chapter 18C, Section 14. The CTTF, which is chaired by the Child Advocate and is made up of representatives from a broad spectrum of stakeholders involved in the juvenile justice and other child-serving systems, was tasked by the Legislature with determining how the Commonwealth can better identify and provide services to children who have experienced trauma, with the goal of preventing future juvenile justice system involvement.

The Legislature created the CTTF as a permanent entity, recognizing the complexity and scale of the group's assignment. Learn more about the CTTF here: https://www.mass.gov/lists/childhood-trauma-task-force-cttf

Definitions of Key Terms

Trauma "results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being." (SAMHSA's Concept of Trauma, 2014). Though commonly used interchangeably, the term differs from the following:

- **Adverse Childhood Experiences (ACEs)** are potentially traumatic events that occur in childhood. Common ACEs include experiencing or witnessing interpersonal or community violence; physical, sexual, or emotional maltreatment; living with a household member experiencing substance use or mental health issues; having an incarcerated parent; having separated caregivers. ACEs are not always traumatic and do not necessarily lead to toxic stress. For more information see: https://www.cdc.gov/violenceprevention/acestudy/index.html
- **Toxic stress** is the body's prolonged response to a harmful or life-threatening experience. It differs from a normal stress response in that there is a lack of caregiver support, reassurance, or emotional attachments. For more information see: https://www.acesaware.org/wp-content/uploads/2019/12/2-What-is-Toxic-Stress-English.pdf
- **Post-Traumatic Stress Disorder (PTSD)** is the clinical diagnosis of a psychiatric disorder. To meet the diagnosis, individuals over the age of six must exhibit a certain set of symptoms defined in the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5) for a period lasting more than a month. For more information see: https://www.ncbi.nlm.nih.gov/books/NBK207191/box/part1_ch3.box16/

Trauma-informed and Responsive (TIR) refers to a set of strength-based, child-centered principles that guide professional or organizational practices. The five principles of TIR practice are: safety; transparency and trust; healthy relationships and interactions; empowerment, voice, and choice; equity, anti-bas efforts, and cultural affirmation. The CTTF's *Framework for Trauma-Informed and Responsive Organizations* (2020) lays out how these guiding principles can be applied across domains of an organization. For more information see: https://www.mass.gov/doc/framework-for-trauma-informed-and-responsive-organizations-0/download

Racial Trauma or race-based traumatic stress (RBTS) refers to the mental and emotional injury caused by encounters with racial bias and ethnic discrimination, racism, and hate crimes—whether it is experienced directly or vicariously (e.g., through second-hand stories, social media, or the news). Any individual who has experienced an emotionally painful, sudden, and uncontrollable racist encounter is at risk of suffering from a race-based traumatic stress injury. For more information see: https://www.mhanational.org/racial-trauma

Secondary Traumatic Stress is the emotional duress that can develop from exposure to the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder (PTSD). For more information see: https://www.nctsn.org/sites/default/files/resources/fact-sheet/secondary_traumatic_stress_child_serving_professionals.pdf

Complex Trauma: According to the National Child Traumatic Stress Network (NCTSN), a person with complex trauma has experienced multiple traumatic events in their lives. These events are often severe, pervasive, and interpersonal in nature, such as abuse or neglect by a parent or other trusted adult. Persistent poverty and structural racism can also contribute to complex trauma. Complex trauma can be particularly disruptive to a child's development due to its chronic nature, its impact on multiple domains of functioning, and the extent to which trusted caregivers can be involved in ongoing exposure. For more information, see: https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma

Developmental Trauma Disorder (DTD) is synonymous with complex trauma and is a clinical diagnosis with qualifying symptoms that are more child-specific than those included in a PTSD diagnosis. As the American Psychological Association argues, "DTD covers adversity not described by PTSD, and it also accounts for the disruptions in development that result from sustained trauma during childhood, which typically occurs in the context of relationships." For more information, see: https://www.apa.org/monitor/2021/07/ce-corner-developmental-trauma

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Senator Adam Gomez^	Senate (Senate President Appointee)
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The Childhood Trauma Task Force is a Committee of the Juvenile Justice Policy and Data Board.

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EXECUTIVE SUMMARY

Childhood trauma is widespread: more than two thirds of children report experiencing a traumatic event by age 16.[1] Research shows that experiencing a traumatic event or set of circumstances can have lasting consequences on children's emotional, physical, and cognitive functioning.[2] **Identifying** and **supporting** children who experience trauma[3] can therefore help them thrive in their homes, schools, and communities as well as ensure the systems established to support them can do so effectively.

Because of the pervasiveness of trauma throughout childhood, every organization that works with children necessarily works with children who have experienced trauma. To better support these children, it is vital for organizations to set up trauma-informed and responsive (TIR) practices and policies—many of which are detailed in the CTTF's *Framework for Trauma-Informed and Responsive Organizations* (2020).[4] **Identifying children impacted by trauma is a core component of TIR care,** and organizations that do so are better positioned to understand and respond to some of the root causes of behavioral, developmental, or physical health concerns families and professionals have about the children in their care.

The goal of this report is threefold:

1. Provide guidance for child-serving organizations on which trauma identification practice(s) they should adopt under various circumstances
2. Provide recommendations on steps child-serving organizations should take during implementation to maximize the benefits while mitigating any potential harms of the selected identification method
3. Recommend ways the state can support child-serving organizations in implementing their chosen trauma identification method as part of broader trauma-responsive practices

Report Background

The following report is the result of two years of research and Task Force discussions about trauma identification and referral practices in child-serving organizations across sectors. It follows the CTTF's 2021 *Interim Report on Trauma Screening and Referral Practices*, which highlighted many successful ways organizations use trauma screening tools to identify children who might have experienced a traumatic event but also demonstrated that screening was not always the most suitable trauma identification method.[5] While trauma screening has come to the forefront of public

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[1] Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents. (2008). Children and Trauma: Update for Mental Health Professionals. American Psychology Association. https://www.apa.org/pi/families/resources/children-trauma-update

[2] For more information on the short- and long-term impacts of experiencing trauma, see the CTTF's 2019 report *Next Steps for Addressing Childhood Trauma: Becoming a Trauma-Informed and Responsive Commonwealth*.

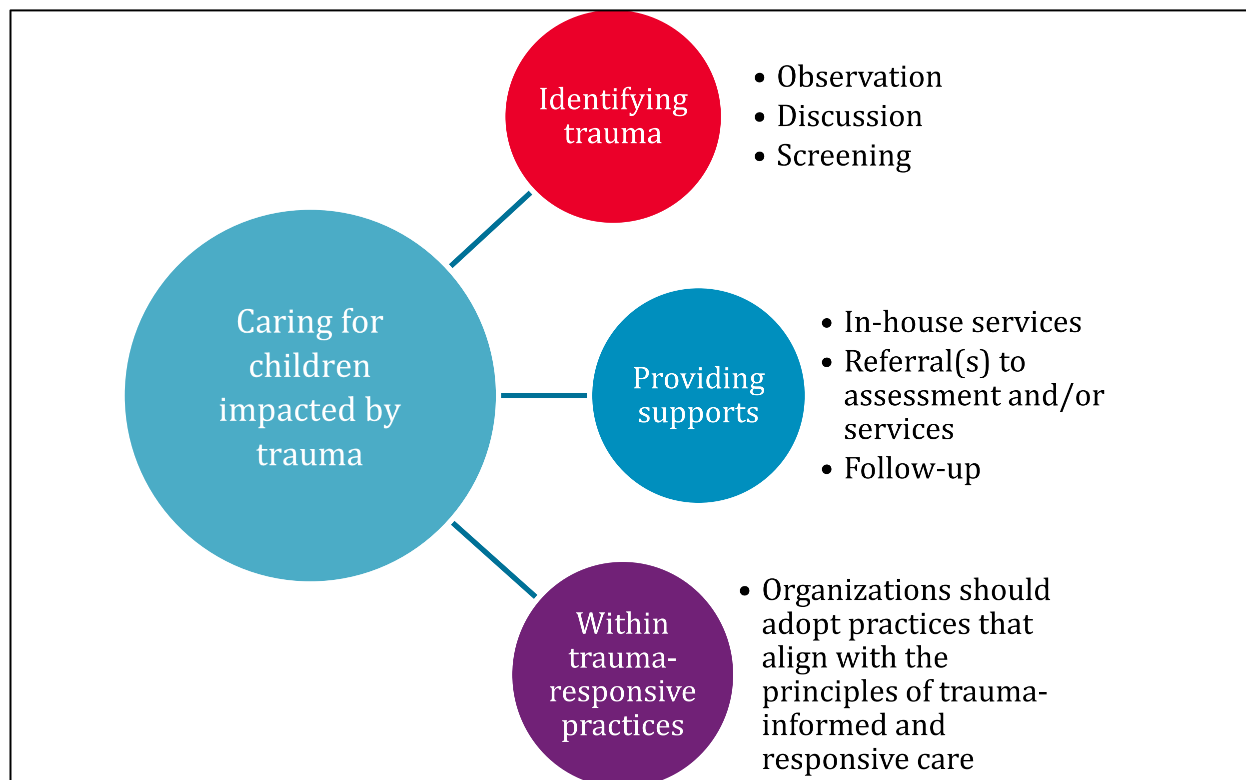
[3] Trauma "results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being." SAMHSA. (2014). *SAMHSA's Concept of trauma and guidance for a trauma-informed approach*. Department of Health and Human Services. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf

[4] Childhood Trauma Task Force. (2020, October). Framework for trauma-informed and responsive organizations. Mass.gov. https://www.mass.gov/doc/framework-for-trauma-informed-and-responsive-organizations-0/download

[5] Childhood Trauma Task Force. (2021, December). Identifying childhood trauma: An interim report on trauma screening and referral practices. Mass.gov. https://www.mass.gov/doc/cttf-2021-report-identifying-childhood-trauma-an-interim-report-on-trauma-screening-and-referral-practices/download

policy debates throughout the United States, it is not, by any means, the only effective way to identify children at risk of experiencing toxic stress after a traumatic event.

As the graphic below demonstrates and this report describes at length, **there are multiple ways professionals can identify children who might be impacted by traumatic experiences**, namely observation, conversation, and screening. As this report details, which trauma identification method organizations should choose depends on their function, their capacity, and, importantly, the needs and characteristics of the children they serve.



A holistic approach to supporting children impacted by trauma

Report Outline

Part 1 of this report lays out recommendations for child-serving organizations to help increase their capacity to identify children impacted by trauma, as well as recommendations for how the Commonwealth can support organizations in these efforts, namely:

1. **Identifying trauma should be part of a broader, holistic approach to meeting children's behavioral health needs**. It would not make sense for organizations to identify children's trauma without paying attention to other behavioral health concerns. The CTTF thus recommends organizations focus on establishing a means to identify and support children with behavioral health needs more generally *before* implementing processes to identify children who might be impacted by trauma.

2. **Organizations developing and implementing a trauma identification and referral process should do so in a trauma-informed and responsive way.** The CTTF recommends that, regardless of the identification approach selected, organizations

promote a sense of safety and trust, empower children and families, promote equity and address potential sources of bias at every step of these processes, and be supportive and respectful. Organizations should implement these TIR principles in all domains of an organization. In particular, organizations should ensure leadership and staff buy-in, train staff, establish strong referral and follow-up processes, and develop feedback loops.

3. **To help ensure high quality implementation, the state should support organizations who are implementing trauma identification practices**. The state-funded Center on Child Wellbeing & Trauma (CCWT) is already delivering no-cost information, tools, and training to help child-serving organizations become trauma-informed and responsive.[6] The CCWT is therefore particularly well-equipped to help organizations implement trauma identification and referral practices. The CTTF thus recommends the state continue to support the CCWT to allow the Center to expand the work it is already doing as well as to provide:
    - Training and technical assistance to help organizations seeking to implement a trauma identification and referral process to plan, develop, and operationalize the above-mentioned requirements for successful implementation
    - Resources on trauma identification and referral, including guidance on how to choose which identification method best fits the needs and capacity of an organization as well as information on particular steps of trauma identification implementation processes.
4. **The state should increase the availability of services and supports needed to recover from trauma.** Organizations who identify youth who might be impacted by trauma should refer them to professionals providing services that will support them in their healing journey. Unfortunately, the state continues to face significant workforce shortages and retention problems in the field of behavioral health, leading to long waitlists and other access challenges. In addition to the state's current efforts to address this problem such as the 2022 *Mental Health ABC Act* as well as the Executive Office of Health and Human Services (EOHHS)'s Behavioral Health Redesign, the CTTF recommends the state:
    - Increase training and certification opportunities for clinicians in relevant evidence-based trauma treatment services
    - Increase the capacity of non-clinicians and community members to provide supports for children and families impacted by trauma
    - Increase racial and ethnic diversity in the behavioral health workforce
    - Increase providers' capacity to provide culturally congruent services

This section of the report also includes specific recommendations for organizations seeking to implement a trauma *screening* process that align with TIR guiding principles outlined in Recommendation #2 above.

Part 2 of the report discusses considerations and recommendations for trauma identification practices—including screening—in six child-serving sectors. Within each set of sector-specific

[6] Center on Child Wellbeing and Trauma. (n.d.). Home. https://childwellbeingandtrauma.org/

recommendations, the CTTF also outlines recommendations for how the state can support child-serving professionals and organizations. The sectors include:

- **K-12 settings:** The CTTF recommends schools adopt a trauma identification approach (be it through observation, discussion, or screening). For schools that are interested in screening their students to identify those impacted by trauma, the CTTF recommends they only do so if they already have TIR policies and practices in place, have a tiered system of support and established referral system, and already screen all students for behavioral health concerns.
- **Pediatric primary care:** The CTTF recommends pediatric providers adopt a systematic way of identifying trauma in their patients (either through observation, discussion, or screening) as part of a strength-based, family-centered trauma-informed care delivery. These recommendations are accompanied by recommendations for health insurance systems and the state to support providers' efforts.
- **Early childhood settings**: The CTTF recommends organizations working with young children adopt effective ways of identifying trauma (be it through observation, discussion, or screening) as well as consider effective ways to support caregivers and their relationships with children. The CTTF also recommends these organizations pay particular attention to ways they can support staff working with young children whose trauma-related behaviors might be particularly challenging because of their inability to verbalize and regulate their emotions.
- **Juvenile justice**: The CTTF focuses its recommendations on trauma identification in the juvenile justice system on those points in the process where trauma identification practices can support improved case management and lead to youth being connected directly to support as needed, namely:
    - For diversion programs, the Task Force recommends the use of screening or other trauma identification methods but only under specific circumstances detailed in the full report.
    - For Probation, the CTTF recommends the systematic use of a mental health and trauma screening tool to inform case management.
    - Given the Department of Youth Services' robust current trauma assessment procedures, the CTTF does not have additional recommendations.
- **Child welfare:** The CTTF makes multiple sets of recommendations for different agencies working with children involved in the child welfare system:
    - For the Department of Children and Families, the CTTF recommends strengthening existing practices and policies to identify children impacted by trauma more systematically, in specific ways detailed in the full report.
    - For Family Resource Centers, the Task Force recommends continuing to prioritize trauma identification as part of their behavioral health assessments and conducting selective trauma screening when appropriate.
    - For Juvenile Courts, the CTTF recommends continuing efforts to implement evidence-based practices that identify and respond to families' trauma.

    - For organizations working with families involved in the child welfare system, the Task Force recommends adopting effective ways to identify trauma (be it observation, discussion, or screening).

- **First responder settings**: The Task Force recommends increasing first responders' capacity to identify children who have witnessed or experienced traumatic events (e.g., the overdose of a parent) and connect them with services that can follow up and provide support if needed.

With these recommendations and the 2021 *Interim Report*, the CTTF fulfills the Legislature's charge to determine how the Commonwealth can better identify children who have experienced trauma. Child-serving professionals and organizations are eager to support families impacted by trauma and, with the necessary supports, they can become more trauma-informed and responsive and enhance Massachusetts' ability to help all children and families recover and thrive.

INTRODUCTION

Childhood trauma is widespread. More than two thirds of children report experiencing a traumatic event by age 16.[7] Some children, including Black and Hispanic/Latino children as well as children living in poverty, face more discrimination and other structural barriers, and are therefore significantly more likely to experience trauma, and to experience it more frequently.[8] This disproportionate experience of trauma is an early source of systemic inequity, the impact of which is seen in our educational, health care, judicial, and social service systems.

As detailed in previous CTTF reports, trauma can have wide-ranging impacts on children's well-being. Research shows that experiencing a traumatic event or set of circumstances can have lasting consequences on children's emotional, physical, and cognitive functioning.[9] **Identifying** and **supporting** children who experience trauma can therefore help them thrive in their homes, schools, and communities as well as ensure the systems established to support them can do so effectively.

All child-serving organizations have an opportunity to support children impacted by trauma. As childhood trauma expert Dr. Alicia Liberman notes, "most traumatized young children and families are not found in mental health clinics but are users of pediatric care, child care, the child welfare system, and law enforcement and the courts, as well as family resource programs, domestic violence shelters, and other community-based services."[10] Because of the prevalence of childhood trauma, **every organization that works with children necessarily works with children who have experienced trauma**. To ensure children are not traumatized or retraumatized as a result of interacting with those systems, it is critical for these organizations to be trauma-informed and responsive.

Organizations that are able to identify children impacted by trauma are better positioned to support them and their families. Indeed, identifying children who might be impacted by trauma and need support is the first step toward acknowledging and understanding some of the root causes of behavioral, developmental, or physical health concerns families and professionals have about the children in their care. If unrecognized or unaddressed, trauma can lead to fraught relationships with family and peers, disruptions to academic achievements, poor engagement in services, and involvement with the juvenile justice system.[11]

As the graphic below demonstrates and this report describes at length, **there are multiple ways professionals can identify children who might be impacted by traumatic experiences**. Child-

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[7] Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents. (2008). Children and Trauma: Update for Mental Health Professionals. American Psychology Association. https://www.apa.org/pi/families/resources/children-trauma-update

[8] Sacks, V. & Murphey, D. (2018). The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity. Child Trends. https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity.

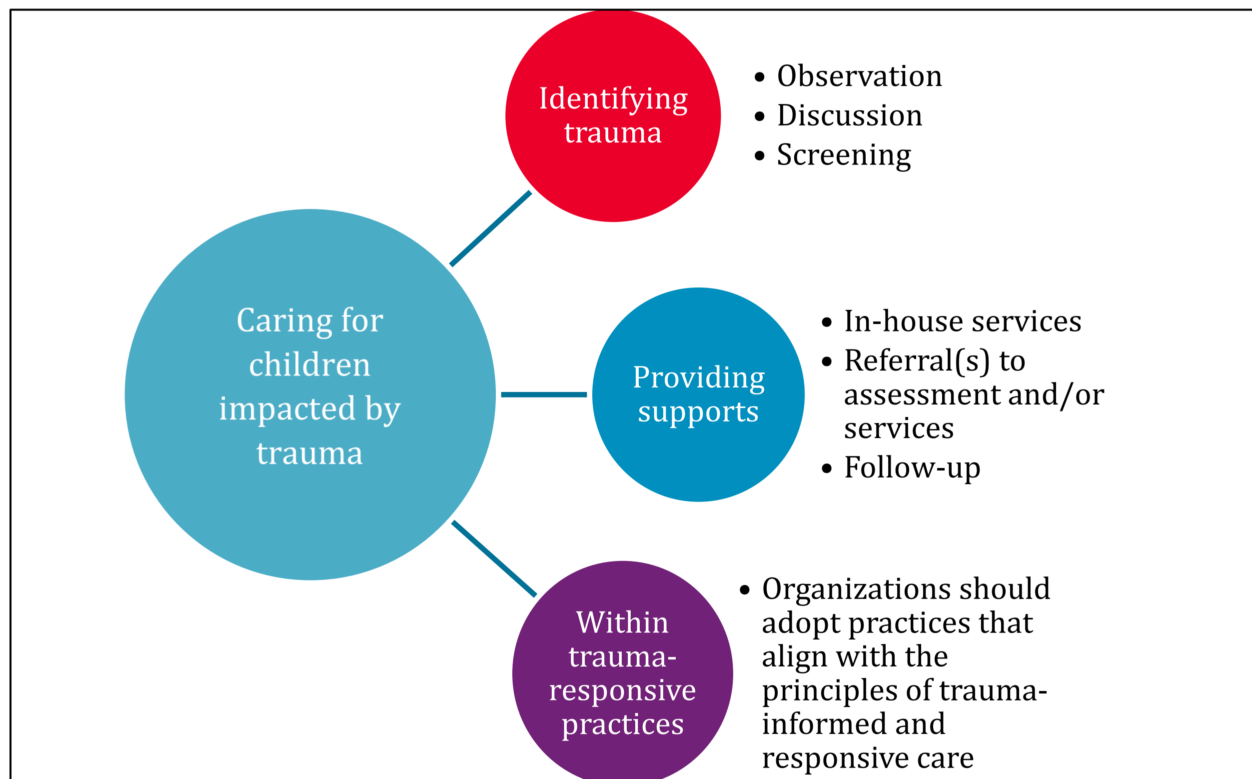
[9] For more information on the short- and long-term impacts of experiencing trauma, see the CTTF's 2019 report *Next Steps for Addressing Childhood Trauma: Becoming a Trauma-Informed and Responsive Commonwealth*.

[10] Liberman, A., Chu, A., Van Horn, P. & Harris, W. Trauma in early childhood: Empirical evidence and clinical implications. *Development and Psychopathology,* 23, 397-410. https://web.archive.org/web/20190219080955id_/http://pdfs.semanticscholar.org/180c/ca5dd06660eebaf807edfa5760d9ab751958.pdf.

[11] SAMHSA. (2014). Screening and Assessment. In *Trauma-informed care in behavioral health services.* Center for Substance Abuse Treatment. https://www.ncbi.nlm.nih.gov/books/NBK207188/ ; Cole, S., O'Brien, J., Gadd, M. G.,

serving professionals can look out for signs of potential trauma, such as PTSD symptoms or an abrupt change in a child's behavior or functioning. They can also identify children who might need trauma-related supports through conversation with the child or their caregiver(s). Finally, child-serving professionals can screen for trauma, that is, use a standardized questionnaire to determine if children have lived through potentially traumatic events and/or if they experience potentially trauma-related symptoms.

All of these techniques can help professionals who work with children determine when a referral to a trained clinician for a more comprehensive assessment is necessary. They can also help professionals better understand when a child and/or their family may need additional supports to help them thrive. *Which* trauma identification method is right for a given sector or organization depends on a variety of factors detailed in this report.



A holistic approach to supporting children impacted by trauma

In recent years, trauma screening in particular has come to the forefront of public policy conversations throughout the United States. For many reasons detailed in this report, providers, researchers, and policy makers in various sectors have turned to screening as a structured way to determine which children are at risk of being negatively impacted by trauma and to help operationalize trauma-informed and responsive practices. Child-serving organizations in a variety of sectors across the country have implemented screening practices to assess risk of toxic stress and/or establish a history of potentially traumatic events.

Ristuccia, J., Wallace, D. L., Gregory, M. (2005). *Helping traumatized children learn: Supportive school environments for children traumatized by family violence.* Massachusetts Advocate for Children. https://traumasensitiveschools.org/wp-content/uploads/2013/06/Helping-Traumatized-Children-Learn.pdf

At the same time, trauma screening has come under scrutiny in many child-serving sectors, especially when the practice is not done in a trauma-responsive way and is not followed up with actual supports. Some child-serving professionals argue that trauma screening, if not properly done, can actually cause harm and/or that children should not be systematically screened for trauma until there are enough services to refer them to.

Regardless of the trauma identification practices organizations adopt, these practices should not be implemented without referral to needed services. One of the most important conclusions the CTTF has drawn from its two-year study of trauma identification is that **implementing practices to identify trauma without also implementing practices to provide supports where needed is unethical and can be harmful**. Efforts organizations and the state make towards increasing trauma identification should therefore *always* be paired with efforts to develop more trauma-informed and responsive organizational practices and increase the availability of services.

History of the CTTF

The Childhood Trauma Task Force (CTTF) was established by *An Act Relative to Criminal Justice Reform* (2018). The CTTF was tasked with determining **how the Commonwealth can better identify and provide services to youth who have experienced trauma,** with a particular emphasis on youth who are currently involved with the juvenile justice system or at risk of future juvenile justice system involvement.

In its first three years, the CTTF focused on understanding the landscape of trauma-focused work in the Commonwealth, designing a *Framework for Trauma-Informed and Responsive Organizations* (2020) to provide clear guidance on what child-serving organizations should do to become more trauma-informed and responsive (TIR) and developing recommendations for how the state could better support child-serving professionals and organizations in doing so. One of these recommendations was that the state create and fund a Center on Child Wellbeing and Trauma (CCWT) to help organizations become TIR.

The CTTF's recommendation became reality in October 2021, when the CCWT, a partnership between the Office of the Child Advocate and the UMass Chan Medical School, was launched with funding included in the annual state budget. The CCWT supports child-serving organizations and systems in becoming trauma-informed and responsive through training, technical assistance, professional learning opportunities, and other practice advancement support, including:

- Organizational assessments to help identify areas of strength and areas for further work
- Targeted technical assistance/coaching support based on identified areas of need
- Training opportunities, including sessions on trauma, vicarious trauma, racial trauma, LGBTQ+ issues, protective and preventative childhood experiences and/or self-care
- Opportunities to participate in professional learning communities
- A resource website and online training opportunities

About this Report

Because of the growing interest in both Massachusetts and the U.S. in screening as a means to systematically identify children who might be impacted by trauma, in 2021 the CTTF began examining trauma screening practices across the nation. This research led to our *Interim Report on*

Trauma Screening and Referral Practices, which does not include any recommendations.[12] Our findings highlight many successful ways organizations use trauma screening tools to identify children who might have experienced a traumatic event, but also demonstrate that screening is not always the most suitable trauma identification method.

The recommendations in this 2022 report reflect the reality that, **when it comes to identifying children impacted by trauma, there is no "one size fits all" approach.** While the CTTF believes that screening children for trauma can be beneficial to children and families *under specific conditions, in specific contexts,* it is not the best approach in other circumstances. Regardless, child-serving professionals and organizations can and should *identify* potential trauma, which can happen in a variety of ways. Indeed, the federal Substance and Mental Health Services Association (SAMHSA) considers recognizing the signs and symptoms of trauma as one of four central pillars of trauma-informed care.[13]

The goal of this report is threefold:

1. Provide guidance for child-serving organizations on which trauma identification practice(s) they should adopt under various circumstances
2. Provide recommendations on steps child-serving organizations should take during implementation to maximize the benefits while mitigating any potential harms of the selected identification method
3. Recommend ways the state can support child-serving organizations in implementing their chosen trauma identification method as part of broader trauma-responsive practices

To do so, this report provides both general and sector-specific recommendations for child-serving organizations regarding the implementation of trauma identification practices:

1. **General Recommendations:** In this first section, the CTTF lays out recommendations for child-serving organizations to help increase their capacity to identify children impacted by trauma, as well as recommendations for how the Commonwealth can support organizations in these efforts. This section also includes specific recommendations for organizations seeking to implement a trauma screening process.
2. **Sector-Specific Recommendations:** Next, the report discusses considerations and recommendations for trauma identification practices—including screening—in six child-serving sectors, starting with sectors that reach a wider, near universal group of children where the prevalence of trauma tends, on average, to be lower (K-12 and pediatric primary care) and then moving to sectors where the set of children reached is narrower and/or where those children are at increased risk of being impacted by trauma (early childhood, child welfare, juvenile justice, first responder settings).

[12] Childhood Trauma Task Force. (2021, December). Identifying childhood trauma: An interim report on trauma screening and referral practices. Mass.gov. https://www.mass.gov/doc/cttf-2021-report-identifying-childhood-trauma-an-interim-report-on-trauma-screening-and-referral-practices/download

[13] Menscher, C. and Maul, A. (2016, April). *Issue brief: Key ingredients for successful trauma-informed care implementation*. Center for Health Care Strategies. https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/

The CTTF's 2021 *Interim Report on Trauma Screening and Referral Practices* laid the groundwork for this current report.[14] The *Interim Report* provides general background on trauma screening and screening processes and details important topics to consider when thinking of implementing screening procedures. These include caregiver consent, the impact of culture, identity, and prior experiences of oppression, as well as the need to integrate a strength-based approach when screening children for trauma. The *Interim Report* also describes trauma screening best practices and considerations in specific child-serving sectors, including K-12, pediatric health, child welfare, juvenile justice, and first responder settings.

While the current report summarizes key findings from the *Interim Report* to contextualize its recommendations, it does not repeat all the information, and readers are advised to refer to the *Interim Report* for more details.

[14] Childhood Trauma Task Force. (2021, December). Identifying childhood trauma: An interim report on trauma screening and referral practices. Mass.gov. https://www.mass.gov/doc/cttf-2021-report-identifying-childhood-trauma-an-interim-report-on-trauma-screening-and-referral-practices/download

Part 1: General Recommendations on Trauma Identification and Referral Practices

GENERAL RECOMMENDATIONS TO CHILD-SERVING ORGANIZATIONS ON TRAUMA IDENTIFICATION AND REFERRAL

As noted above, SAMHSA considers recognizing the signs and symptoms of trauma as one of four central pillars of trauma-informed care.[15] Identifying trauma can benefit the child, their family, and the adults that work with them. The many benefits include:

- **Understanding some of the underlying causes of children's mental and behavioral health concerns:** Children who live through trauma can experience severe mood and behavioral issues that impact their wellbeing and their functioning at home, in school, and in their communities. Being able to identify trauma helps adults who care for them shift away from asking *What's wrong with you?* to *What happened to you?*[16]
- **Mitigating the lifelong impacts of childhood trauma:** Research shows that childhood trauma is significantly related to chronic depression and suicidality in adolescence and adulthood and also increases the risk of substance misuse and involvement with the legal system.[17] When organizations are able to identify children impacted by trauma, it allows them to then take the necessary steps to support them and help them heal.
- **Improving children and adults' engagement in services:** Individuals who have been traumatized can feel a reduced sense of safety and trust, which can lead to a lack of engagement with organizations and systems, including resistance to treatment in clinical settings.[18] Studies are increasingly showing that trauma-informed and responsive practices,

[15] SAMHSA. (2014). *SAMHSA's Concept of trauma and guidance for a trauma-informed approach*. Department of Health and Human Services. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf.

[16] Menscher, C. and Maul, A. (2016, April). *Issue brief: Key ingredients for successful trauma-informed care implementation*. Center for Health Care Strategies. https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/

[17] Negele, A., Kaufhold, J., Kallenbach, L. and Leuzinger-Bohleber, M. (2015). Childhood trauma and its relation to chronic depression in adulthood. *Depression Research and Treatment,* 25, https://doi.org/10.1155/2015/650804 ; Wagner, K. D. (2016, November). Effects of childhood trauma on depression and suicidality in adulthood. *Psychiatric Times*, 33(11). https://www.psychiatrictimes.com/view/effects-childhood-trauma-depression-and-suicidality-adulthood ; Rogers, C., Forster, M., Grigsby, T., Albers, L. Morales, C., Unger, J., (2021, October). The impact of childhood trauma on substance use trajectories from adolescence to adulthood: Findings from a longitudinal Hispanic cohort study. *Child Abuse & Neglect*, 120, Article 105200. https://doi.org/10.1016/j.chiabu.2021.105200 ; Honorato, B., Caltabiano, N. & Clough, A. (2016, April). From trauma to incarceration: exploring the trajectory in a qualitative study in male prison inmates from north Queensland, Australia. *Health & Justice*, 4, Article 3. https://doi.org/10.1186/s40352-016-0034-x

[18] Menscher, C. and Maul, A. (2016, April). *Issue brief: Key ingredients for successful trauma-informed care implementation*. Center for Health Care Strategies. https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/ ; Jaworska-Andryszewska, P., & Rybakowski, J. K. (2019). Childhood trauma in mood disorders: Neurobiological mechanisms and implications for treatment. *Pharmacological Reports*, *71*(1), 112–120. https://doi.org/10.1016/j.pharep.2018.10.004 ; https://pubmed.ncbi.nlm.nih.gov/30544098/ ; Wrobel A., Russell S. E., Dean O. M., Cotton S., Berk M., Turner A. (2021). Influence of childhood trauma on the treatment outcomes of pharmacological and/or psychological interventions for adolescents and adults with bipolar disorder: Protocol for a systematic review and meta-analysis. BMJ Open, *11*(4), Article 044569. https://bmjopen.bmj.com/content/11/4/e044569.

from primary care to educational settings, can help improve engagement.[19]

- **Preventing trauma-related staff burnout and turnover:** Professionals working with children who have experienced trauma are at increased risk of experiencing secondary traumatic stress, which in turn can lead to work dissatisfaction, burnout, and high organizational turnover.[20]

As noted in the introduction, there are multiple approaches to trauma identification:

- **Observation** of signs and symptoms of trauma, such as changes in behavior or mood as well as significant changes in child's functioning (e.g., sharp decrease in grades or disengagement from hobbies and preferred activities). This approach has the benefit of being less resource-intensive than screening and applicable to *all* child-serving sectors. At the same time, some argue that this approach can leave room for bias and is less systematic than screening, creating the opportunity to under- or overidentify specific groups of youth based on their symptoms, age, race, ethnicity, sexual orientation or gender identity. This is particularly the case if the "observer" has limited experience with behavioral health issues and/or has not received sufficient training in how to recognize a wide range of signs and symptoms of trauma.
- **Conversation** with child and/or caregiver, as trained professionals can either directly ask questions related to a known potentially traumatic event or enquire about the causes of a child's changed behavior or functioning. Additionally, organizations can provide opportunities for children and families to talk about trauma and destigmatize the topic by providing general education on the prevalence and impact of trauma. The benefits and drawbacks are similar to those for observation: more opportunity to under- or over-identify children depending on their symptoms, familial background, race/ethnicity, gender, sexual orientation, or disabilities.
- **Screening**, which, as detailed later in this report, generally implies the use of a short, standardized questionnaire to establish a history of potentially traumatic events and/or reactions to a traumatic experience. There are two approaches to screening:
    - Universal screening, where all children and/or their caregivers in a given setting are administered a screener. This approach requires a lot of resources (e.g., time, funding, staff, training and technical assistance), but provides a systematic and, some argue, more equitable approach to trauma identification. Indeed, administering a screener to *all* children in a given setting means that professionals receive information regarding potentially traumatic experiences and reactions to

[19] Chaudhri, S., Zweig, K.C., Hebbar, P., Angel, S. & Vasan, A. (2019). Trauma-informed care: A strategy to improve primary healthcare engagement for persons with criminal justice system involvement. *Journal J GEN INTERN MED* **34**, 1048–1052 (2019). https://doi.org/10.1007/s11606-018-4783-1 ; Brunzell, T., Witter, M., & Abbott, L. (2020, December). Toward meaningful engagement: Trauma-informed positive education strategies for struggling students. *Adolescent Success, 20*(1). https://www.berrystreet.org.au/uploads/main/Files/Research-Articles/Adolescent-Success-Dec-Volume-20-1-BSEM-final.pdf ; Jumarali, S., Nnazulezi, N., Royson, S., Lippy, C., Rivera, A., Toopet, T. (2021). Participatory research engagement of vulnerable populations: Employing survivor-centered, trauma-informed approaches. *Journal of Participatory Research Methods, 2*(2). https://doi.org/10.35844/001c.24414.

[20] Bride, B. (2004). The impact of providing psychosocial services to traumatized populations. *Stress, Trauma, and Crisis, 7*(1), 29–46. https://doi.org/10.1080/15434610490281101.

the latter regardless of a child's symptoms, race, ethnicity, gender, sexual orientation, gender identity, familial background, and/or disabilities.

- Selective screening, where only children and/or their caregivers who meet certain pre-established criteria are administered a trauma screener. This approach also requires more resources than observation and conversation, though fewer than universal screening does. Some argue that selective screening could be biased by under-identifying children with internalizing behaviors (e.g., anxiety) or over-identifying those with externalizing behaviors (e.g., aggression). Without rigorous training and guidelines, the criteria for selective screening could also target children based on race, ethnicity, gender, sexual orientation, gender identity, familial background, and/or disabilities.

Given the variety of ways organizations can identify children who have experienced trauma, the CTTF developed the following recommendations for child-serving professionals and organizations to increase their capacity to identify trauma and to ensure that any trauma identification practices are implemented in a way that maximizes any benefits and minimizes the potential for harm, particularly for our most vulnerable children and families:

1) **Identifying Trauma Should Be Part of a Broader, Holistic Approach to Meeting Children's Behavioral Health Needs**
2) **Organizations Developing and Implementing a Trauma Identification and Referral Process Should Do So in a Trauma-Informed and Responsive Way**

This section also lays out general, cross-sector recommendations for the state to support high quality trauma identification and referral practices:

3) **To Help Ensure High Quality Implementation, the State Should Support Organizations Who Are Implementing Trauma Identification Practices**
4) **The State Should Increase the Availability of Services and Supports Needed to Recover from Trauma**

General Recommendation #1: Identifying Trauma Should Be Part of a Broader, Holistic Approach to Meeting Children's Behavioral Health Needs

Trauma is one of many potential root causes of behavioral health issues a child may experience, and sometimes behavioral health issues can have multiple, overlapping, and/or intertwined root causes. Further, the trauma a child may have experienced is not their "whole story" – each child has unique circumstances, strengths, resources, and challenges, and each may react to potentially traumatic experiences in different ways.

The CTTF was specifically tasked with focusing on trauma identification, and that is primarily what we have done in this report. We recognize, however, that identifying trauma and providing trauma-related supports should not be done in isolation. Instead, **the CTTF believes trauma identification should be done as *part of* a broader, holistic approach to meeting children's behavioral health needs** and creating environments where they can thrive. In some situations, the child-serving sector or organization is already generally well set up to identify and support behavioral health issues more generally. In these cases, the CTTF's recommendations regarding trauma identification are meant to enhance existing efforts to identify and support children with behavioral health issues.

On the other hand, some organizations do not have an existing structure to identify children with behavioral health issues and provide the necessary services (e.g., referrals, assessment, treatment). In those situations, **the CTTF recommends organizations focus on establishing means to identify and support children with behavioral health needs more generally *before* implementing processes to identify children who might be impacted by trauma.**[21]

General Recommendation #2: Organizations Developing and Implementing a Trauma Identification and Referral Process Should Do So in a Trauma-Informed and Responsive Way

In the same way the CTTF believes it would not make sense to implement trauma identification practices without paying attention to children's overall behavioral health needs first and foremost, **the CTTF believes organizations implementing a trauma identification and referral process should do so within broader trauma-informed and responsive practices**.

The CTTF's *Framework for Trauma-Informed and Responsive Organizations* lays out guiding principles for trauma-informed and responsive (TIR) practices.[22] The CTTF highly encourages organizations working with children and families to read this *Framework*.

When applied to trauma identification specifically, the CTTF recommends that, regardless of the approach selected, organizations:

- **Promote a sense of safety and trust** by engaging in open, clear, and collaborative conversations with the child and/or their caregiver(s) regarding the purpose as well as the benefits and/or potential drawbacks of the organization's chosen trauma identification approach.
- **Empower children and families** by using a strength-based approach. Being trauma-informed and responsive (TIR) does not necessarily mean organizations should focus solely on a child and their family's possible traumatic experiences. In fact, the "responsive" part of being TIR highlights organizations' need to focus on the child and family's positive experiences, existing support systems, and healthy strategies they have adopted to help them cope with traumatic experiences. Organizations adopting any trauma identification approach can, for example, incorporate questions on Positive Childhood Experiences (PCEs) in the screening process or during a conversation about trauma. The Healthy Outcomes from Positive Experiences (HOPE) team at Tufts Medical Center have developed a resource listing four ways to assess PCEs.[23]
- **Promote equity and address potential sources of bias** at every step of the trauma identification and referral processes, from planning to implementation. Concretely, this means that organizations should ask themselves if and how the adopted method enables professionals to identify both internalizing (e.g., anxiety) and externalizing (e.g., aggression)

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[21] The exception to this General Recommendation is for CTTF's recommendations for first responders (e.g., police officers, firefighters, EMTs). While first responders are typically not in a position to focus on childrens' behavioral health more holistically, they are well placed to identify when a child has experienced a potentially traumatic event and connect that child and family to behavioral health professionals.

[22] Childhood Trauma Task Force. (2020, October). Framework for trauma-informed and responsive organizations. Mass.gov. https://www.mass.gov/doc/framework-for-trauma-informed-and-responsive-organizations-0/download

[23] Healthy Outcomes from Positive Experiences. (n.d.). Four ways to assess positive childhood experiences. Positiveexperience.org. https://positiveexperience.org/wp-content/uploads/2021/11/Four-Ways-to-Access-Positive-Childhood-Experiences.pdf

behaviors. Additionally, organizations should assess if the necessary training, policies, and guidelines are in place to avoid over- or under-identifying certain groups of children based on their gender identity, race/ethnicity, family background, sexual orientation, or disabilities, for instance. Promoting equity and addressing bias also requires organizations to acknowledge the cultural diversity of the children they serve and how trauma can present itself and be experienced differently depending on the child's familial or cultural background.

- **Be supportive and respectful** throughout the identification and referral processes by validating children's positive and adverse experiences, consistently signaling opportunities for children and caregivers to have control over the process (e.g., to pause or stop the process), and destigmatizing trauma and its impact on people.

Operationalizing trauma identification and referral processes in a TIR way also requires efforts in multiple domains of an organization. The CTTF recommends organizations:

- **Ensure leadership and staff buy-in**: Research conducted for our 2021 *Interim Report* made clear that professionals at *all* levels of the organization must understand the benefits of identifying trauma and the purpose of adopting a specific trauma identification approach. Similarly, leadership and staff must understand how any trauma-related information should be used as well as actively support the implementation process of the selected trauma identification approach.[24]
- **Train staff:** In addition to understanding how and why to identify trauma, child-serving professionals must understand how trauma can manifest differently in individuals as well as how it can affect multiple domains of a child's life. Staff must also receive training on how to discuss trauma with the child and their caregiver and how to refer the child for further assessment and/or services and follow up with the family. Training should incorporate a discussion of existing policies and procedures to ensure the safety of children, including any relevant mandated reporter requirements.
- **Establish a strong referral and follow-up process**: Identifying trauma without following up with the necessary supports can be harmful to the child and their family. Our *Interim Report* details what an effective referral process requires:
    - A mechanism for connecting the child with immediate help—preferably a warm handoff
    - Smooth connections to a more detailed assessment process (if necessary) and/or necessary supports
    - Established relationships with providers that can offer services in a timely manner. When possible, these services should speak directly to activities or topics they enjoy engaging in. For instance, if a child expresses a passion for drawing, art-based therapy or a community-based art program might help them recover from trauma
    - A system for following-up with the youth and their caregivers

[24] For examples of how buy-in was intrinsic to the successful implementation of trauma screening within an organization, see *Interim Report*, pp. 33 and 53.

- **Develop a feedback loop:** While organizations must set up measures to protect the confidentiality of the information children and their families provide, it is also necessary for them to collect and analyze data to help inform the efficacy of on-going implementation of the chosen trauma identification approach and highlight ways to improve the system in place. Data collection and analysis helps organizations better understand the prevalence of trauma and specific traumatic events and inform the organizations' service needs, policies, and partnerships with community organizations. Additionally, organizations should engage with children and families to better understand if their current process is actually achieving its goal of supporting those who have experienced trauma. Finally, data collection and analysis can be used to monitor possible discriminatory or biased practices.

General Recommendation #3: To Help Ensure High Quality Implementation, the State Should Support Organizations Who Are Implementing Trauma Identification Practices

The CTTF recognizes that not all organizations have the time, knowledge, and staffing resources in place to engage in the above-mentioned considerations. As discussed in the introduction, the state-funded Center on Child Wellbeing & Trauma (CCWT) is already delivering no-cost information, tools, and training to help child-serving organizations become trauma-informed and responsive. The CCWT is therefore particularly well-equipped to help organizations implement trauma identification and referral practices. The CTTF thus recommends the state continue to support the CCWT to allow the Center to expand the work it is already doing as well as to provide:

1. **Training and Technical Assistance** (TTA) to help organizations seeking to implement a trauma identification and referral process to plan, develop, and operationalize the above-mentioned requirements for successful implementation. This TTA should include:
    - "Trauma Identification Overview" training for staff at all levels of an organization discussing the benefits and drawbacks of various trauma identification methods as well as how to integrate a healing-centered approach throughout the process.
    - Sector-specific training for staff directly involved in the chosen identification process. The training should include structured support on how to effectively engage youth, families, and communities using a strength-based approach as well as tools to help organizations think through the culturally specific needs of the communities they serve.
    - Technical assistance to help organizations develop a system to collect and regularly analyze aggregate data they have at their disposal to understand the prevalence and types of trauma, which could in turn inform policy and programmatic decisions.
    - Guidance on how to build a TIR referral system, which would include recommendations on how to provide a warm handoff, map resources and create a culturally diverse directory, routinely engage community providers for sustained collaboration, and develop Memorandums of Understanding (MOUs).
2. **Resources on trauma identification and referral**, which should include:
    - Guidance for child-serving organizations from various sectors on how to choose a trauma identification approach that best fits the population of children they serve, their function, and their organizational capacity.
    - Sample language that organizations can adapt, providing information on trauma and

how it can affect children in multiple life domains, the benefits and potential drawbacks of identifying trauma, matters of confidentiality, and who to contact within the organization for more information. This should be available in multiple languages.

General Recommendation #4: The State Should Increase the Availability of Services and Supports Needed to Recover from Trauma

Implementing practices to increase identification of trauma without also setting up mechanisms to offer concrete supports is ineffective and unethical. Organizations who identify youth who might be impacted by trauma should refer them and their caregivers to professionals providing services that will support them in their healing journey. Such services can range from trauma-focused clinical assessments and interventions to community-based programs and services to meet families' behavioral health and/or basic needs.

Unfortunately, it is often difficult for youth and their families to access needed supports, particularly clinical behavioral health supports, as **the state is facing significant workforce shortages and retention problems in the field of behavioral health**.[25] The CTTF applauds recent state efforts to increase behavioral health supports and reform the way behavioral health care is delivered in the state. In particular, the CTTF would like to highlight:

- The 2022 *Mental Health ABC Act: Addressing Barriers to Care (ABC)*, which, among many important provisions, includes:
  - Changes in law to better advance mental health insurance coverage parity with physical health coverage, which, it is hoped, will expand the number of providers providing mental health services.
  - Increased focus on, and resources to support, student's behavioral health in schools, including the creation of a Technical Assistance Center for School Based Behavioral Health at UMass.
  - The creation of an online portal with real-time data on Emergency Department boarding and bed availability to facilitate bed searches.
  - Increased access to Emergency Service Programs that provide behavioral health crisis assessment, intervention, and stabilization.
- Ongoing efforts under the Executive Office of Health and Human Services "Behavioral Health Redesign"[26] to dramatically increase the availability and accessibility of high quality behavioral health services.

To ensure children and families throughout the Commonwealth can receive trauma-focused supports, the CTTF recommends the state:

- Increase training and certification opportunities for clinicians in relevant evidence-based trauma treatment services, such as Attachment, Regulation and Competency (ARC),

[25] Raths, D. (2022, February). Survey highlights behavioral health workforce gaps in Massachusetts. Healthcare Innovation. https://www.hcinnovationgroup.com/population-health-management/behavioral-health/news/21257093/survey-highlights-behavioral-health-workforce-gaps-in-massachusetts

[26] Executive Office of Health and Human Services. (n.d.). Roadmap for Behavioral Health Reform. Mass.gov. https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Child-Parent Psychotherapy (CPP)

- Increase the capacity of non-clinicians and community members to provide supports for children and families impacted by trauma. This could be done, for instance, by funding trauma-focused initiatives, especially in communities that have a dearth of behavioral health services, high rates of poverty, and/or high rates of community violence.
- Increase racial and ethnic diversity in the behavioral health workforce to be able to offer more culturally congruent services. This could be done, for example, by incentivizing the development of dual-language degree and accreditation programs in the behavioral health field.[27]
- Increase providers' capacity to provide culturally sensitive services by helping staff develop and acquire the skills needed to identify and assist patients from diverse cultures as well as by establishing policies that support culturally sensitive, trauma-responsive care.

In doing all of the above, the CTTF recommends the Commonwealth **prioritize services for communities where there is a greater risk of experiencing trauma**, such as in areas where families face economic hardships and higher rates of community violence. The state should also prioritize areas of the state that lack appropriate behavioral health services as well as supports associated with social determinants of health.

[27] See for example: School of Social Work (n.d.). Maestría Bilingüe en Trabajo Social en Línea. Loyola University Chicago. https://www.luc.edu/socialwork/academics/graduate/maestriabilingueentrabajosocialenlinea/ ; School of Social Work. (n.d.). Post-Master's bilingual school social work certificate program. Adelphi University New York. https://www.adelphi.edu/program/graduate/bilingual-school-social-work/

RECOMMENDATIONS FOR EFFECTIVE, EQUITABLE, HEALING-CENTERED TRAUMA SCREENING IMPLEMENTATION

As described in the Introduction and throughout this report, there has been increased interest, both nationally and in Massachusetts, among professionals and organizations across child-serving sectors in using screening tools to identify children who might be impacted by trauma. While in the second part of this report, the sector-specific recommendations discuss trauma *identification* more broadly and at times include recommendations for trauma *screening* specifically, the CTTF is mindful that organizations are interested in or already in the process of screening children for trauma. This section therefore addresses general recommendations on how to implement effective, equitable, and healing-centered trauma screening and referral practices. For guidance on how to select a trauma screening tool, refer to Appendix B.

What is Trauma Screening?

Trauma screening is a formal, structured way to assess possible impacts of trauma and/or risk of toxic stress, and can include questions on potentially traumatic events/experiences and/or reactions to a traumatic event (e.g., behavioral, mood, or developmental concerns). In alignment with the National Child Traumatic Stress Network's (NCTSN) recommendation, when discussing the use of a screening tool, this report defines trauma screening as a structured method for evaluating the presence of exposure to potentially traumatic events/experiences and traumatic stress symptoms/reactions.[28] Screening can also include questions regarding developmental delays, and/or environmental factors that put children at increased risk of experiencing traumatic events (e.g., discrimination, family stressors, social determinants of health).

Screening comes in different formats:

- For the most part, screening involves the use of a short questionnaire meant to be filled out by the child themselves (if old enough), their caregiver, and/or a staff member. Many providers interested in screening choose to use validated screening tools, that is, "an instrument that has been psychometrically tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition)."[29]
- In some settings, screening can also mean asking the same, pre-established question(s) orally. For example, some providers, especially in the medical field, screen children for trauma by asking them "Have you recently experienced something scary or upsetting?"

The CTTF's *Interim Report* describes at length the process of trauma screening as well as different types of screening tools and methods. It also lays out examples of how organizations throughout the U.S. have implemented trauma screening practices. While this current report summarizes key

[28] The National Child Traumatic Stress Network. (n.d.). Trauma Screening. https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-screening

[29] The Joint Commission. (n.d.). Definition of validated and non-validated screening tool for substance use. https://manual.jointcommission.org/Home/Questions/UserQuestionId03Sub0015

findings from the *Interim Report* to contextualize its recommendations, it does not repeat all the information, and readers are advised to refer to the *Interim Report* for more details.

This report's recommendations reflect the Task Force's belief that screening children for trauma can be beneficial to children *under specific conditions, in specific contexts*. These benefits can include:

- Increasing child-serving organizations' ability to identify children and youth who are experiencing trauma and need support. In particular, screening can help identify children with internalizing behaviors (e.g., irritability, lack of concentration, withdrawal) that are often less evident than externalizing behaviors (e.g., verbal or physical aggression, vandalism, substance use). At the same time, screening can also help explain a child's challenging or disruptive behaviors that are rooted in their traumatic experiences and avoid punitive disciplinary measures that are not supportive of the child's needs. This consideration further supports NCTSN's recommendation that trauma screening tools include both potentially traumatic events and reactions.
- More equitable responses to children, particularly Black and Latino children who are, statistically, more likely to experience traumatic events but also more likely to see adults respond in a punitive manner to challenging behaviors that could be trauma-driven. If implemented appropriately, a screening process – particularly a universal one – can help reduce disparities and bias in how adults interpret a child's behaviors, what may be causing the behaviors, and what the appropriate response should be.

At the same time, the CTTF recognizes that there is a potential for harm to children if a screening process is implemented poorly. These harms can include:

- Retraumatizing and/or stigmatizing children who have experienced trauma if a screening is administered without attention to TIR principles outlined in General Recommendation #2.
- Wasting time and resources of all involved – children, caretakers, child-serving professionals – if a screening is conducted but the information is not properly used to then connect the child with supports as needed.
- Decreasing child and family trust in child-serving systems if they are not properly engaged in the process, if they experience bias or culturally insensitivity through the process, and/or if information is collected through screening but not used to provide support.

Recommendations for Organizations

Research conducted for our 2021 *Interim Report* on best practices and considerations for trauma screening makes clear that **trauma screening, if not implemented in a trauma-informed and responsive way, is not effective—and can in fact be harmful.**[30] The CTTF therefore recommends organizations wanting to implement trauma screening do so in a trauma-informed and responsive (TIR) way. At every stage of the screening implementation process, organizations should have the safety of the child in mind, be transparent and foster trust, empower children and their caregivers, and promote inclusivity and anti-bias efforts.

[30] Childhood Trauma Task Force. (2021, December). Identifying childhood trauma: An interim report on trauma screening and referral practices. Mass.gov. https://www.mass.gov/doc/cttf-2021-report-identifying-childhood-trauma-an-interim-report-on-trauma-screening-and-referral-practices/download

In practical terms, this means that **at the beginning stages** of trauma screening implementation efforts, organizations should:

- When selecting a screening tool, consider which trauma-related issues are more likely to be experienced by the population of children. For example, organizations working with young children should select a developmentally attuned screener, while organizations working with youth involved in the juvenile justice system might select a screener addressing community violence and racial trauma.
- Actively engage youth, families, and communities by:
    - **Providing clear information to youth and their family** on the screening and referral processes, including the purpose and benefits as well as possible downsides of screening.
    - **Creating opportunities for honest conversations** on how bias, power dynamics, and culture can impact the screening and referral processes for those who administer the screener and those who complete it. Organizations should acknowledge and directly address potential stigmas or uncertainties families might have regarding screening for trauma or referring a child/caregiver to trauma-based services, including whether or not the person conducting the screening is a mandated reporter and how that may affect any actions they may, legally, have to take based on the results. Additionally, organizations screening children and/or their caregivers should consider how their cultural background and personal experiences may affect how they experience and relate to a traumatic event.
    - **Securing caregiver consent.** Due to the sensitive nature of asking youth about potentially traumatic experiences, organizations must obtain caregivers' consent to administer the screening. *Active consent* is when caregivers must give the explicit permission (often in writing) for the organization to administer a screen. *Passive consent* is when caregivers must "opt out" of the process. Organizations should weigh the benefits and limitations of each methods, discussed in more detail in the 2021 *Interim Report*. Whatever their choice, organizations should always share information on the screen's scope, confidentiality protections, and what next steps could follow the screen.[31]
    - **Communicating information in multiple formats** (e.g., email, phone call, face-to-face conversation) and in multiple languages.

During and after screening, organizations should make sure they:

- **Encourage youth and their families to identify individual, family, and community strengths and supports** (see examples in General Recommendation #2). Organizations can also use a validated screening tool measuring resilience, such as the Child & Youth Resilience Measure.[32]
- **Have a collaborative conversation regarding the results of the screening** and what next steps (if any) could be taken. Organizations should be mindful that cultural and familial

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[31] Ibid., pp. 15-16.
[32] Resilience Research Centre. (n.d.). Child and Youth Resilience Measure & Adult Resilience Measure. CYRM/ARM. https://cyrm.resilienceresearch.org/

backgrounds as well as prior experiences of oppression might affect family consent and subsequent service engagement. For example, a family who had a negative experience with a therapist from a different racial/ethnic background might not be interested in engaging in clinical treatment and might prefer working with a therapeutic mentor from their community instead.

- **Thank the youth/family** for completing the process.
- **If needed, provide a warm handoff to** establish an initial, face-to-face contact between the child/caregiver and the service provider.

Recommendations for State Support

As in our "General Recommendations for Trauma Identification and Referral," the CTTF recommends the state continue to support the Center on Child Wellbeing and Trauma to allow the Center to expand the work it is already doing as well as to provide:

1. **Training and Technical Assistance** (TTA) to help organizations seeking to implement a trauma screening process plan, develop, and operationalize the above-mentioned requirements for successful implementation. This TTA would be the same as the one detailed in Recommendation #4 above, with the addition of the need for training to also dispel common misconceptions regarding the use of trauma screening tools, such as:
    - Screening for trauma re-traumatizes children: While asking questions regarding a child's potentially traumatic experiences can cause brief distress for a child, providers equipped with the proper tools – including but not limited to strong service referral processes – can effectively ease children's feelings and ensure they are getting the longer-term support they need. Additionally, reports and interviews with jurisdictions that have implemented trauma screening demonstrate that most children screened are not highly distressed by the questions—and in fact may feel relieved and validated.[33]
    - **S**creening forces children to repeat their stories over and over again: A screener is not the same as an assessment, which is an in-depth process conducted by a trained clinician. Screening is the first step toward better understanding a child's experience(s) of trauma and leads, if necessary, to a trauma assessment. Similarly, it is not an investigative tool: children and caregivers completing the questionnaire are simply answering yes/no to help confirm known traumas and, potentially, identify new ones.
2. **Resources on trauma screening and referral**, as detailed in Recommendation #3 above.

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[33] Skar A. S., Ormhaug S. M., Jensen T. K. (2019). Reported levels of upset in youth after routine trauma screening at mental health clinics. *JAMA Network Open, 2*(5), Article 94003. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2733436 ; Lange, B. & Lang, J. (2020). Screening youth in the child welfare and juvenile justice systems for trauma. Child Health & Development Institute. https://www.chdi.org/publications/issue-briefs/issue-brief-75/

Part 2: Recommendations on Sector-specific Trauma Identification and Referral Practices

K-12 SETTINGS

Students nationwide experience a wide range of potentially traumatic experiences, which can impact their academic achievement, social functioning, and overall development.[34] Additionally, while many students experience trauma, many more have behavioral health challenges, which can be caused by a multitude of factors—including trauma. Indeed, a Center for Disease Control and Prevention (CDC) study of teacher and parent reports found that about one in six students had "enough behavioral or emotional symptoms and impairment to be diagnosed with a childhood mental disorder."[35]

Over the past two decades, schools throughout the country have increasingly been paying attention to their students' emotional and behavioral health needs, as those can affect how students learn, engage, and create healthy relationships with peers and staff. To do so, schools throughout the U.S. have focused on Social Emotional Learning, established mental health services in school-based health centers, and developed tiered systems of support—to name a few of the most common strategies. Additionally, more and more schools have adopted behavioral health screening tools to systematically identify those who might be experiencing difficulties as well as assess how their policies, practices, and general climate affect students.

As described in Part 1, **conversations about trauma identification must take place within the broader context of schools' efforts to meet the social, emotional, and behavioral health needs of the students they serve**. This section of the CTTF report therefore focuses its discussion on trauma identification—and in particular screening—within the various approaches to behavioral health identification schools have adopted in the Commonwealth and nationwide. To provide context for the CTTF recommendations on trauma screening in K-12, this section of the report details:

1. Different approaches to identifying behavioral health and trauma-related concerns in schools
2. Examples of universal behavioral health and trauma screening initiatives in schools
3. Arguments in favor and against various approaches to trauma identification in schools

Different Approaches to Behavioral Health/Trauma Identification in Schools

Schools throughout the country have adopted various approaches to identifying students whose emotional, social, or psychological issues might be impacting their behaviors and overall health – both generally and focused on trauma specifically. This section describes the common identification approaches as they have been implemented in K-12 settings:

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[34] Siceloff, E.., Bradley, J. &Flory, K. (2017). Universal behavioral/emotional health screening in schools: Overview and feasibility. *Report on Emotional & Behavioral Disorders in Youth, 17*(2), 32-38. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6350819/pdf/nihms-982096.pdf

[35] Centers for Disease Control and Prevention. (n.d.). Mental health symptoms in school-aged children in four communities. CDC.gov. https://www.cdc.gov/childrensmentalhealth/features/school-aged-mental-health-in-communities.html

1. **Observation:** Based on "red flags" (e.g., sharp drop in grades, increase in Office Discipline Referrals) or noticing behaviors that may be trauma-related, staff engage in a discussion with the student, which might reveal behavioral health issues, a history of traumatic event(s), and/or trauma symptoms, leading to a referral for further assessment and other necessary services.
2. **Conversation:** If a student and/or their caregiver proactively identifies potential behavioral health and/or trauma-related concerns, this would lead to a longer conversation with a member of school staff and, depending on the circumstances, referral for additional assessments and services.
3. **Screening**, which includes either:
   - A universal screening approach, where all students (in a classroom, grade, or entire school) are screened.
   - A selective screening approach, where only students meeting certain criteria are screened. These criteria can be based on:
     - Observation by school personnel (e.g., teachers, nurses, or mental health counselors) who are trained to notice potential mental health or trauma-related behaviors.
     - Data, such as when students reach a certain number of Office Discipline Referrals or missed school days, when their grades drop sharply, or when their score on a broader behavioral health or substance use screener suggests the need for further screening specific to trauma.
     - Student or caregiver request

Examples of Behavioral Health and Trauma Screening Initiatives in Massachusetts

Massachusetts school districts are increasingly implementing universal behavioral health screening practices, though the CTTF is aware of only a handful of schools that universally screen for trauma as part of a broader behavioral health screen. This recent increase can be partially attributed to a heightened awareness of the importance of identifying students' behavioral health needs during the COVID-19 pandemic as well as increased state support to implement universal screening practices in K-12 settings, as described below. The *Interim Report* describes in more detail some of the following screening initiatives:

- Schools throughout the state are legislatively required to engage in Screening, Brief Intervention, and Referral to Treatment (SBIRT), a comprehensive, integrated approach to prevent and treat substance use disorders among students.[36] SBIRT is a program developed by SAMHSA and adopted in over 30 states across the nation.[37]
- Methuen Public Schools began adopting universal behavioral health screening practices in 2015 as part of an overall effort to increase health services and supports for students. During the COVID-19 pandemic, the district added the UCLA COVID-19 Brief Trauma Screen

[36] MASBIRT. (n.d.). Massachusetts screening, brief intervention and referral to treatment - training & technical assistance. https://www.masbirt.org/
[37] SAMHSA. (n.d.). Screening, brief intervention, and referral to treatment (SBIRT). Samhsa.gov. https://www.samhsa.gov/sbirt

to better understand students' trauma-related needs and as part of its three-year strategic plan.[38]

- In 2021, the state Department of Elementary and Secondary Education awarded 32 grants to school districts to provide training and technical assistance to implement universal behavioral health screening. Over the course of six months, teams began developing and piloting systems to screen students for behavioral health or Social Emotional Learning (SEL) and follow up with them when needed. However, in many districts that have implemented screening, this practice is relatively new, and many more have not yet taken this step.
- The Behavior Intervention Monitoring Assessment System 2 (BIMAS 2) is administered in many Boston Public Schools. It operates on a web-based platform with a data management system and measures students' social, emotional, and behavioral functioning. Unlike other screening tools, it is completed by teachers based on their observations of students.

Arguments in Favor and Against Various Trauma Identification Approaches

By and large, there has not been any notable opposition to the *concept* of universally screening students for behavioral health needs, as most agree that unmet behavioral health needs can interfere with learning and academic achievement, and schools are the single best place to reach the largest percentage of children and youth. In fact, most students who receive behavioral health services do so in schools, and mental health professionals working in K-12 settings make up "the largest cadre of primary providers of mental health services for children."[39] That said, many schools have constrained/limited resources, and some argue that even if universal screening is a good idea in theory, in practice it is not feasible or advisable without sufficient implementation and referral resources.

However, arguments in favor of and against various trauma identification approaches have been put forth. These arguments are detailed in the CTTF's *Interim Report* and include the following:

- **Observation:** This approach leaves the most room for staff interpretation of students' behaviors, which, as research in the medical field as well as in child welfare and juvenile justice sectors demonstrates, can create opportunities for bias to impact decision-making.[40] It can also lead to certain potentially trauma-related behaviors being missed, which is why

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[38] Methuen Public Schools. (n.d.). Strategy for District improvement. https://docs.google.com/document/d/13bLOKdpLCoQWsPhPIl_rWU42-7Dmh_U1bKXi-SzqAn0/edit

[39] Barrett, S. Eber, L., & Weist, M., Eds. (2017). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Center on PBIS. https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support ; Atkins, M. S., Frazier, S. L., Birman, D., Adil, J. A., Jackson, M., Graczyk, P. A., Talbott, E., Farmer, A. D., Bell, C. C., & McKay, M. M. (2006). School-based mental health services for children living in high poverty urban communities. *Administration and policy in mental health*, *33*(2), 146–159. https://doi.org/10.1007/s10488-006-0031-9 ; Jaycox, L. H., Morse, L. K., Tanielian, T., & Stein, B. D. (2006). *How Schools Can Help Students Recover from Traumatic Experiences: A Tool Kit for Supporting Long-Term Recovery* (1st ed.). RAND Corporation. https://www.rand.org/pubs/technical_reports/TR413.html

[40] Merino, y., Adams, L., Hall, W. (2018, March). Implicit bias and mental health professionals: Priorities and directions for research. *Psychiatric Services, 69*(6), 723-725. https://doi.org/10.1176/appi.ps.201700294 ; Liu, F. F., Coifman, J., McRee, E., Stone, J., Law, A., Gaias, L., Reyes, R., Lai, C. K., Blair, I. V., Yu, C. L., Cook, H., & Lyon, A. R. (2022). A Brief Online Implicit Bias Intervention for School Mental Health Clinicians. *International journal of environmental research and public health*, *19*(2), 679. https://doi.org/10.3390/ijerph19020679 Ards, S. D., Myers, S., Ray, P., Kim H-E., Monroe, K., Arteaga, I. (2012, August). Racialized perceptions and child neglect. *Children and Youth Services Review, 34*(8), 1480-1491. https://doi.org/10.1016/j.childyouth.2012.03.018

many argue that training should highlight internalizing behaviors such as irritability, lack of concentration, and withdrawal, as these can be less evident than externalizing behaviors (e.g., verbal or physical aggression, vandalism, substance use).

- **Universal screening:**
    - Proponents of this approach argue that universal screening is more effective and equitable, as it can identify students whose trauma-related symptoms are not readily apparent (e.g., anxiety) and the use of a systematic process results in less opportunity to overidentify or under identify students with certain externalizing/acting out behaviors or from certain racial, cultural, class, or family backgrounds.
    - On the other hand, some argue that many schools do not have the necessary resources to screen all students for trauma, and that schools should prioritize other strategies for identification.
- **Selective screening:**
    - Proponents of this approach argue that this model makes better use of scarce resources while keeping some of the benefits of implementing a structured screening tool.
    - On the other hand, without robust training, selective processes can leave room for bias and can under-identify internalizing behaviors such as anxiety and depression as well as over-identify or under-identify students based on race, ethnicity, sexual orientation, gender identity, or family history.

Recommendations for Schools

The CTTF recognizes that there are many benefits to adopting a structured process (e.g., universal or selective screening) for identifying students who may have experienced trauma and be in need of support, including increasing the identification of students with internalizing behaviors and limiting opportunities for bias.

At the same time, the CTTF also strongly believes that **establishing a trauma screening process is not the first, second, or even third step a school should take to better support students.** This is particularly important, as trauma screening implemented in the absence of these other steps can be ineffective or even harmful. Instead, trauma screening should be thought of as a more advanced step to be considered *after* higher priority processes have been thoroughly implemented. These include:

1. **Being trauma-informed and responsive**: Schools should ensure they have integrated key principles of trauma-informed and responsive (TIR) practice into all domains of school functioning. Training educators on TIR practices can, among other things, help ensure that they are well-equipped to recognize students whose functioning may be impacted by a traumatic event and who may be in need of support, even in the absence of a formal screening process. Schools can refer to the CTTF's *Framework for Trauma-Informed and Responsive Organizations* for an in-depth overview of how to implement principles of a TIR

approach in various organizational domains.[41] Additionally, districts in the Commonwealth have access to a wide array of supports from the Department of Elementary and Secondary Education (DESE) to develop supportive, trauma-responsive environments for students.[42] Schools can also receive support on building trauma-informed environments from organizations such as the Center on Child Wellbeing and Trauma at UMass Chan Medical School and the BIRCh Project at UMass Boston.[43]

2. **Having a tiered system of support and established pathways for connecting students who are identified as needing support with services**: To make the best use of available resources and ensure that students identified as needing support receive it, schools should implement frameworks of tiered supports. Those usually include universal, preventative supports (Tier 1) for all students, educators, and staff; a targeted, more intensive array of services that focus on specific needs of a smaller number of students (Tier 2); and intensive, individualized supports for a minority of students with greater needs (Tier 3). Schools can use data from behavioral health screening processes to identify any gaps in service availability and focus service expansion efforts where the need is greatest.
3. **Screening all students for behavioral health**: As discussed above, any processes for screening for trauma experiences and symptoms should take place within an overall framework of screening for behavioral health issues more broadly. For that reason, the CTTF recommends that schools first focus on establishing a behavioral health screening process before considering adding a trauma-focused screener.

The CTTF only recommends schools consider implementing a trauma screening process after they have implemented all of the above.

The CTTF recognizes the different financial, logistical, and staffing capacities of 400+ school districts in the Commonwealth as well as the varying needs of students in different parts of the state. Accordingly, the CTTF believes there is no one-size-fits all approach to trauma screening, but instead recommends schools consider each of the following methods:

- **Universal screening**: Schools screen all students (in a given class, grade, or schoolwide) for traumatic symptoms and experiences as part of a larger behavioral health screening process.
- **Selective screening**: Schools only screen students for traumatic symptoms and experiences who meet pre-established criteria based on all or some of the criteria discussed above (i.e. "red flags," observation, student/caregiver referral). For schools opting to adopt this approach, the CTTF recommends they critically examine their criteria to ensure the selection process is not biased towards students with externalizing behaviors or those from a specific racial, cultural, economic, or family background.

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[41] Childhood Trauma Task Force. (2020, October). Framework for trauma-informed and responsive organizations. Mass.gov. https://www.mass.gov/doc/framework-for-trauma-informed-and-responsive-organizations-0/download
[42] Many schools use programs, initiatives, and structures offered by the Department of Elementary and Secondary Education (DESE) that help them develop supportive, trauma-responsive environments for students. These include programs such as Trauma Sensitive Schools, Safe and Supportive Schools, Massachusetts Tiered Systems of Supports (MTSS) Academies, as well as Bullying Prevention and Intervention. See: https://www.doe.mass.edu/sfs/
[43] Center on Child Wellbeing and Trauma. (n.d.). Home. https://childwellbeingandtrauma.org/ ; UMass Boston. (n.d.). About the BIRCh Project. Behavioral Health Integrated Resources for Children Project. https://www.umb.edu/birch/about#about_birch

In addition to the implementation recommendations included in Part 1 of this report, the CTTF has developed a graphic outlining a step-by-step process schools should consider when planning to screen their students for behavioral health or trauma-related concerns (see Appendix A) drawing from case studies in Massachusetts and other parts of the U.S. Additionally, the CTTF has compiled a list of screening implementation resources that can be accessed for free on any of the following platforms:

- **BIRCh universal screening training modules**, which can help school professionals "prepare to implement screening, fine tune and problem solve around existing screening practices, and engage in planning around linking screening data to intervention."[44] Although these seven modules were developed for social, emotional, and behavioral (SEB) screening, the information provided can be applied to behavioral health and trauma screening practices as well. School staff viewing these resources through BIRCh's LMS system can receive a certificate for their licensure renewal.
- **Trauma ScreenTIME** training modules, which provides child-serving professionals with best practices for trauma screening, as well as wide array of resources such as infographics, brochures, fact sheets, and a list of selected trauma and adversity screening measures.[45]
- **The SHAPE System** assessment and resource library, which can help school personnel map their mental health services, assess the quality of their school's system of support, create reports and strategic planning briefs, and select trauma/behavioral health screening and organizational assessment tools.[46]
- **Massachusetts School Mental Health Consortium** resources to help school personnel establish trauma-sensitive schools and foster Social-Emotional Learning (SEL), bolster the availability and quality of early intervention and treatment services, as well as implement screening and monitor psychosocial progress among students.[47]
- **Comprehensive, Integrated Three-Tiered Model of Prevention** (Ci3T), which offers data-driven guidance on implementing screening for signs of internalizing and externalizing behaviors within a tiered model of prevention.[48]

Recommendations for State Support

Many schools need support to successfully implement a screening process (whether that is a broader behavioral health screening or a more specific trauma screening). **The CTTF therefore recommends the state continue to provide districts with implementation training and technical assistance (TTA) to ensure behavioral health and trauma screening can be done efficiently and in a trauma-responsive way**, and expand TTA availability to meet demand as needed.

Training and technical assistance should include guidance on how schools can:

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[44] BIRCh Project. (n.d.). Universal social, emotional, and behavioral screening: 7 module training series. YouTube. https://www.youtube.com/playlist?list=PL64anp4FPpRVSUziUawCEEbck7qDW91PX
[45] Trauma SCREENTIME. (n.d.). About. Child Health and Development Institute. https://www.traumascreentime.org/
[46] School Health Assessment and Performance Evaluation System. (n.d.). The SHAPE System. National Center for School mental Health. https://www.theshapesystem.com/
[47] MASMHC. (n.d.). Resources. Massachusetts School Mental Health Consortium. https://masmhc.org/resources/
[48] Comprehensive Integrated Tree-Tiered Model Prevention. (n.d.). Systematic Screening. Ci3T. https://www.ci3t.org/screening

- Develop an implementation timeline
- Select a screening tool
- Develop a plan to foster buy-in and engagement from students, families, and school staff
- Plan for the administration of screening
- Conduct a coordinated follow-up to address the needs of identified students

The state should also continue providing – and expand, as needed – supports for schools seeking to implement trauma-informed and responsive practices as well as those seeking to establish and/or improve their tiered systems of support. This would include ongoing training and coaching to ensure school policies and practices prevent compassion fatigue and trauma-related burn out.

Finally, the CTTF recommends the state support and develop systems for cross agency coordination to ensure that initiatives, programs, and services are not siloed and can be most effectively used to serve children throughout the Commonwealth. This could include, for example, ensuring that the new Office of Behavioral Health Promotion, established in *An Act Addressing Barriers to Care for Mental Health* (2022), facilitate communication and partnership in the development of interagency initiatives that promote trauma identification and trauma-responsive practices in schools.

PEDIATRIC PRIMARY CARE

Pediatric primary care represents a key sector to promote the physical, mental, and social wellbeing of children and families. More than 90% of children see their pediatrician for an annual well-child visit at their pediatrician's office several times each year.[49] Pediatricians are trained to take a holistic approach to children's health by paying attention to their physical as well as developmental, emotional, and behavioral health.

Given the known links between trauma and negative health outcomes as well as patient engagement and treatment adherence, medical professionals are increasingly adopting trauma-informed care frameworks and strategies in their practices. Today, pediatric providers widely accept the benefits of trauma-informed care—as demonstrated by the plethora of peer-reviewed articles, webinars, trainings, medical education curricula as well as publications from renowned health organizations on the topic.

In addition to understanding the impact trauma can have on lifelong health and promoting resilience, **identifying children who have experienced traumatic events is a critical aspects of trauma-informed care**.[50] Unfortunately, despite appreciating the value of trauma-informed care, many pediatricians don't always have the training, resources, or capacity to identify and provide appropriate support as needed to children who might have experienced traumatic events.

In recent years, there has been increased interest in using screening tools in primary care to identify children impacted by trauma.[51] This approach has generated much debate about who and when to screen as well as what screener to use and under which conditions.

Much of the conversation has also focused on how providers should best respond when they have identified that a child may have been impacted by trauma. As elaborated in this section, **screening—and trauma identification generally—in primary care settings is only one part of trauma-informed care** and should always be followed by concrete supports when necessary. Indeed, the *purpose* of screening a child for trauma is to make those connections to additional supports when indicated.

To provide context for the CTTF recommendations on trauma screening in pediatric primary care, this section of the report details:

1. Different approaches to identifying trauma and risk factors
2. Examples of universal trauma screening initiatives in pediatric primary care

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[49] Lang, J. L. et al. (2021). Validating the Child Trauma Screen among a cross-sectional sample of youth and caregivers in pediatric primary care. *Clinical Pediatrics 60*, 4-5, 252-258. https://doi.org/10.1177/00099228211005302

[50] Duffee, J., Szilagyi, M., Forkey, H. Kelly, E. (2021, August). Trauma-informed care in child health systems. *Pediatrics, 148*(2). https://doi.org/10.1542/peds.2021-052579

[51] Keeshin, B., Byrne, K., Thorn, B., & Shepard, L. (2020). Screening for Trauma in Pediatric Primary Care. *Current psychiatry reports*, *22*(11), 60. https://doi.org/10.1007/s11920-020-01183-y ; Kia-Keating, M., Barnette, M., Liu, S., Sims, G. & Ruth, A. (2019, December). Trauma-responsive care in a pediatric setting: Feasibility and acceptability of screening for adverse childhood experiences. *American Journal of Community Psychology, 64*(3-4), 286-297. https://doi.org/10.1002/ajcp.12366

3. Arguments in favor of universal trauma screening in pediatric primary care
4. Cautions about and arguments against universal trauma screening in pediatric primary care
5. The American Academy of Pediatrics' (AAP) recent policy statement on trauma identification (including screening) as part of trauma-informed care as well as the AAP's accompanying clinical report highlighting ways pediatric providers could use trauma screening tools as one of many strategies for trauma-informed care

Trauma Identification Approaches for Pediatric Primary Care

There is no one way of identifying children impacted by trauma. Each of the following models of trauma identification has its benefits and shortcomings, and providers often elect to use one or more approaches depending on their comfort, training, and capacity. Common approaches to identifying and/or supporting children who might be impacted by trauma include:

1. **Surveillance,** which includes monitoring for signs of trauma as well as conversations with children and their caregivers as a part of health maintenance. The AAP advises physicians to ask a question such as ""Has anything scary or concerning happened to you or your child since the last visit?" to initiate a conversation on the topic.[52] Medical surveillance is a fundamental aspect of prevention in primary care, and some providers argue that it is sufficient to identify children at risk of trauma.
2. **Universal education:** Providers educate children and caregivers on the prevalence and impact of trauma, thereby normalizing and destigmatizing the topic. This model gives children and caregivers the opportunity to ask more questions and/or offer information about potentially traumatic events they experienced. This model can also give providers an opportunity to discuss the potential usefulness of completing a trauma screening tool, if need be.
3. **Selective screening**, where providers administer a screening tool to only *some* children and/or their caregivers based on one or more of the following:
    - Youth or caregiver self-referral
    - Observation of possible trauma-related symptoms
    - Knowledge of potentially traumatic events
    - Scores on other screening tools (e.g., behavioral health or developmental screeners)
4. **Universal screening,** where providers administer a screening tool to *all* children and/or their caregivers.

Additionally, to identify needed supports, providers might elect to screen for factors that put children at risk of experiencing trauma by:

5. **Screening parents/caregivers for adverse experiences and/or psychosocial issues,** which allows providers to focus on the caregiving relationship and promote relational health. Some pediatricians have found screening caregivers in this way to be useful given that past traumatic experiences (in childhood or adulthood) can impact the caregiving

[52] Forkey, H., Szilagyi, M., Kelly, E., Duffee, J. (2021, August). Trauma-informed care. *Pediatrics, 148*(2) https://doi.org/10.1542/peds.2021-052580

relationship, and that issues such as substance use, depression, or intimate partner violence are common and can disrupt the home environment and family relationships.[53] If followed by supports for the child's caregiver(s), this model can help support the child-caregiver relationship and overall child health.

6. **Screening for Social Determinants of Health (SDOH)**, which some pediatricians argue is a more practical alternative, as providers can refer children and families to more widely available services (e.g., housing-, food-, personal safety-related supports).[54] While screening for SDOH does not identify children who might be impacted by trauma, it can help identify supports the whole family might need to feel safe and address practical challenges in the face of adversity. Additionally, families might be less reticent to speak about social needs, which carry less stigma. The American Academy of Family Physicians and the Centers for Medicare & Medicaid Services published SDOH screening tools health care providers can use in their practices.[55]

Examples of Universal Trauma Screening Initiatives in Pediatric Primary Care

Over the past decade, there have been small and large-scale efforts to implement the use of trauma screening tools in pediatric primary care. The 2020 *Interim Report* describes two large-scale efforts of universal trauma screening in pediatric primary care:

- The **California-wide ACEs Aware initiative,** which trains and provides payments to Medicaid providers to use an Adverse Childhood Experiences (ACEs) questionnaire to detect risk of toxic stress in children and adults.[56] While there are many benefits to this overall initiative (especially the significant state effort to increase providers' knowledge of the prevalence and impact of trauma), the CTTF believes that the cautions and criticisms regarding the use of a checklist of adverse experiences, as further discussed in the *Interim Report*, are strong enough to discourage recommendations in favor of this model.

- The Utah **Pediatric Integrated Post-trauma Services (PIPS)** program, which developed a Care Process Model for Pediatric Traumatic Stress (CPM-PTS) in collaboration with NCTSN, the AAP, and the American Academy of Child and Adolescent Psychiatry.[57] The CPM-PTS includes a tool used to screen for potentially traumatic events, symptoms of traumatic stress, and suicidality. The CPM-PTS also includes a detailed roadmap to help providers

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[53] For proponents of screening parents for ACEs or psychosocial issues see for example: Kia-Keating, M., Barnette, M., Liu, S., Sims, G. & Ruth, A. (2019, December). Trauma-responsive care in a pediatric setting: Feasibility and acceptability of screening for adverse childhood experiences. *American Journal of Community Psychology, 64*(3-4), 286-297. https://doi.org/10.1002/ajcp.12366 ; Bair-Merritt MH, Zuckerman B. (2016). Exploring parents' adversities in pediatric primary care. *JAMA Pediatrics, 170*(4), 313–314. https://doi:10.1001/jamapediatrics.2015.4459.

[54] Multiple providers interviewed by OCA staff advanced this model as an alternative to trauma screening. There is a wide literature supporting SDOH screening, see for instance: Kostelanetz, S., Pettapiece-Phillips, M., Weems, J., Spalding, T., Roumie, C., Wilkins, C. & Kripalani, S. (2022, June). Health care professionals perspectives on universal screening of social determinants of health: A mixed-methods study. *Population Health Management, 25*(3), 367-374. https://doi.org/10.1089/pop.2021.0176

[55] American Academy of Family Physicians. (n.d.) Social needs screening tool. AAFP.org. https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf; Billioux, A., Verlander, K., Anthony, S., Alley, D. (2017, May). Standardized screening for health-related social needs in clinical settings: The Accountable Health Communities screening tool. National Academy of Medicine. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf.

[56] Aces Aware. (n.d.). Learn About Screening. State of California Department of Health Care Services. https://www.acesaware.org/learn-about-screening/

[57] Pediatric Integrated Post-trauma Services. (n.d.). Home. Utah PIPS. https://utahpips.org/

decide when and how to support children who might be impacted by trauma. The PIPS team presented their work implementing this universal screening model in primary care settings across the U.S. at the July 2021 CTTF meeting.[58]

Trauma screening tools can also be used effectively in integrated behavioral health practices. In these settings, primary care physicians are able to refer and provide warm hand offs to behavioral health specialists and social workers that can help connect families to needed services. Integrated practices also enable primary care providers to easily follow-up with families to ensure that trauma identification leads to concrete and effective supports for children and their caregivers.

In Massachusetts, Team UP for Children at Boston Medical Center is an example of an initiative that works to increase the capacity of community health centers to deliver trauma-responsive integrated behavioral health care to children and their caregivers.[59] The program does so by:

- Training teams to map out ways to support children and their families by using a strength-based approach
- Adopting a trauma-responsive lens when using screening tools to identify children at risk of behavioral health and developmental issues or trauma-related concerns
- Focusing on the various developmental needs and issues children of different ages can have and how those can present differently when young children are impacted by trauma (see Team UP's BRANCH program)[60]

Arguments in Favor of Universal Trauma Screening in Pediatric Primary Care

Proponents of universal trauma screening in pediatric primary care settings advance the following arguments:

- **Screening for health concerns is a routine part of pediatricians' practice**. Pediatricians regularly screen children for developmental delays and disabilities. In Massachusetts, MassHealth providers are required to conduct behavioral health screenings at well-child visits. Given the potential impact that experiencing a traumatic event can have on a child's physical and behavioral health and providers' training on how to use screening tools, there is value in screening for trauma in pediatric care when the provider is equipped to respond.
- **The effectiveness of using screening tools to identify trauma-related concerns in primary care settings has been sufficiently demonstrated.** In addition to the above-mentioned initiatives, an academic review of ten evidence-based trauma interventions in pediatric primary care reveals that the use of screening tools to assess trauma-related risks or behaviors, coupled with training of staff and efforts to increase knowledge of existing community providers, leads to primary care pediatricians' increased feelings of competence to identify and support children who are impacted by trauma.[61] The review

[58] Childhood Trauma Task Force. (2021, July 19). Meeting Presentation. Mass.gov. https://www.mass.gov/doc/cttf-july-19-2021-meeting-presentation/download
[59] TeamUP for Children. (2020, September). BRANCH: Final Report. https://teamupforchildren.org/sites/default/files/BRANCH%20External%20Report.pdf
[60] TeamUP for Children. (2020, September). BRANCH: Final Report. https://teamupforchildren.org/sites/default/files/BRANCH%20External%20Report.pdf
[61] Flynn, A., Fohtergill, K., Wilcox, H., Coleclough, E, Horwitz, R., Ruble, A., Burkey, M., Wissow, L. (2015). Primary care interventions to prevent or treat traumatic stress in childhood: A systematic review. *Academic Pediatrics, 15*(5), 480-492. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4578291/

also demonstrates that these training and screening interventions can lead to improved outcomes for children, as measured by a reduction in maltreatment reports, exposure to domestic violence, or challenging behaviors. Finally, some of the interventions examined found that parents viewed the interventions favorably and felt they helped improve parent-doctor interactions.

- **Screening *all* pediatric patients is a more equitable approach and limits the impact of bias.** Some frame the debate around universal trauma screening as one of health equity, as implementing structured approaches to screening *all* children in primary care settings leaves less room for bias than observation or selective screening.[62]
- **Some research suggests caregivers find trauma screening beneficial when done in a trauma-informed and responsive way**. A recent study on parents' perspectives of screening for childhood adversity in pediatric primary care revealed that caregivers generally want to discuss potentially traumatic events with their children's doctor and perceive the latter as being well positioned to help them if needed, but *only if providers adopt a person-centered, trauma-sensitive approach in their practice*.[63] Similarly, a study of low-income parents' perspectives on how pediatricians could screen for social determinants of health highlights their belief that this could be beneficial and effective – but only if done in the context of a trusting, non-judgmental relationship.[64]

Cautions About and Arguments Against Universal Screening for Trauma in Pediatric Primary Care

Those who argue or caution against universally screening for trauma focus primarily on the logistical realities of pediatricians' resources and availability of trauma supports. Arguments include:

- **It would be unethical and useless to screen without offering necessary supports.** Many who caution against universal trauma screening argue that pediatricians often do not have the necessary networks of community providers to refer children to and that there is a chronic lack of available trauma-focused services. Additionally, some warn that, without clear guidance (highlighted in policies or a care practice model), pediatric providers might not know how to best support children whose screening score puts them at risk of being impacted by trauma.[65]
- **Providers have limited time for each visit.** A survey of parents of children ages four to 35 months revealed that a third of well-child visits last less than 10 minutes and half last

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[62] This argument was advanced by some providers OCA staff interviewed in preparation for this report. Similar arguments have been made for universal screening to assess other health concerns or risks. See for instance: Deatrick, J., Kazak, A., Scialla, M., Madden, R., McDonnell, G., Okonak, K. & Barakat L. (2022). *Psycho-Oncology: Journal of the Psychological, Social and Behavioral Dimensions of Cancer,* 31(9), 1483-1490. https://doi.org/10.1002/pon.5978

[63] Conn, A.-M., Szilagyi, M. A., Jee, S. H., Manly, J. T., Briggs, R., & Szilagyi, P. G. (2018). Parental perspectives of screening for adverse childhood experiences in pediatric primary care. *Families, Systems, & Health, 36*(1), 62–72. https://doi.org/10.1037/fsh0000311

[64] Public Agenda. (2019). *It's About Trust: How Pediatricians Can Screen Children for Social Factors*. https://www.publicagenda.org/its-about-trust-how-pediatricians-can-screen-children-for-social-factors/

[65] These cautions against universally screening for trauma were advanced by some of the providers interviewed by OCA staff in preparation for this report.

between 11 and 20 minutes.[66] This does not provide physicians with enough time to screen all children for trauma in addition to assessing other health concerns and establishing a trusting relationship with families.

- **The current fee-for-service system does not include reimbursement for trauma screening.** While MassHealth and some commercial insurers reimburse pediatricians for the use of behavioral health screening tools, they do not, to the best of our knowledge, currently cover the use of trauma-specific screening tools. The CTTF would like to note, however, that MassHealth's upcoming Section 1115 Demonstration Waiver implementation includes future opportunities to pilot a new value-based primary care payment model. This payment model would require primary care practices to work towards enhanced team-based care and behavioral health integration. The new payment model would allow practices to have more flexibility in delivering care, including bolstering screening and referral workflows.
- **The U.S. Preventive Services Task Force (USPSTF) does not currently recommend screening children for trauma.** The USPSTF is the leading panel of national experts in disease prevention and evidence-based medicine that makes recommendations about clinical preventive services. The Task Force assesses the balance of benefits and harms of screening for various concerns and, to date, has not examined screening for toxic stress.

American Academy of Pediatrics' Stance on Trauma Screening

In 2021, the American Academy of Pediatrics issued a policy statement highlighting the role trauma identification, either through observation or standardized screening, plays in trauma-informed care.[67] The policy statement was published alongside a clinical report meant to provide detailed guidance to medical providers on trauma-informed care and, of particular interest to this report, trauma screening.[68] The AAP policy statement and clinical practice guide do not specifically recommend that all pediatricians universally screen patients for trauma, but instead describe a variety of approaches that pediatricians might opt to establish in their practice.

The AAP policy statement highlights that **screening should only be implemented "within the larger context of trauma-informed approaches"** and if there is leadership buy-in. The policy statement adds that screening should "always be for the benefit of children and adolescents, avoid retraumatization, and identify protective as well as risk factors."[69]

The AAP's accompanying clinical report highlights multiple ways pediatric providers can use screening tools to identify children who might be negatively affected by traumatizing experiences:[70]

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[66] Halfon, N., Steens, G., Larson, K., Olson, L. (2011, October). Duration of a well-child visit: Association with content, family-centeredness, and satisfaction. *Pediatrics, 148*(4), 657-664. https://doi.org/10.1542/peds.2011-0586
[67] Duffee, J., Szilagyi, M., Forkey, H. Kelly, E. (2021, August). Trauma-informed care in child health systems. *Pediatrics, 148*(2). https://doi.org/10.1542/peds.2021-052579.
[68] Forkey, H., Szilagyi, M., Kelly, E., Duffee, J. (2021, August). Trauma-informed care. *Pediatrics, 148*(2) https://doi.org/10.1542/peds.2021-052580.
[69] Duffee, J., Szilagyi, M., Forkey, H. Kelly, E. (2021, August). Trauma-informed care in child health systems. *Pediatrics, 148*(2). https://doi.org/10.1542/peds.2021-052579.
[70] Forkey, H., Szilagyi, M., Kelly, E., Duffee, J. (2021, August). Trauma-informed care. *Pediatrics, 148*(2) https://doi.org/10.1542/peds.2021-052580.

- Providers can elect to screen pediatric patients who have experienced potentially traumatic events (selective screening). The AAP specifically mentions this for children with pediatric medical traumatic stress.
- Providers can opt for a universal screening approach, which includes either:
  - Administering a screener such as the Pediatric Traumatic Stress Screening Tool developed by Utah PIPS (detailed below) to all patients, or
  - Considering the potential impact of trauma when administering developmental, mental health, or behavioral health screening tools at well-child visits.

The AAP's policy statement and accompanying clinical report also stress **the importance of framing trauma screening in the context of individual and family resilience**. While no resilience screeners have been validated, these instruments can still be used to have a discussion "around promoting strengths in the caregiver-child relationship to protect a child from toxic stress and build adaptive skills."[71]

Pediatric Medical Traumatic Stress

Between 15 and 25% of children and their siblings experience trauma after:

- Sudden or life-threatening illness or injury
- Painful or frightening treatment or procedures
- A stay at the hospital or Emergency Department

Because of this, the National Child Traumatic Stress Network advises health care providers to screen for indicators of toxic stress and provides examples of screening tools they can use.

See: NCTSN (2014). *Pediatric Medical Traumatic Stress: A Comprehensive Guide.* https://www.nctsn.org/sites/default/files/resources//pediatric_toolkit_for_health_care_providers.pdf

Recommendations on Trauma Screening in Pediatric Primary Care

There is a growing recognition of the role medical providers can play in identifying and supporting children who might be impacted by trauma as part of trauma-informed care. To ensure these efforts are successful, **the work of providers must be supported by larger medical systems and the state**. Therefore, the CTTF's recommendations on trauma screening focus on providers, public/private health insurers, and the state.

Recommendations for Providers

The AAP 2021 policy statement does not provide specific screening recommendations for pediatric providers. Rather, it directs clinicians to the accompanying clinical report for trauma-informed care best practices. The CTTF recommendations for providers are based on the AAP's clinical guidance on trauma identification, as described above.

Identification of trauma exposure and symptoms in the pediatric setting has value for improving child health when medical providers working with children systematically incorporate trauma identification as part of a strength-based, family-centered trauma-informed care delivery. The CTTF

[71] Forkey, H., Szilagyi, M., Kelly, E., Duffee, J. (2021, August). Trauma-informed care. *Pediatrics, 148*(2) https://doi.org/10.1542/peds.2021-052580.

recommends screening only in that context. As described above, models of trauma identification can include:

- **Surveillance**, which consists of monitoring for signs of trauma as well as asking patients or their caregivers if anything scary, concerning, and/or upsetting happened recently
- **Selective screening** for risk of toxic stress when:
    - Patients present with symptoms of trauma or reveal experience(s) of potentially traumatic event(s)
    - Patients are at increased risk based on results of developmental, behavioral health, or environmental factors screener
- **Universal screening** for risk of toxic stress, which could be particularly appropriate in integrated behavioral health care practices

Given the arguments against screening for Adverse Childhood Experiences (ACEs) described in detail in the 2021 *Interim Report*, **the CTTF does not recommend primary care providers use an ACEs questionnaire to assess risk of toxic stress.** Rather, if providers want to use a screening tool, the CTTF recommends they use a validated, developmentally appropriate screener that asks about potentially traumatic events/experiences as well as traumatic stress symptoms, as advised by the National Child Traumatic Stress Network (NCTSN).[72]

The CTTF also urges **providers interested in using a trauma screening tool to only do so in conjunction with trauma-informed clinical strategies and skills**, as the AAP 2021 Clinical Report outlines.[73] The latter include:

- Knowledge of trauma and its impact on functioning in multiple domains
- Support for the caregiver-child relationship and family resilience
- Recognition of the cultural context of trauma experiences, response, and recovery
- Guidance for families and health care workers
- Avoidance of retraumatization
- Processes for referral to evidence-based treatments
- Prevention and treatment of staff's compassion fatigue (i.e., Secondary Traumatic Stress)

Finally, the CTTF recommends providers interested in utilizing trauma screening tools consider using an established, structured roadmap, such as the Care Practice Model developed by PIPS team in Utah, to **identify and stratify treatment response, refer the child if necessary, and follow up at regular intervals.**

As part of a trauma-informed care framework that addresses how to respond to identified needs, the above-mentioned models of trauma identification can be coupled with the following:

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[72] NCTSN. (n.d.) Trauma Screening. The National Child Traumatic Stress Network. https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-screening

[73] Forkey, H., Szilagyi, M., Kelly, E., Duffee, J. (2021, August). Trauma-informed care. *Pediatrics, 148*(2) https://doi.org/10.1542/peds.2021-052580.

- **Universal education** of children and their caregivers on the prevalence and impact of trauma, in order to destigmatize the topic as well as initiate a conversation about possible trauma-related issues that might be affecting the family and discuss services that could be useful.
- **Screening for Social Determinants of Health (SDOH)** to identify needs around housing, food, utilities, employment, childcare, or personal safety families might have, with the goal of referring families to the resources and supports.
- **Screening caregivers for psychosocial issues or adverse experiences** to support children's relational health, with the goal of referring caregivers to needed resources and supports.

Recommendations for Health Systems

While providers play an important role in identifying and supporting children who experience trauma, they cannot do this without support from larger health systems. Knowing this, the AAP laid out recommendations to "expand and improve system-wide strategies for identification and treatment of all children and adolescents affected by traumatizing experiences."[74] The CTTF therefore recommends MassHealth and commercial insurance providers:

- Reimburse providers for the use of a trauma screening tool when they are used as a means to guide further treatment, as well as services needed to support the utilization of screening tools (e.g., office-based management, case management)
- Offer guidance to pediatricians on how, when, and what trauma screening tools to use. This includes training and technical assistance as well as developing or updating guides for providers, such as MassHealth and MBHP's *Primary Care Behavioral Health Screening Toolkit for the MassHealth Children's Behavioral Health Initiative (CBHI)* (2010) to include guidance on using trauma screeners.[75]
- Consider opportunities to pilot and evaluate initiatives that include the use of screening tools and training as part of trauma-informed care strategies, such as Team UP for Children or the Utah PIPS model.
- Consider opportunities for how the new value-based primary care payment model through the MassHealth Section 1115 Demonstration Waiver can incentivize identification of trauma and referrals.

Recommendations for State Support

The above-mentioned recommendations can only be implemented with supports from the government, which is why the AAP recommends states "mandate coverage for TIC services by government and private payers, including screening, diagnosis, office-based management,

[74] Duffee, J., Szilagyi, M., Forkey, H. Kelly, E. (2021, August). Trauma-informed care in child health systems. *Pediatrics, 148*(2). https://doi.org/10.1542/peds.2021-052579.

[75] MassHealth & the Massachusetts Behavioral Health Partnership. (2010, March). Primary Care Behavioral Health Screening Toolkit for the MassHealth Children's Behavioral Health Initiative (CBHI). MCPAP. https://www.mcpap.com/pdf/PCCScreeningToolkitFINAL331909.pdf

counseling, case management, community collaboration, and home visiting."[76] In line with the AAP, the CTTF recommends the Commonwealth:

- Mandate public and private health insurances to cover trauma screening in conjunction with services to respond to screening results that support providers' ability to meet patient needs, such as office-based management (e.g., patient education and brief in-office intervention), case management (e.g., referral and follow-up), and the development of networks of community-based services.
- Support efforts to integrate behavioral health care into pediatric primary care settings to increase availability of pediatric behavioral health support. This can be done by:
    - Expanding the Massachusetts Child Psychiatry Access Project (MCPAP), which provides behavioral health consultation services to primary care providers, to support children exposed to trauma specifically. Continued support includes increasing access to MCPAP in regions currently underutilizing the project, continued promotion of MCPAP services to pediatric primary care providers throughout the state, and expansion efforts focused on specific populations of children, such as those in foster care.
    - Increasing the integration of behavioral health in primary care to facilitate referrals and broaden the availability of trauma-related service.
- Support and expand on existing training and technical assistance initiatives to implement trauma-responsive clinical practices, including strengthening trauma identification through screening or other means that best fit pediatric practices' capacity and professional preferences.

[76] Duffee, J., Szilagyi, M., Forkey, H. Kelly, E. (2021, August). Trauma-informed care in child health systems. *Pediatrics, 148*(2). https://doi.org/10.1542/peds.2021-052579.

EARLY CHILDHOOD SETTINGS

Infants and young children under six are disproportionately exposed to traumatic events compared to older children. They are more likely to experience maltreatment, live in homes with domestic violence, be placed in foster care, and suffer accidental injuries that can lead to hospitalization.[77] Exposure to trauma is even more prevalent among young children living in poverty.[78]

Because their brains are rapidly developing, infants and young children are particularly vulnerable to trauma, which can lead to short- and long-term cognitive, developmental, emotional, and behavioral issues.[79] For example, the stress and disrupted sense of safety children can feel following traumatic situations can hinder their curiosity to explore the world around them and their ability to create meaningful relationships, which can lead to missed opportunities for learning.[80] A meta-analysis of studies on the relationship between childhood maltreatment and language confirms the negative impact of early experiences of trauma on language skills.[81] Research on child maltreatment also shows that the earlier in their life children are abused or neglected, the more symptoms of anxiety and depression they can have in adulthood.[82]

The impact of trauma on young children's ability to regulate their emotions and communicate effectively is particularly problematic in early education and care settings, where externalizing behaviors (e.g., aggression, tantrums, defiance) can be met with exclusionary discipline measures. Indeed, the national

What Are Early Childhood Settings?

There are many settings that provide care and supports to young children to help them thrive in various domains of their lives. In this report, when referring to early childhood settings, the CTTF includes a variety of organizations and program types, such as:

- Early care and education (e.g., family child care programs, group and school age child care programs, Head Start and Early Head Start programs)
- Home visiting programs
- Teen parenting programs
- Early Intervention programs
- Family shelters

[77] Liberman, A., Chu, A., Van Horn, P. and Harris, W. W. (2011). Trauma in early childhood: Empirical evidence and clinical implications. *Development and Psychopathology 23*, 397-410. https://web.archive.org/web/20190219080955id_/http://pdfs.semanticscholar.org/180c/ca5dd06660eebaf807edfa5760d9ab751958.pdf

[78] Osofsky, J. D., Stepka, P. T., & King, L. S. (2017). Introduction: Recognizing the impact of trauma exposure on young children. In J. D. Osofsky, P. T. Stepka, & L. S. King, *Treating infants and young children impacted by trauma: Interventions that promote healthy development* (pp. 3–13). American Psychological Association. https://www.apa.org/pubs/books/Treating-Infants-and-Young-Children-Intro-Sample.pdf

[79] Chu, A. T. and Lieberman, A. F. (2010). Clinical implications of traumatic stress from birth to age five. *Annual review of clinical psychology 6*, 469–494. https://doi.org/10.1146/annurev.clinpsy.121208.131204

[80] Cole, S., O'Brien, J., Gadd, M. G., Ristuccia, J., Wallace, D. L., Gregory, M. (2005). *Helping traumatized children learn: Supportive school environments for children traumatized by family violence.* Massachusetts Advocate for Children.

[81] Lum, J. A., Powell, M., Timms, L., & Snow, P. (2015). A meta-analysis of cross sectional studies investigating language in maltreated children. *Journal of Speech, Language, and Hearing Research, 58*(3), 961–976. https://doi.org/10.1044/2015_JSLHR-L-14-0056

[82] Kaplow, J. B., & Widom, C. S. (2007). Age of onset of child maltreatment predicts long-term mental health outcomes. *Journal of Abnormal Psychology*, *116*(1), 176–187. https://doi.org/10.1037/0021-843X.116.1.176

rate of preschool expulsion in state-funded pre-K programs is over three times the rate of expulsion in K-12 schools.[83]

Additionally, experiencing trauma at a young age can severely impact children's sense of security and, in cases of maltreatment or witnessing domestic violence, children's attachment to their caregivers, upon which they rely so much to grow and thrive.[84] Research has also demonstrated how caregivers' experiences of adversity, such as intimate partner violence, homelessness, financial stress, or childhood trauma can negatively affect their caregiving skills, especially if the latter's behaviors are also impacted by traumatic experiences.[85] This is particularly important as disturbances in these foundational relationships can affect children's capacity to form healthy relationships throughout their lives.[86] Because of this, **identifying and supporting young children who are impacted by trauma also requires supporting the adults who take care of them**.

Despite the prevalence of trauma in young children's lives and the impact it can have on their health and wellbeing, child-serving professionals do not always have the support and training they need to identify young children who might be impacted by trauma. This is compounded by young children's incapacity or lack of vocabulary to describe what happened to them as well as by the fact that signs of trauma among young children can present differently than in older children or adults. Additionally, it can be harder to notice internalizing behaviors, such as anxiety, compared to externalizing behaviors, which can be more disruptive.

To provide context for the CTTF recommendations on trauma identification in early childhood settings, this section of the report details:

1. Different approaches to identifying trauma in early childhood settings
2. Examples of various approaches organizations working with young children have adopted to identify those impacted by trauma identification
3. Arguments in favor/against and cautions regarding various trauma identification approaches

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[83] Bartlett, J. D., Smith, S., & Bringewatt, E. (2017). *Helping Young Children Ho Have Experienced Trauma: Policies and Strategies for Early Care and Education.* Child Trends. https://www.ddcf.org/globalassets/17-0428-helping-young-children-who-have-experienced-trauma.pdf

[84] Liberman, A., Chu, A., Van Horn, P. and Harris, W. W. (2011). Trauma in early childhood: Empirical evidence and clinical implications. *Development and Psychopathology 23*, 397-410. https://web.archive.org/web/20190219080955id_/http://pdfs.semanticscholar.org/180c/ca5dd06660eebaf807edfa5760d9ab751958.pdf

[85] Vivrette R., Briggs E., Lee R., Kenney K., Houston-Armstrong T., Pynoos R., Kiser L.. (2016). Impaired Caregiving, Trauma Exposure, and Psychosocial Functioning in a National Sample of Children and Adolescents. *Journal of Child and Adolescent Trauma, 11*(2):187-196 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7163895/ ; Kiser, L. J., Nurse, W., Lucksted, A., & Collins, K. S. (2008). Understanding the Impact of Trauma on Family Life From the Viewpoint of Female Caregivers Living in Urban Poverty. *Traumatology*, *14*(3), 77–90. https://doi.org/10.1177/1534765608320329 ; San Cristobal P., Santelices M., Miranda Fuenzalida D. (2017). Manifestation of Trauma: The Effect of Early Traumatic Experiences and Adult Attachment on Parental Reflective Functioning. *Frontiers in Psychology, 8*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5364177/.

[86] Bartlett, J. D., Smith, S., & Bringewatt, E. (2017). *Helping Young Children Ho Have Experienced Trauma: Policies and Strategies for Early Care and Education.* Child Trends. https://www.ddcf.org/globalassets/17-0428-helping-young-children-who-have-experienced-trauma.pdf.

Trauma Identification Approaches in Early Childhood Settings

Organizations serving young children have different functions, resources, and approaches to trauma-responsive care. Because of this, organizations serving young children have adopted various trauma identification approaches, including:

- **Observation:** Organizations increase their staff's capacity to identify children impacted by trauma by providing training on trauma and child development as well as coaching (i.e., reflective supervision), where staff is regularly guided through challenges that might arise with children and/or their caregivers. This approach requires careful consideration of how trauma may present differently depending on the child's age and cultural background. Additionally, this approach might be best suited for organizations that only provide one service and have a smaller staff (e.g., family child care program) as it is less resource-intensive than screening, for instance.
- **Caregiver education:** Staff provide education to caregivers on the prevalence and impact of trauma, which can help normalize and destigmatize the topic. This model gives caregivers the opportunity to ask more questions and/or offer information about potentially traumatic events their child or themselves experienced. This model can also provide staff with opportunities to discuss the potential usefulness of completing a trauma screening tool as well as issues of how to manage the stress that can come with working with traumatized children.
- **Screening** (selective or universal), where organizations ask caregivers to fill out a form that includes questions regarding potentially traumatic events and developmentally focused trauma-related reactions as well as questions on household risk factors and caregiver wellbeing. Screening might be more appropriate for early childhood organizations that provide multiple services including behavioral health and/or developmental supports as well as ongoing case management to young children at high risk of experiencing trauma (e.g., Head Start, Early Intervention, Home Visiting programs).

Examples of Trauma Identification Approaches in Early Childhood Settings

The CTTF has identified various examples of organizations in Massachusetts and nationwide that have increased their capacity to identify and support young children impacted by trauma. These organizations have opted to adopt the following approaches:

- **Observation:** The Building Resilient Children initiative (2019-2020) in Worcester, Massachusetts, demonstrates how, with the right supports, early education and care educators can create safe and nurturing environments for all.[87] In just a few months, educators received training, coaching, and participated in biweekly learning collaboratives to learn how to identify trauma, build childhood resilience and advance racial equity, leading to a clear reduction of challenging behaviors, suspensions, and expulsions as well as an increase in educators' self-perceived capacity to handle difficult behaviors and build relationships with families.

[87] Smolkin, A. (2020, June). Building Resilient Children: Final Report. Commonwealth Medicine. https://commed.umassmed.edu/sites/default/files/publications/UMASS_Document_CFP_BRC_ExecutiveSummary_2020_v3_SP%5B1%5D.pdf

- **Universal screening**: Organizations working with young children at increased risk of experiencing trauma, such as Head Start and Early Head Start programs, serve children from families with very low income as well as children who are homeless or in foster care. To ascertain their eligibility and identify areas of support needed, Head Start and Early Head Start programs ask families about some potentially traumatic experiences at intake. While the questionnaires vary depending on the program, this essentially functions as a universal trauma screening process.[88]
- **Selective screening:** Head Start programs in a dozen states have adopted selective screening practices, such as those that have implemented the Trauma Smart program.[89] Children who participate in Trauma Smart are screened for symptoms of trauma during clinical consultation if a history of traumatic event(s) is established.

Arguments in Favor and Against Screening in Early Childhood Settings

Most child-serving professionals agree that identifying and addressing trauma among young children is important to help them thrive, but there is not widespread agreement **that screening tools are the best way to do so**. While the use of screening tools to identify trauma in early childhood settings is not common, there is growing interest in this model of trauma identification among early childhood professionals.[90]

In addition to general arguments in favor of screening described in this report, the main argument specifically in support of screening young children to identify trauma is that t**rauma symptoms among very young children present differently than in older children.** Some programs have found that a structured approach that is embedded in policies and procedures and lays out potential symptoms of trauma in young children can help identify trauma more systematically. For example, an OCA survey to Early Intervention providers in Massachusetts revealed that all 32 survey respondents would find using a screening tool "useful and practical" to identify trauma among the children they serve.

Cautions and arguments against the use of screening tools to identify trauma in young children include:

- **Commonly used screeners are completed by caregivers and are not always reliable.** Indeed, caregivers might not notice or understand changes in their child's behavior, especially if they are themselves struggling with mental health or substance use issues. Similarly, caregivers might minimize traumatic experiences or their children's reactions to it out of guilt, shame, or because they live in families and communities where trauma and adversity is the norm.[91]

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[88] Head Start early Childhood Learning & Knowledge Center. (n.d.). Community Assessment Matrix. Administration for Children & Families. https://eclkc.ohs.acf.hhs.gov/program-planning/article/community-assessment-matrix
[89] Trauma Smart. (n.d.). Our model. Crittenton Children's Center. https://traumasmart.org/our-model/
[90] Child Abuse and Neglect Technical Assistance and Strategic Dissemination Center. (2017). Helping young children who have experienced trauma. Digital Dialogue. https://cblcc.acf.hhs.gov/wp-content/uploads/From-the-Field-Bartlett_508.pdf
[91] Fraser, J., Noroña, C., Bartlett, J., Zhang, J., Spinazzola, J., Griffin, J., Motagna, C., Todd, M., Bodian, R. & Barto, B. (2019, September). Screening for trauma symptoms in child welfare-involved young children: Findings from a statewide trauma-informed care initiative. *Journal of Child and Adolescent Trauma, 12*(3), 399-409. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7163841/

- **We don't know enough about the use of trauma screening tools with young children.** Implementation of universal trauma screening in early childhood settings is not as widespread as in other child-serving sectors, so less is known about implementation needs and effectiveness. In fact, while some researchers argue for trauma screening, few large early childhood organizations currently specifically advocate for the use of screening tools to identify trauma (though they may link to external resources on trauma screening).
- **Professionals cannot rely on screening tools to identify trauma-related symptoms in infants.** While screeners have been developed and validated for children as young as one year old, none have been validated for use with infants.[92]
- **Organizations serving young children are frequently underfunded and strapped for resources.** Asking staff to administer screening tools without comprehensive training and necessary supports could be harmful to children and families.
- If organizations opt to implement a selective screening model, the latter requires **careful consideration of how selective screening can leave room for bias** and can under-identify internalizing behaviors such as anxiety and withdrawal.

Recommendations for Early Childhood Providers

Given the prevalence of trauma among young children as well as the short- and long-term impacts it can have on their functioning and relationships with their parents and caregivers, **the CTTF recommends organizations serving young children adopt effective ways to identify and refer those who might be experiencing trauma as part of their efforts to build trauma-informed and responsive environments and practices**.

Organizations adopting trauma identification processes should have structures in place to ensure that caregivers of children who have experienced potentially traumatic events are offered concrete supports (e.g., training on how to identify signs of trauma, and how to respond to related challenging behaviors, assessment, treatment, peer supports). Depending on the type of child-serving organization, these supports can be provided in-house or by referral to community-based providers. The processes by which staff identify children who might be impacted by trauma should be embedded in policies and implemented in a strength-based, trauma-responsive way.

While being able to identify children who experience trauma is a critical part of being a trauma-informed and responsive organization, the CTTF recognizes that **there is not a single model of trauma identification that would work in all early childhood settings**. Given important differences in terms of organizations' functions, resources, and approaches to serving young children, the CTTF recommends organizations serving young children adopt any of the above-mentioned approaches to trauma identification, following the implementation recommendations described in Part 1 of this report.

Working with young children can be particularly challenging because of their inability to verbalize and regulate their emotions. The CTTF therefore recognizes that supporting young children who have experienced trauma also requires supporting the providers that care for them in various early childhood settings. **The CTTF recommends organizations working with young children**

[92] Screening tools developed specifically for young children include the Child Behavior Checklist PTSD Scale for children 23 months to six years, the Young Child PTSD (YCP) Screen for children one to three years old, and the Pediatric Emotional Distress Scale for children two to ten years old.

establish regular reflective supervision practices to ensure staff and their supervisors can have an open, supportive dialogue to navigate some of the challenges inherent to working with children who are impacted by trauma.

Finally, given the importance of the caregiving relationship in young children's development and ability to thrive, **the CTTF recommends organizations wanting to support young children who have experienced trauma also consider ways to support their parents/caregivers.** This can be done by:

- Educating staff and caregivers on the impact current and past trauma can have on the caregiving relationship and parents' capacity to cope with their child's trauma as well as highlighting caregivers' strengths and resilience in the face of adversity
- Adopting policies and procedures that emphasize a holistic approach to trauma-responsive care by strengthening the caregiver-child relation (as opposed to a child-centered only approach)
- Providing parents with information on available supports, making referrals and/or warm hand offs whenever possible

Recommendations for State Support

To help organizations serving young children increase their capacity to identify and support children who might be impacted by trauma, **the CTTF recommends the state provides support for early childhood organizations wanting to adopt trauma-informed and responsive practices**, including:

- **Training and coaching to professionals serving young children to develop trauma-responsive practices and increase their capacity to identify trauma and build resilience to avoid compassion fatigue**. In particular, the CTTF recommends the state continue to increase funding for the Early Childhood Mental Health Consultation grant administered by the Department of Early Education and Care as well as allow the grants to include one-on-one consultation with children in addition to classroom consultation. Additionally, the CTTF recommends training include information on how educators' requirements as mandated reporters can affect trauma identification practices and how to discuss these with caregivers.
- **Technical assistance to ensure screening can be done efficiently and in a trauma-responsive way**
- **Support to help organizations implement reflective supervision practices.**

JUVENILE JUSTICE

Trauma is highly prevalent among youth involved with the juvenile justice system. Research shows that nearly 90% of youth involved with the legal system have been exposed to at least one potentially traumatic event and about 30% have PTSD, a rate eight times higher than those seen in community samples of same-age peers.[93] Additionally, involvement with the legal system can often be traumatizing in its own right. Arrests, detention, removal from one's family and community, as well as court proceedings are highly stressful events that can negatively impact youth's wellbeing.[94] Of note, the trauma of juvenile justice involvement is disproportionately borne by Black and Latino youth.[95]

Experiencing trauma puts youth at a higher risk of repeated involvement with the juvenile justice system. Additionally, youth who have been arrested and report experiencing traumatic events are significantly more likely to be rearrested more quickly than those who do not report traumatic events.[96]

Juvenile justice professionals have increasingly been paying attention to the need to identify trauma among the children they work with. The National Child Traumatic Stress Network (NCTSN) in fact lists trauma identification as the second essential element of a trauma-informed juvenile justice system. Similarly, the Coalition for Juvenile Justice advises juvenile justice and social service agencies and courts to take the necessary steps to "recognize and respond to the impact of trauma on the children they serve."[97]

Because "juvenile justice settings" represents a broad sector ranging from prevention and diversion to court-involvement and incarceration, the purpose and benefits or drawbacks of trauma identification and identification methods differ depending on the organization and the situation. To provide context for the CTTF recommendations on trauma identification in juvenile justice settings, this section of the report discusses trauma identification and referral practices in Family Resource Centers, diversion programs, Probation, the Juvenile Court, and at the Department of Youth Services (DYS). Additionally, this section details:

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[93] National Judicial Task Force to Examine State Courts' Response to Mental Illness. (2022, March). Juvenile justice mental health diversion: Guidelines and principles. Behavioral Health State Court Leadership Brief. https://www.ncsc.org/__data/assets/pdf_file/0029/74495/Juvenile-Justice-Mental-Health-Diversion-Final.pdf ; Kerig, P, Ford, J. & Olafson, E. (2014). *Assessing exposure to psychological trauma and posttraumatic stress symptoms in the juvenile justice population.* National Child Traumatic Stress Network. https://www.nctsn.org/sites/default/files/resources//assessing_exposure_to_trauma_and_posttraumatic_stress_symptoms_in_juvenile_justice_population.pdf

[94] Cummings, A., Clark, T., Conrad, C. & Johnson, A. (2022). Trauma: Community of color exposure to the criminal justice system as an adverse childhood experience. *University of Cincinnati Law Review,* 90(3). https://scholarship.law.uc.edu/cgi/viewcontent.cgi?article=1436&context=uclr

[95] Juvenile Justice Policy and Data Board. (2021). *Massachusetts juvenile justice system: 2021 annual report.* Mass.gov. https://www.mass.gov/doc/jjpad-2021-annual-report/download

[96] Wolff, K., Baglivio, M. & Piquero, A. (2015, November). The relationship between adverse childhood experiences and recidivism in a sample of juvenile offenders in community-based treatment. *International journal of offender therapy and comparative criminology*, *61*(11), 1210–1242. https://doi.org/10.1177/0306624X15613992

[97] Coalition for Juvenile Justice. (n.d.). Trauma. News and Resources. https://www.juvjustice.org/our-work/safety-opportunity-and-success-project/national-standards/section-i-principles-responding-8

1. Different approaches to identifying trauma in various juvenile justice settings
2. Examples of trauma screening practices in various juvenile justice settings
3. Arguments in favor and against trauma screening in juvenile justice settings

Trauma Identification Approaches in Juvenile Justice Settings

In Massachusetts and across the nation, professionals working with youth at risk of being involved in the legal system increasingly understand the benefits of being trauma-informed and responsive (TIR). Identifying those impacted by trauma is a large part of TIR practices and, as in other child-serving sectors, there are different approaches to trauma identification in juvenile justice settings.

Many juvenile justice professionals rely on **observation** and **discussion** to better understand if a child has experienced trauma and how it might impact them. Massachusetts Probation Service, for instance, has previously provided training on trauma and its impact on youth's overall functioning to Juvenile Probation Officers (JPOs). If a JPO believes a youth they are working with has mental health- and trauma-related needs, JPOs may, on a case-by-case basis, recommend that a judge refer the youth to the Court Clinic for a full assessment.

Some juvenile justice professionals in the U.S. are using **screening tools** to systematically identify potentially traumatic events or trauma reactions among youth involved in the legal system. The National Child Traumatic Stress Network (NCTSN), the National Council of Juvenile and Family Court Judges, and the Coalition for Juvenile Justice all advocate for the use of trauma screening.[98]

Examples of Trauma Screening Practices in Juvenile Justice Settings

1. **Trauma Screening in Probation Departments Across the U.S.**

As part of efforts to support the juvenile justice system in becoming more trauma-responsive, the National Center for Mental Health and Juvenile Justice strongly recommends Juvenile Probation Officers (JPOs) use trauma screening tools to identify traumatic events and symptoms.[99] This is already practiced in many states: at least 14 Probation Departments use the MAYSI-2 statewide and more states use it in at least some counties.[100] The MAYSI-2 screens for concerns with mental health, substance misuse, suicide ideation, and trauma. Additionally, some jurisdictions use trauma-specific screeners: in Connecticut, for example, JPOs use the Child Trauma Screen for all intakes.[101]

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[98] Kerig, P., Ford, J., & Olafson, E. (2014). Assessing Exposure to Psychological Trauma and Posttraumatic Stress Symptoms in the Juvenile Justice Population. The National Child Traumatic Stress Network. https://www.nctsn.org/sites/default/files/resources//assessing_exposure_to_trauma_and_posttraumatic_stress_symptoms_in_juvenile_justice_population.pdf ; Stoffel, E., Korthase, A., & Gueller, M. (2019). Assessing Trauma for Juvenile and Family Courts. National Council of Juvenile and Family Courts. https://www.ncjfcj.org/wp-content/uploads/2019/07/NCJFCJ_Assessing_Trauma_Final.pdf ; Coalition for Juvenile Justice. (n.d.). Trauma. News & Resources. https://www.juvjustice.org/our-work/safety-opportunity-and-success-project/national-standards/section-i-principles-responding-8

[99] Allen, O., Cocozza, J., Hill, A., Keator, K., Morris, J. & Parker, T. (2016, January). *Strengthening our future: Key elements to developing a trauma-informed juvenile justice diversion program for youth with behavioral health conditions*. National Center for Mental Health and Juvenile Justice at Policy Research Associates, Inc. https://ncyoj.policyresearchinc.org/img/resources/2016-Publication-Strengthening-Our-Future-089881.pdf

[100] National Youth Screening & Assessment Partners. (n.d.). Massachusetts Youth Screening Instrument – Second Version. NYSAP. http://www.nysap.us/maysi2/index.html ; Alix Rivière. April 28, 2022. Personal communication.

[101] Alix Rivière. April 20, 2022. Personal communication.

2. **Trauma Screening in MA State Diversion Learning Labs**

In 2021, the OCA and DYS launched diversion programs in three counties to pilot a statewide diversion model. The programs use the MAYSI-2 screening tool, which includes questions on traumatic experiences, to help identify if further assessment is needed and inform case planning.

3. **Trauma Screening at the MA Department of Youth Services (DYS)**

As described at length in the *Interim Report*, DYS staff use the MAYSI-2 and other screening tools developed internally to identify mental health- and trauma-related issues youth in their care or custody might have.

The use of screening tools differs depending on whether the youth is detained while awaiting adjudication or committed to the custody of DYS. For detained youth, DYS staff administer the above-mentioned screeners before assigning them a room to ensure their physical and emotional safety. When a youth is committed to the custody of DYS, staff conduct a full clinical assessment over a 35-to-40 day period and provide treatment services as indicated.

Arguments in Favor and Against Various Trauma Identification Methods in Juvenile Justice Settings

Whether through observation, conversation, or by using a trauma screening tool, teaching juvenile justice professionals to systematically identify youth's traumatic events and symptoms can help them:

- **Identify supports** that can help youth improve overall functioning and life outcomes and avoid behaviors that, while often a reflection of the youth's adaptation to difficult life situations, could potentially lead to involvement with the delinquency system. Indeed, youth who have experienced trauma may be more impulsive and more susceptible to peer pressure than those who haven't.[102] Additionally, identifying how trauma has impacted a youth and referring them to appropriate services can help promote positive development.
- **Inform case management** and decision-making processes. Trauma screening tools or directed conversations can reveal potential triggers and situations that could lead to re-traumatization or lead to behaviors that could be a violation of their terms of probation.

The pros, cons, and considerations of various trauma identification methods described in Part 1 (e.g., resource constraints, opportunities for bias, potential for "missing" some youth in the process) all apply in juvenile justice settings.

More specific to juvenile justice settings, however, some practitioners have expressed concern about how information about trauma a youth may have experienced is used *during court proceedings* due to the possibility that revealing information about a youth's trauma may inadvertently lead to deeper court involvement. For example:

- NCTSN warns defense attorneys that information on trauma disclosed to court personnel or court-contracted practitioners can potentially impact the youth's legal case. NCTSN therefore urges defense attorneys to have trauma screenings administered "in a way to

[102] VandenWallBlake, R. (2013, November). Considering childhood trauma in the juvenile justice system: Guidance for attorneys and judges. *Child Law Practice Today.* https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/child_law_practice/vol_32/november-2013/considering-childhood-trauma-in-the-juvenile-justice-system--gui/

ensure that information is kept confidential until the attorney and the client agree that there is a reason to share it with others."[103]

- Court awareness of prior trauma a child may have experienced can negatively impact sentencing in delinquency matters. For example, a national study on youth with previous child welfare involvement facing delinquency charges found that, even controlling for age, gender, race, and offense type, they were less likely to receive probation as a result of their first alleged offense and more likely to be placed in group homes supervised by probation or in correctional settings than youth without previous child welfare involvement.[104]

Finally, as described in Part 1 of this report, effective implementation matters. While trauma identification practices, including the use of trauma screening tools, can help juvenile justice professionals better identify trauma among youth they are working with – research shows that, **without proper training and clear guidance on how to best use the information that is collected, these processes can be ineffective**. For instance, one study of three probation sites utilizing the MAYSI-2 in other states found that it was used inconsistently and often too late in the assessment process to effectively inform case management.[105] Other studies show that Probation Officers' identification of trauma (regardless of method) does not necessarily translate into trauma-informed intervention or case planning.[106]

Recommendations on Trauma Identification in Juvenile Justice Settings

In line with the general principles for trauma-responsive screening practices outlined in Part 1 as well as given the above-mentioned concerns, **the CTTF has decided to focus on trauma identification methods in settings that are able to offer trauma-focused supports and case management** to youth at risk of involvement or involved with the juvenile justice system, namely:

- **Diversion programs**, which allow youth who commit offenses to be directed away from more formal legal involvement. There are many local and state-run diversion programs throughout the Commonwealth.
- **Juvenile Probation**, which provides services and case management for youth involved with the Child Requiring Assistance (CRA) system as well as youth who were adjudicated delinquent or whose case was resolved as a continuance without a finding (CWOF) in delinquency proceedings.
- **The Department of Youth Services** (DYS), which serves youth who are committed to the Department as a result of a delinquency or youthful offender case proceeding, as well as youth who are held in pretrial detention.

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[103] NCTSN, The National Juvenile Defender Center & Center on Children and the Law. (n.d.). Trauma-informed legal advocacy: A resource fo rjuvenile defense attorneys. https://www.nctsn.org/sites/default/files/resources/resource-guide/trauma_informed_legal_advocacy_a_resource_for_juvenile_defense_attorneys.pdf

[104] Ryan, J. P. et al. (2007). Maltreatment and delinquency: Investigating child welfare bias in juvenile justice processing. *Children and Youth Services Review 29*, 1035-1050. https://doi.org/10.1016/j.childyouth.2007.04.002

[105] Guy, L., Vincent, G., Grisso, T. & Perrault, R (205, September). Advancing the use of risk assessment in juvenile probation. UMass Medical School and Systems and Psychosocial Advances Research Center. https://www.ojp.gov/pdffiles1/ojjdp/grants/249155.pdf

[106] Holloway et al. (2018). Juvenile probation officers' evaluation of traumatic event exposures and traumatic stress symptoms as responsivity factors in risk assessment and case planning. *Law and Human Behavior, 42*(4), 369-384. https://pubmed.ncbi.nlm.nih.gov/29620395/ ; Maschi, T. & Schwalbe, C. (2012). Unraveling probation officers' practices with youths with histories of trauma and stressful life events. *Social Work Research, 36*(1), 21-30. https://doi.org/10.1093/swr/svs007.

Recommendations for Diversion Programs

Given the high prevalence of trauma and mental health issues among youth involved with the juvenile justice system, organizations such as the National Center for State Courts and NCTSN advocate for the use of standardized screeners to identify trauma and mental health issues for youth who are diverted from deeper involvement in the legal system.[107]

As the JJPAD report on *Improving Access to Diversion and Community-Based Interventions for Justice-Involved Youth* noted, there is wide variation in diversion policies and practices throughout the Commonwealth and no state entity currently provides oversight of all diversion programs.[108] To date, it is the CTTF's understanding that **most diversion programs in Massachusetts (aside from the programs currently operated under contract by DYS) do not screen youth for trauma,** and it is unclear if and how diversion coordinators in other programs collect and use knowledge about a youth's trauma for diversion case management in most programs.

The CTTF believes **screening or using other trauma identification methods as part of a broader identification of mental health needs can be beneficial to youth, but only under the following circumstances:**

- Screening and/or inquiries regarding trauma should only be conducted if the youth is involved in a diversion program long enough to provide them with ongoing services, and if the screening results are used to inform case management and service referrals. In some circumstances, diversion is a short and informal process – e.g., requiring a youth perform a short amount of community service – and does not include ongoing case management. In those cases, screening is not recommended given that there would be little opportunity to effectively use the information collected.
- The use of a screening or discussions regarding trauma should only be done by a trained practitioner, preferably a dedicated case manager (i.e., not a police officer or a prosecutor).
- Screening or other forms of trauma identification should be used to help the diversion case manager determine how best to support youth for success in the diversion program; information *should not* be a factor in whether youth is diverted.
- Screening or discussions regarding trauma should be administered within strict confidentiality procedures to ensure information from a screening is never used in any legal proceedings.
- Participation in the screening process or answering questions about potential traumas should be optional for the youth and their family; whether or not the youth is diverted should not be contingent on participation or answering these questions.

Recommendations for Juvenile Probation

Juvenile Probation, a division of the Massachusetts Probation Service, has a large role to play in helping youth involved in the CRA system as well as those supervised on a delinquency case receive

[107] National Judicial Task Force to Examine State Courts' Response to Mental Illness. (2022, March). Juvenile justice mental health diversion: Guidelines and principles. National Center for State Courts. https://www.ncsc.org/__data/assets/pdf_file/0029/74495/Juvenile-Justice-Mental-Health-Diversion-Final.pdf

[108] Juvenile Justice Policy and Data Board. (2019, November). Improving Access to Diversion and Community-Based Interventions for Justice-Involved Youth. Mass.gov. https://www.mass.gov/doc/jjpad-board-2019-report-improving-access-to-diversion-and-community-based-interventions-for-justice-involved-youth/download

needed supports and achieve goals set through their respective court orders or CRA processes. The role of Juvenile Probation is to monitor and support youth in following court orders. To do so, JPOs collect a variety of information about youth that they supervise, develop individualized case management strategies to facilitate successful intervention, and also help ensure clear communication and coordination among the multiple actors involved with the youth (e.g., schools, providers, caregivers).

To date, Juvenile Probation Officers (JPOs) do not use a structured tool to assess the mental health- and trauma-related needs of youth they supervise. Instead, on a case-by-case basis, JPOs may recommend that a judge refer youth to the Court Clinic for a full assessment. As mentioned in Part 1 of this report, some individuals caution that such an approach can leave room for bias and is less systematic than screening, creating the opportunity to under- or overidentify specific groups of youth based on symptoms, age, race, ethnicity, sexual orientation or gender identity, etc. This is particularly the case if the JPO has limited experience with behavioral health issues and/or has not received sufficient training in how to recognize a wide range of signs and symptoms of trauma. It is for this reason that many Probation departments across the country have adopted the use of a standardized behavioral health screener, as described above.

Given that understanding how behavioral health issues, including trauma, can impact youth's overall functioning, their involvement with state systems, and their receptiveness to probation supervision can help JPOs effectively interact with the youth they supervise, **the CTTF recommends Juvenile Probation:**

- Systematically use a mental health and trauma screening tool (such as the MAYSI-2) for youth involved in the CRA system and those supervised on a delinquency case.
- Implement this tool in accordance with the recommendations in Part 1, including incorporating the screening results in case planning and management and ensuring youth who are identified as needing behavioral health and trauma-related supports receive them.

Recommendation for the Department of Youth Services

Given DYS' robust trauma screening and assessment procedures and policies already in place, the CTTF does not have any further recommendations to make on trauma identification at DYS.

Recommendations for State Support

The CTTF recommends the state continue to assist professionals working at Probation, DYS, and local or state diversion programs on increasing their capacity to identify and support children impacted by trauma by providing training and technical assistance to:

- Increase juvenile justice professionals' understanding of the prevalence and impact of trauma as well as how trauma can present and affect youth's involvement in the juvenile justice system.
- Help organizations working with youth at risk or already involved in the legal system select an appropriate trauma identification method (including a trauma screening tool) that best fits the organization's capacity as well as the youth's current situation, developmental capacities, spoken language, and family circumstances.
- Help juvenile justice organizations develop clear policies on the administration of trauma identification methods, including trauma and mental health screening tools, as well as how

to use identification/screening results for case management and referral to appropriate services.

CHILD WELFARE

Children involved with child protective services are more likely to have been exposed to traumatic events and suffer from traumatic stress than their peers in the general population. It is estimated, for instance, that 70% of children in foster care suffer from complex trauma.[109] The trauma of maltreatment is often compounded by experiences of discrimination, poverty, or community violence, but also by a child's involvement with the child welfare system. Indeed, court involvement, home removals, and repeated changes in out-of-home placements can be highly traumatic.

In addition to keeping children safe from harm, agencies and organizations in the child welfare system are increasingly working to support family preservation and meaningfully improve the lives of children and their caregivers. As part of these efforts, child welfare agencies and organizations have focused on implementing trauma-informed and responsive policies and practices. As discussed in other sections of this report, being able to identify the types and impacts of trauma is an integral part of trauma-informed care. To do so, organizations that are part of child welfare systems need systematic ways to identify potentially traumatic events and symptoms to inform decision-making as well as case management and planning.

What organizations are part of the Child Welfare System?

While the term child welfare is often used to describe child protective services, it more accurately describes a group of public and private organizations that are focused on ensuring that children live in safe, stable, and nurturing environments. The CTTF includes the following in its definition of child welfare system:

- The Department of Children and Families (DCF)
- Foster homes and congregate care providers
- Family/Juvenile courts
- Community-based organizations offering family wellbeing and preservation services, including but not limited to Family Resource Centers (FRCs), Early Intervention programs, home visiting programs, Head Start and Early Head Start, and mental health treatment providers

Research demonstrates that implementing trauma-responsive practices, including ensuring staff have the capacity to identify potentially traumatic events and trauma-related reactions, produces better outcomes for children involved with child welfare services.[110] Benefits of being able to identify trauma and respond appropriately with trauma-responsive case planning/management and referrals include:

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[109] Tullberg, E et al. (2017). The Atlas Project: Integrating Trauma-Informed Practice into Child Welfare and Mental Health Settings. *Child Welfare 95*(6), 107-125.

[110] For examples of benefits of trauma-informed courts see: Casey Family Programs. (2019, November). How does the Safe Babies Court Team approach improve outcomes for infants and toddlers? Casey.org https://www.casey.org/media/SF_Safe-Babies-Court-Teams_fnl.pdf. For examples of benefits of trauma-informed child protective services see: Murphy, K., Moore, K., Redd, Z. & Malm, K. (2017, April). *Children and Youth Services Review, 75*, 23-34. https://doi.org/10.1016/j.childyouth.2017.02.008; Lang, J. (2019, May). Building a trauma-informed child welfare system. Child Health and Development Institute. https://www.chdi.org/our-work/mental-health/trauma-informed-initiatives/concept/

- Improved child and family functioning and wellbeing
- Decreased number of out-of-home placements
- Improved placement stability and permanency outcomes
- Reduced length of stay in out-of-home care
- Reduced use of crisis services and psychotropic medications

Over the past couple of decades, child welfare systems across the nation have increasingly implemented trauma-informed policies and practices. "Baby courts," for example, have spread throughout the country and with it the idea that, by recognizing the signs of trauma and providing the right supports, courts can help minimize the impact of trauma and court involvement on young children and families involved in child welfare cases and greatly improve outcomes.[111]

The federal government has supported this shift toward trauma-responsive practices in child welfare through legislation and grant funding. In the early 2010s, for example, with the support of grants from SAMHSA, the NCTSN, and the Children's Bureau, close to a dozen state and tribal child protective agencies worked to ensure family assessment, case management, and decision-making were trauma-informed and responsive.[112] As discussed further below, Massachusetts used its grant on efforts to enhance DCF's trauma-responsive practices, including increasing the ability of staff, foster parents and others to properly identify and address trauma and increasing the availability of trauma-focused evidence-based treatments. Other states, including Connecticut, Michigan, and Louisiana, chose to focus on the implementation of a trauma screening tool in particular.

To provide context for the CTTF recommendations on trauma identification in Massachusetts' child welfare system, this section of the report details:

1. Examples of child welfare agencies and organizations using observation and discussion to identify children impacted by trauma
2. Examples of child welfare agencies and organizations using trauma screening to identify children impacted by trauma
3. Arguments in favor and against solely using observation/discussion to identify trauma in child welfare
4. Arguments in favor and against the use of screening tools to identify trauma in child welfare

Examples of Child Welfare Agencies and Organizations Using Observation and Discussion to Identify Children Impacted by Trauma

Those working with children and families involved with the child welfare system are often professionally trained to look for signs of trauma and talk to children and families about some of

[111] Center for the Study of Social Policy. (n.d.). Infant-Toddler Court Program. https://cssp.org/our-work/project/infant-toddler-court-program/#story

[112] For a review of these initiatives, see for instance: Murphy, J. & Ingoldsby, E. (2020, September). Trauma-informed innovative practices: Insights from the Children's Bureau discretionary grantees on addressing trauma in child welfare. James Bell Associates. https://www.jbassoc.com/wp-content/uploads/2020/09/Trauma-Informed-Innovative-Practices.pdf as well as the CTTF April 2022 presentation: https://www.mass.gov/doc/cttf-april-4-2022-meeting-presentation/download

the trauma they have experienced. While some child welfare professionals are specifically trained in interview techniques, others rely on experience gained from working with families.

1. MA Department of Children and Families

Like many other child protective services agencies in the U.S., the Massachusetts Department of Children and Families (DCF) has a multi-pronged approach to identifying potential trauma, including observation and discussion with caretakers, the child as well as service providers and collaterals to collect information on potentially traumatic events a child might have experienced, both at intake and throughout the course of a case, and reactions they might have had to these events. As per federal legislation, children in an out-of-home placement are also provided Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.[113]

In recent years, the Commonwealth has built upon the work of the Massachusetts Child Trauma Project (MCTP), which was a federally-funded initiative (2011-2017) to integrate trauma-informed care into the state's child welfare system.[114] In particular, MCTP focused on training staff at the Department of Children and Families (DCF) as well as foster parents and providers on trauma-informed care, expanding the availability of trauma-focused evidence-based treatments across the state, and developing a trauma assessment and referral system (LINK-KID).[115] To ensure the continued implementation of trauma-responsive practices after the grant ended, MCTP established in each Area Office Trauma-Informed Leadership Teams (TILT) bringing together DCF staff, mental health providers, and other community partners.

DCF continues to incorporate trauma-informed care throughout the agency's interactions with children and their families. One way the Department does so is by providing training on the impact of trauma to all new social workers as well as recurrent opportunities for its 4,200+ staff to learn more about trauma-responsive practices (e.g., Psychological First Aid, de-escalation strategies related to reactions to trauma), secondary traumatic stress, and the intersection of trauma and culture—among other trauma-related topics.[116] Recurrent opportunities also include partnerships with universities to offer trauma certificate programs to master's level social workers. DCF also provides information to foster parents on how trauma may present itself and tips on how caregivers can respond to it through the Massachusetts Approach to Partnerships in Parenting (MAPP) trainings and those offered virtually (both live and through an e-learning platform) by the MSPCC.[117]

As documented in publicly available policies, DCF caseworkers collect different types of trauma-related information to inform what next steps should be taken at various process points of DCF's

[113] Centers for Medicare and Medicaid Services. (n.d.). Early and Periodic Screening, Diagnostic, and Treatment. Medicaid.gov. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

[114] Crime Solutions. (n.d.). Program profile: Massachusetts Child Trauma Project (MCTP). National Institute of Justice. https://crimesolutions.ojp.gov/ratedprograms/656#pd

[115] Child Trauma Training Center. (n.d.). LINK-KID: A centralized referral service. UMass Chan Medical School. https://www.umassmed.edu/cttc/cttc-services/link-kid/

[116] Massachusetts Department of Children and Families. (n.d.). MA DCF Training plan (2020-2024). Mass.gov, https://www.mass.gov/doc/dcf-training-plan-2020-2024/download

[117] Massachusetts Department of Children and Families. (n.d.). Massachusetts Approach to Partnerships in Parenting (MAPP) trainings. Mass.gov. https://www.mass.gov/guides/massachusetts-approach-to-partnerships-in-parenting-mapp-trainings ; MSPCC. (n.d.). Online foster care training videos. MSPCC.org. https://www.mspcc.org/online-foster-care-training-videos/

involvement with families.[118] For example, during the Protective Intake phase, when DCF responds to a 51A report of suspected maltreatment, response workers inquire about potentially traumatic events related to the caregiver and their capacity to parent to assess the child's safety and risk of maltreatment. If DCF decides a case should be opened, caseworkers then engage in an assessment of a family's functioning, parental capacities, and child's safety, risks, and wellbeing to inform actions, tasks, and supports needed by each household member. In this phase of DCF's involvement with families, case workers collect more information on trauma-related behaviors and symptoms.

In practice, DCF social workers observe and talk about both trauma events and reactions throughout their work with children and families. Depending on the urgency of a situation, the acuity of behavioral health concerns, and the social worker's experience and clinical knowledge, information about a child and family's trauma may come up at various stages of a case and impact case management practices differently. Caseworkers regularly refer children with acute trauma-related behavioral health needs to partner organizations offering trauma-focused clinical services throughout the Commonwealth. Issues regarding trauma and its impact on clinical formulation and case planning are also commonly discussed during case reviews with caseworkers and supervisors.

While the Department's policies provide general guidance for case workers to follow with regards to the types of questions to ask and how to integrate the information into case planning, these policies – even combined with supervision and case consultation – cannot fully account for DCF staff's varying levels of experience and clinical knowledge on trauma as well as the competing priorities of cases that are often very complex. Over the years, DCF has added and currently has a variety of clinical specialists with expertise in specific topics, including domestic violence, substance use, mental health, and developmental disabilities, to support staff in identifying and assessing trauma and related concerns.

2. Congregate Care Providers

Understanding the negative impact that out-of-home placements in residential settings can have on children involved with the child welfare system, congregate care providers throughout the U.S. are also increasingly working on enhancing their capacity to recognize signs of trauma among the children they serve and respond to challenging behaviors in a trauma-informed manner.

Some congregate care providers are adopting trauma-responsive and evidence-based practices such as Risking Connections and the Restorative Approach, which include training staff on identifying trauma and its impact through observation and engagement.[119] A 2019 study implementation of Risking Connections in five child congregate care agencies demonstrated that the training significantly increased staff's knowledge and implementation of trauma-informed care principles as well as their beliefs in the importance of these principles in their work.[120]

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[118] Massachusetts Department of Children and Families. (2021, May). Protective intake policy. Mass.gov https://www.mass.gov/doc/dcf-protective-intake-policy/download; Massachusetts Department of Children and Families. (2021, August). Family assessment and action planning. Mass.gov. https://www.mass.gov/doc/family-assessment-action-planning-policy-2/download.

[119] Brown, S. M., Baker, C. N., & Wilcox, P. (2012). Risking connection trauma training: A pathway toward trauma-informed care in child congregate care settings. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(5), 507–515. https://doi.org/10.1037/a0025269 ; Trauma Stress Institute. (n.d.) Restorative Approach Training. https://www.traumaticstressinstitute.org/services/restorative-approach-training/

[120] Brown, S. M., Baker, C. N., & Wilcox, P. (2012). Risking connection trauma training: A pathway toward trauma-informed care in child congregate care settings. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(5), 507–515. https://doi.org/10.1037/a0025269

Examples of Child Welfare Agencies and Organizations Using Screening to Identify Children Impacted by Trauma

Some agencies and organizations in child welfare systems across the U.S. are using trauma screening tools to identify the type(s), chronicity, and impact trauma has on children they work with.[121]

1. Child Protective Services

Some child protective services agencies have implemented this approach to trauma identification. Depending on the jurisdiction, screening takes place:

- **At intake**, once the agency has established the need for state involvement. The goal of screening children for trauma at this point is often to promote child well-being, improve family functioning, and avoid out-of-home placement. Louisiana, for example, chose to use a trauma screening tool in all open cases as the first step toward improving the functioning of children who have trauma-related psychiatric problems and to provide a structure for caseworkers to discuss trauma with families.[122] In North Carolina, some counties use trauma screening tools as part of their intake and assessment process, while others opted to use a screener when a child is receiving in-home services.[123]
- **Before out-of-home placement**, to inform placement decision and service needs. Caseworkers in some North Carolina counties use a trauma screening tool to match specific trauma exposures with foster parents' skills and experiences, match caregivers and providers to child's individual needs, and identify potential triggers to avoid inadvertent re-traumatization.[124]
- **After out-of-home placement**, to improve placement stability. Connecticut's child protection agency administers a trauma screen to all children three years and older shortly after a home removal during the child's Multidisciplinary Evaluation, which results in a comprehensive report, including recommendations regarding the child's trauma-related needs.[125]

2. MA Family Resource Centers

Depending on the needs of the child and family, Family Resource Centers (FRCs) in Massachusetts can use a screening tool that asks questions tangentially related to trauma. When a family comes to an FRC to help resolve a youth's behavioral health issues or concerns around family functioning, FRC staff may complete a Child Screening Information Form at intake to gather information on the child's education, physical/mental health, physical/emotional safety, involvement with state agencies, and civic engagement. While this screening tool asks a few questions related to trauma

[121] For more information on how child welfare agencies across the U.S. have used trauma screening tools, see the PowerPoint presentation of the CTTF's April 2022 meeting: https://www.mass.gov/doc/cttf-april-4-2022-meeting-presentation/download

[122] Scheeringa, M.S., Mai, T.A. (2018). Louisiana Child Welfare Trauma Project (LCTP): Background, Implementation, and Results. https://www.michaelscheeringa.com/uploads/1/2/0/2/120202234/lctp_background_implementation_and_results.pdf

[123] Project Broadcast. (2018, October). *Companion Guide for the Project Broadcast Trauma Screening Tool.* North Carolina.

[124] Project Broadcast. (2018, October). *Companion Guide for the Project Broadcast Trauma Screening Tool.* North Carolina.

[125] Lang, J. (2021, September). Trauma screening in child welfare (and beyond): Presentation to the Childhood Trauma Task Force. Mass.gov. https://www.mass.gov/doc/dr-jason-lang-ct-presentation-trauma-screening-child-welfare/download

(e.g., "has this child/youth witnessed violence?"), its primary aim is to better understand youth's behavioral health needs, not what potentially traumatic events youth experienced and how it has impacted them.

Staff can also use the Family Strengths and Needs Assessment (specifically designed for MA FRCs) to better understand a wide range of needs caregivers and their children might have, ranging from housing, transportation, and employment to physical and behavioral health supports—including trauma-related ones. This wide-ranging assessment can be used to evaluate caregivers' capacity to cope with trauma experienced by their children as well as the latter's adjustment to traumatic life events. Given the breadth of this assessment tool, which includes thirty-eight domains for caregivers and twenty-four for children, it can take multiple visits for FRC staff to get a full picture of a family's needs.

What are Family Resource Centers?

FRCs were originally established to help youth whose behavioral health issues put them at risk of being involved with the Child Requiring Assistance (CRA) system. Today, FRCs are family-focused hubs of support that provide a wide range of services to children and caregivers, including referrals to trauma-focused services.

For more information, see: https://www.frcma.org/

3. Family/Juvenile Courts

Family/Juvenile courts hearing child welfare cases are also increasingly making use of trauma screening practices to better understand the trauma-related roots of family dysfunction and needs. For example, in the family treatment court models implemented in jurisdictions throughout the U.S., professionals working in the courts and in partner organizations are not only trained to recognize the signs and symptoms of trauma, but they are also encouraged to use screening and assessment to better identify children and parents' trauma-related needs as well as those related to social determinants of health.[126] Another example of trauma-responsive court practices is the National Infant-Toddler Court Program, which brings together various stakeholders to provide trauma-responsive services, including timely screenings, assessments, and referrals as early as possible in the case process.[127]

Arguments in Favor and Against Solely Using Observation and Discussion to Identify Trauma

Some argue that, with adequate training, observation and discussion are effective and sufficient to identify potentially traumatic events children might have experienced as well as trauma-related symptoms and behaviors. In particular, because this approach is less resource intensive, it can more easily be embedded in existing staff training and doesn't require the organization-wide buy-in that implementing trauma screening practices does.

At the same time, others argue that this approach, without clear guidance, policies, and supports, might not lead to a universal, systemic identification of the wide range of traumas that might impact a child's wellbeing and functioning. CTTF discussions with multiple child protective agencies across

[126] Center for Children and Family Futures & National Association of Drug Court Professionals. (2019). Family treatment court best practice standards. Prepared for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Office of Justice Programs (OJP), U.S. Department of Justice (DOJ). https://www.nadcp.org/wp-content/uploads/2019/09/Family-Treatment-Court-Best-Practice-Standards_Final2.pdf.
[127] Zero to Three. (n.d.). Safe Babies Court Teams. https://zero-to-three-review.herokuapp.com/resources/services/safe-babies-court-teams.

the U.S. revealed that, without a concrete list of traumatic events to inquire about, caseworkers could sometimes miss traumas unrelated to the family's functioning, such as those associated with hospitalizations, medical procedures, loss or separation from a loved one, forced migration, community violence, race-based violence, environmental or man-made disasters.

Finally, as discussed in other sections of this report, some argue that relying solely on observation and discussion can leave room for bias and is less systematic than screening, creating the opportunity to under- or overidentify specific groups of youth based on symptoms, age, race, ethnicity, sexual orientation, or gender identity. This is particularly the case if the "observer" has limited experience with behavioral health issues and/or has not received sufficient training in how to recognize a wide range of signs and symptoms of trauma.

Arguments in Favor and Against the Use of Screening Tools to Identify Trauma

The *Interim Report*'s description of trauma screening initiatives in child protection agencies shows that some jurisdictions have successfully used trauma screeners to operationalize trauma-informed care, avoid out-of-home placements or inform placement decisions when needed, as well as increase placement stability.

Importantly, the CTTF's review of states implementing trauma screening in their child welfare systems demonstrates that, in many cases, **the use of a screening tool elicited new information regarding children's traumatic experiences and/or symptoms**. For example, a survey of Connecticut caseworkers having administered the trauma screen to youth and caregivers revealed that 45% of staff learned new information about the youth's trauma history and 27% reported the results led to changes in the child's treatment plan. Close to 70% reported the information learned from the screening was worth the time it took to administer.[128]

At the same time, important challenges to sustaining trauma screening practices have caused some jurisdictions to reduce or end the use of trauma screening tools in their child welfare systems.[129] Challenges in implementing and sustaining trauma screening practices include:

- **Resource intensity:** Child welfare agencies throughout the U.S. are often understaffed, leading many caseworkers to having a higher-than-recommended caseloads and needing to work overtime, which can lead to high turnover rates in child protection agencies.[130] Adding trauma screening tools is thus seen by some as an additional step that may not necessarily result in different outcomes for children. Additionally, implementing screening procedures requires investments of both time and money.
- **The need for organization-wide buy-in:** Both leadership and staff commitment to the use of screening tools to identify trauma is necessary to ensure the practice is effective and useful. Screening initiatives reviewed by the CTTF revealed that early identification and ongoing involvement of key supporters in leadership and staff was essential to the success of these projects.

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[128] Child Health and Development Institute of Connecticut. (2020). Issue Brief 75: Screening Youth in the Child Welfare and Juvenile Justice Systems for Trauma. https://www.chdi.org/publications/issue-briefs/issue-brief-75/

[129] This is the case for Louisiana, Montana, and New York City, for instance.

[130] Kim, J., Yi, E. H., Pierce, B., & Hall, J. (2019). Effective workload management in child welfare: Understanding the relationship between caseload and workload. *Social Policy & Administration, 53*(7), 1095-1107. https://ncwwi-dms.org/resourcemenu/resource-library/workload/1510-effective-workload-management/file

- **Lack of implementation flexibility:** The CTTF's review of trauma screening practices in child welfare systems throughout the U.S. revealed that what works in theory might significantly differ from what can be done in practice and that child protective services agencies must therefore be able to study implementation and open to revising plans as necessary.

Finally, many argue that without meaningful ways to respond to screening results given the existing lack of trauma-focused services and significant wait times to access these services, screening children for trauma would be ineffective and could in fact be harmful and unethical.

Recommendations

In the past couple of decades, organizations and agencies that are part of the child welfare system have slowly begun shifting away from models that focus solely on protecting children from maltreatment and towards models that promote child and family wellbeing by focusing on preventative supports and trauma-responsive care. The following recommendations are meant to bolster efforts organizations and agencies in Massachusetts' child welfare system are already engaged in to identify and support children impacted by trauma.

Recommendations for the Department of Children and Families

The CTTF recommends DCF continue to strengthen existing practices and policies to systematically identify children affected by trauma and incorporate trauma-related information in its assessment and case planning process. In particular, the CTTF recommends DCF:

- **Collect and record information regarding potentially traumatic events not directly related to the family environment**, including those related to medical injuries, hospitalizations, accidents, community violence, bullying, race-based violence, environmental and man-made disasters, etc. Doing so at intake and throughout the course of an open case could help ensure that caseworkers identify and record relevant information that could help prevent retraumatization as well as match specific trauma exposures with foster parents' skills/experience.
- **Strengthen existing procedures to collect developmentally attuned information on trauma-related behaviors**. In particular, DCF could provide additional guidance to caseworkers to help them better identify possible relational or attachment difficulties that might indicate a traumatic stress response in young children.
- **Incorporate ways to consistently identify the frequency and acuity of possible trauma-related behaviors and symptoms** to help prioritize children in need of further trauma-focused services (e.g., assessment or clinical treatment).

The CTTF recognizes that, while the use of a trauma screening tool provides a clear structure to collect trauma-related information, implementation of these tools poses important challenges to child protective agencies and may not be the best trauma identification approach for DCF. The Department can nevertheless ensure **structured** and **systematic** trauma identification practices by:

- **Ensuring changes in trauma identification practices are embedded in guidance or policy** so that they last, regardless of leadership transitions or staff turnover. This could include updating the Department's Protective Intake and Family Assessment and Action

Planning policies to reflect the changes recommended above to increase the systematic identification of potentially traumatic events and trauma-related behaviors and symptoms.

Additionally, the Department could add to the Family Assessment and Action Planning policy a list of suggested questions caseworkers can ask to assess if a child has any potential trauma-related behaviors or symptoms. This "checklist" can help guide busy caseworkers and ensure important behaviors or symptoms aren't missed. These questions should be developmentally attuned and include different questions depending on the child's age and developmental capacity as well as information regarding the frequency of reactions experienced to assess acuity and needs.

- **Adding additional functionalities to DCF's electronic record system (i-FamilyNet)** to ensure caseworkers can easily see the sum total of information related to a child's traumas to help inform the development of a clinical formulation and family action plan**.** As the repository of all of the information about a child and their family with an open case, i-FamilyNet contains different sections that inform case management and planning (e.g., Intake/Responses, Demographics, Services/Placements). Each section contains various tabs and prompts that guide clinical decision making. The CTTF recommends DCF add functionalities that help guide caseworkers' trauma-responsive case practice. For example, the "Important Observations" section could include a prompt to detail a child's trauma experiences to help avoid retraumatization at various stages of DCF involvement.

The CTTF is aware that recent statutory requirements amended by *An Act Addressing Barriers to Care for Mental Health* (2022) may lead to changes to the Department's policy regarding steps taken during a medical examination for children entering DCF placement or custody. Indeed, the new legislation requires physicians who examine children in DCF custody to assess children's behavioral health and trauma-related needs.[131] The CTTF applauds the Legislature's passage of this legislation and hopes this report's recommendations can help inform changes in policies needed to increase identification of trauma-related needs for children in DCF care.

Recommendations for Family Resource Centers

The CTTF notes that FRCs already have screening and assessment practices as well as trauma training requirements that provide opportunities to introduce further trauma identification and screening practices without needing extensive organizational and policy changes. The CTTF therefore suggests FRCs integrate the following recommendations within existing practices and structures whenever possible:

- **Continue to prioritize identification of trauma as potential explanation for behavioral issues and family dysfunction** that are leading families to the FRC, which may include continuing trainings for staff (especially new staff) on trauma and its impacts on children.
- **Conduct selective trauma screening** for children and caregivers in specific circumstances, such as (but not limited to) families coming to FRCs to help solve challenges around their

[131] The new statutory requirements amended by *An Act Addressing Barriers to Care for Mental Health* (2022) require that DCF *"ensure that every child, upon entry into the foster care system, shall be screened and evaluated [...] and assessed for behavioral health symptoms and sequelae [...]"* and that *"each child with identified behavioral health needs shall be provided appropriate referrals to related professionals to conduct more comprehensive diagnostic assessment, prescribe treatment and ensure the behavioral health and trauma-related needs of such child are addressed in a timely manner."* https://www.mass.gov/info-details/mass-general-laws-c119-ss-32

children's behaviors or family dynamics to prevent further involvement with state systems and promote healthy family relationships. Screening should be conducted in alignment with the general principles for trauma-responsive screening practices outlined in the first part of this report.

- **Provide support** (e.g., training, policies/procedures, organizational workflow documents) to help Family Partners and Clinicians decide in what circumstances and what type of trauma-focused services (e.g., assessment or treatment) should be recommended to the family based on the results of any trauma identification or screening practices.

Recommendations for Juvenile Courts

The CTTF recognizes that the Juvenile Court is already engaged in adopting trauma-informed and responsive practices, such as the above-mentioned family treatment court best practices, which promote trauma identification.[132]

To further bolster such efforts, **the CTTF recommends courts hearing child welfare cases continue to implement evidence-based practices that prioritize recognizing and responding to trauma in children and caregivers.** In particular, the Task Force recommends courts partner with state agencies and community-based organizations to investigate trauma-responsive models of court practices that focus on infant and toddlers to ensure families with young children who are in foster care or at risk of removal can receive the supports they need and flourish, such as the Safe Babies Court Teams program.[133]

Recommendations for Organizations Working with Families Involved in Child Welfare

As described in the introduction of this section, the child welfare system is composed of many different types of organizations and agencies, including those offering services to prevent maltreatment and support family preservation as well as those that serve youth in foster care. Given the prevalence of trauma and of complex trauma in children involved in child welfare, the CTTF recommends organizations serving families involved or at risk of involvement with child welfare adopt effective ways to identify and refer those who might be experiencing trauma as part of their efforts to build trauma-informed and responsive environments and practices.

While being able to identify children who experience trauma is a critical part of being a trauma-informed and responsive organization, the CTTF recognizes that **there is not a single model of trauma identification that would work in all of these settings**. Given important differences in terms of organizations' functions, resources, and approaches to serving young children, the CTTF recommends organizations serving children and families involved in the child welfare system adopt any of the approaches to trauma identification discussed in this section, following the implementation recommendations described in Part 1 of this report.

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[132] Office of Juvenile Justice and Delinquency Prevention. (n.d.) Massachusetts PATH court: Prevention and treatment for the health and stability of children and families. https://ojjdp.ojp.gov/funding/awards/15pjdp-21-gk-04497-dgct

[133] Zero to Three. (n.d.). Safe Babies Court Team Approach. National Infant-Toddler Court Program. https://www.zerotothree.org/our-work/itcp/the-safe-babies-court-team-approach/

Recommendations for State Support

The CTTF recommends the state continue to assist professionals working in child welfare on increasing their capacity to identify and support children impacted by trauma by providing training and technical assistance to:

- Increase child welfare professionals and foster parents' understanding of the prevalence and impact of trauma as well as how trauma can present and affect youth's involvement in state systems.
- Help organizations working with children and families at risk or already involved in the child welfare system select an appropriate trauma identification method (including a trauma screening tool if indicated) that best fits the organization's capacity as well as the youth's current situation, developmental capacities, spoken language, and family circumstances.
- Help child welfare organizations develop clear policies on the administration of trauma identification methods, including trauma and behavioral health screening tools, as well as how to use identification/screening results for case management and referral to appropriate services.

With appropriate funding, this support could be provided by the state Center on Child Wellbeing and Trauma.

Additionally, given the importance of system-wide collaboration to effectively identify and support children who receive child welfare services, the CTTF recommends Massachusetts develop a statewide strategy to help organizations and agencies working in silos build constructive and complementary relationships across the child welfare system and other youth-serving systems to support children who have experienced trauma. This strategy should include increased data collection and analysis to better understand the trauma-related needs of children and families involved or at risk of being involved with the child welfare system as well as the state's capacity to meet those needs to help inform service programming and funding decisions.

FIRST RESPONDER SETTINGS

Events that involve first responders (e.g., law enforcement, firefighters, EMTs) are, by nature, potentially highly traumatic. In the immediate aftermath, children who witness or directly experience events that threaten their sense of safety or that of their loved ones can feel disconnected, unbalanced, or even numb. While these are normal reactions to abnormal events that usually last for a few days or weeks, some children can experience prolonged symptoms of PTSD and need support.

Research on witnessing fatal or life-threatening events point to the importance of paying attention to peritraumatic symptoms (i.e., symptoms that occur immediately after the event) and screening immediately following potentially traumatic incidents, as the type and degree of distress experienced is a robust predictor of later PTSD. [134] Because of this, **the American Academy of Pediatrics advocates for the identification of trauma symptoms shortly after the event takes place** to triage emergency cases.[135]

As described in the CTTF's *Interim Report,* some jurisdictions have developed programs where children are screened for traumatic stress reactions following events involving first responders. The Child Development-Community Policing program in Charlotte-Mecklenburg County, NC, for instance, ensures that mental health professionals are on call 24/7 to assist law enforcement at a scene involving children who are victims or witnesses to violence. Among the trauma screening tools at their disposal, clinicians use an ANS (Autonomic Nervous System) measure for immediate indicators of emerging trauma responses within 12 hours of a critical incident.[136]

The CTTF's study of successful initiatives that identify trauma in first responder settings revealed that they share four core components:

- **Collaboration** between first responder (usually law enforcement) and child trauma professionals (e.g., social worker, clinician)
- The use of a **trauma screening tool** by child trauma professionals
- A strong **referral system** to behavioral health or trauma-specific services as well as family support services (e.g., housing, food)

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[134] Song, S-H., Kim, B-N., Choi, N-H., Ryu, J., McDermott, B., Cobham, V., Park, S., Kim, J-W., Hong, S-B., Shin, M-S., Yoo, H-J., Cho, S-C. (2012, May). A 30-month prospective follow-up study of psychological symptoms, psychiatric diagnoses, and their effects on quality of life in children witnessing a single incident of death at school. *The journal of Clinical Psychiatry 73*(5):594-600. https://pubmed.ncbi.nlm.nih.gov/22697206/ ; Bui, E., et al. (2010, May-June). Peritraumatic reactions and posttraumatic stress symptoms in school-aged children victims of road traffic accident. *General Hospital Psychiatry 32*(3), 330-333. https://doi.org/10.1016/j.genhosppsych.2010.01.014.

[135] Forkey, H., Szilagyi, M., Kelly, E. T., Duffee, J., & Council on Foster Care, Adoption, and Kinship Care, Council on Child Abuse and Neglect, Committee on Psychosocial Aspects of Child and Family Health. (2021). Trauma-Informed Care. *Pediatrics*, *148*(2), e2021052580. https://doi.org/10.1542/peds.2021-052580

[136] See The Child Development-Community Policing Program: https://medicine.yale.edu/childstudy/communitypartnerships/cvtc/cdcp/ ; Massachusetts Childhood Trauma Task Force. (2021, October 4). *Childhood Trauma Task Force* [PowerPoint slides]. Office of the Child Advocate. https://www.mass.gov/doc/cttf-october-4-2021-meeting-presentation/download

- **Training** for both first responders and child professionals on child development/trauma as well as profession-specific procedures

While the CTTF is not aware of any first responder-child trauma professional program in the Commonwealth that incorporates trauma screening practices, some cities have implemented programs aimed at supporting children following traumatic events. The city of Chelsea, for instance, has developed the Police Action Counseling Team (PACT), a partnership between MGH Chelsea and the Chelsea Police Department to help identify children who are victims of or witness to violence and other trauma. Upon being called by law enforcement, a social worker provides age-appropriate interventions and psychoeducation to help children express their feelings and concerns and ensure parents are equipped to respond to their children's potential responses to trauma in the future. Other such initiatives are described at length in previous CTTF reports and presentations.[137]

Recommendations for First Responders

While the above-mentioned trauma screening initiatives are noteworthy efforts, the CTTF believes that first responder organizations need to implement trauma-informed and responsive practices and policies *before* undertaking a resource-intensive screening implementation process.

As a first step, the CTTF recommends first responders increase their capacity to identify and talk to children on the scene of a traumatic event in a trauma-responsive way and refer them to appropriate supports. First responder organizations should make the necessary changes in policies and procedures to ensure that children on the scene of a potentially traumatic event are systematically identified and referred to supports.

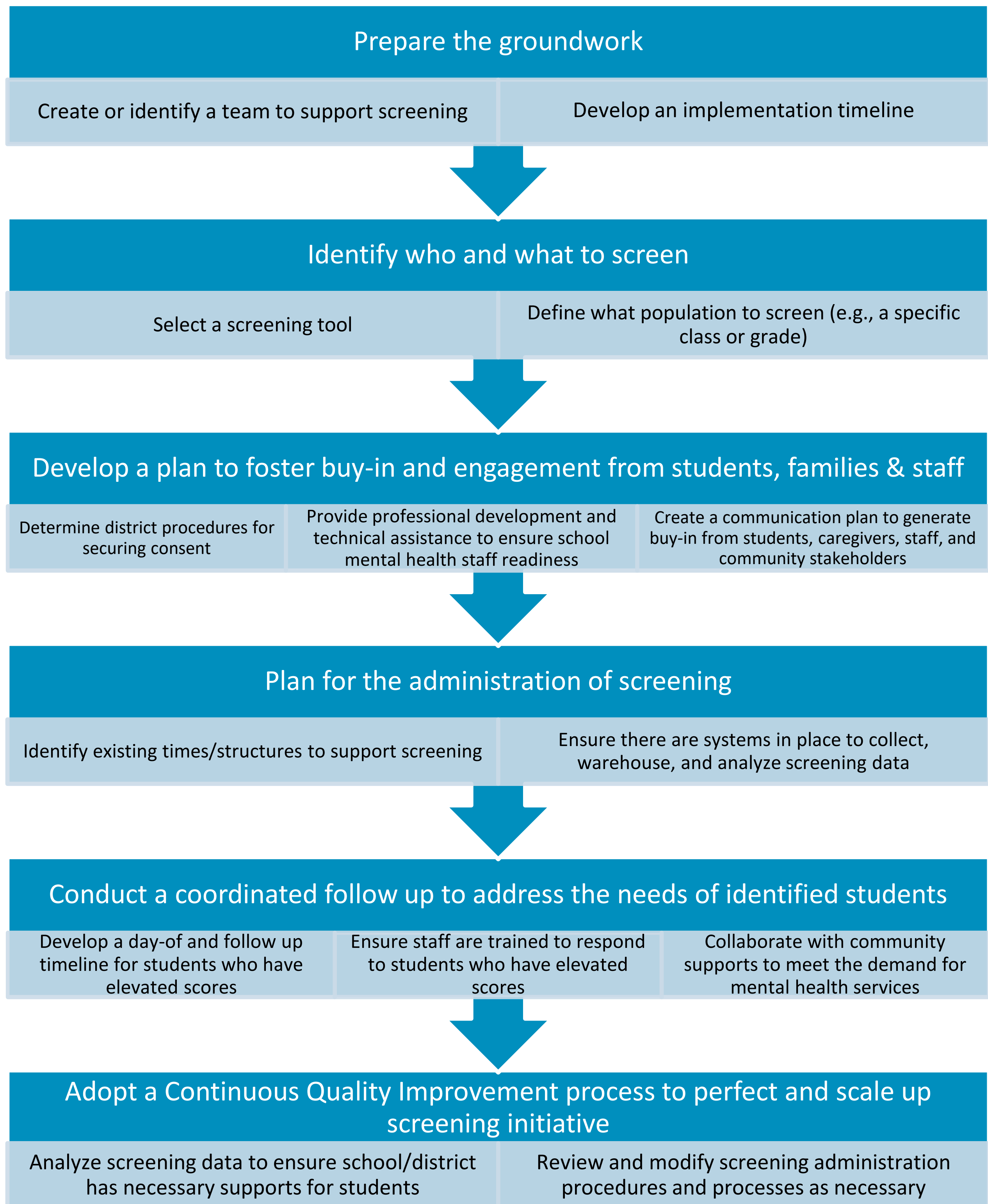
Recommendations for State Support

To support first responders, the CTTF recommends the state provide:

- **Training** on how to identify and talk to children on the scene (in a developmentally appropriate way) and what steps first responders should take.
- **Toolkits** to guide first responders when children are on the scene of a potentially traumatic event. These toolkits could include short action plans or checklists as well as recommendations on ways organizations (e.g., police departments) could include guidance or policies to support identification of children.
- **Funding** to support the development and implementation of first responder-mental health collaboration initiatives across the state, where trained professionals might use screening tools to identify children at risk of experiencing toxic stress.

[137] For more examples of Massachusetts initiatives see: Childhood Trauma Task Force. (2020, December). From aspiration to implementation: A framework for becoming a trauma-informed and responsive Commonwealth, pp. 18-20. https://www.mass.gov/doc/cttf-2020-report-from-aspiration-to-implementation-a-framework-for-becoming-a-trauma-informed/download ; Childhood Trauma Task Force. (2021, December). Identifying childhood trauma: An interim report on trauma screening and referral practices, p. 60. https://www.mass.gov/doc/cttf-2021-report-identifying-childhood-trauma-an-interim-report-on-trauma-screening-and-referral-practices/download ; Childhood Trauma Task Force. (2022, May). May 20, 2022 Presentation. https://www.mass.gov/doc/cttf-may-2-2022-meeting-presentation/download.

Appendix A: Screening Implementation Guidelines for K-12 Schools[138]



[138] This graphic was developed based on CTTF research on local and nationwide screening implementation best practices.

Appendix B: Selecting a Trauma Screening Tool

"Trauma screening" is a broad term used to indicate the use of a standardized questionnaire to help determine whether a child has "experienced trauma, displays symptoms related to trauma exposure, and/or should be referred for a comprehensive trauma-informed mental health assessment."[139] The CTTF's research on trauma identification found that there are dozens of screening tools being used by child-serving organizations to identify children at risk of experiencing trauma.

There are many different types of trauma screeners that differ based on the target population, primary screening purpose, the extent to which it has been developed and validated through a rigorous research process, language, and price. For instance, while many screeners assess behavioral health issues that can point to trauma-related concerns, fewer ask specific questions about symptoms associated to Post-Traumatic Stress Disorder (PTSD). Similarly, the length of screening tools varies considerably, with some having 10 items, while others include 60-110 items.

The plethora of screeners can make it difficult for organizations to decide what tool they should use if they establish that screening is the right trauma identification method for them. This appendix is meant to help guide organizations interested in using a screening tool; it is not a recommended or exhaustive list of trauma screening tools.

Identifying Priorities in a Screening Tool

First, organizations seeking to implement a trauma screening tool should ask themselves the following questions to select the most appropriate screening instrument:

- **What are the particularities of the population to be screened?** Some organizations work with very young children, others with children with developmental delays, others still with children at risk of experiencing community violence or children/families who speak a language other than English. Identifying some of the most important particularities of the children and families served can help organizations narrow down what screening instruments are more appropriate.
- **What does the organization wish to assess through a screener?** As explained above, trauma screeners can identify many aspects of a child's life that puts them at risk of being impacted by trauma. For example, some screeners focus more broadly on a child's environment (e.g., housing, family substance use, caregiver mental health), while others focus on trauma-specific symptoms (e.g., sleep disturbances, attachment difficulties, outbursts of anger, developmental delays). While it might make sense for some child-serving organizations to specifically focus on potentially traumatic events and trauma-related reactions, others might benefit from using a screener that assess the child's environment. This might especially be the case for organizations working with small children, as very few tools screening for trauma symptoms were developed specifically for infants and toddlers.
- **What is the organization's capacity?** The choice of screening tool should match the capacity of an organization to administer it. A few examples of things to consider include:

[139] NCTSN. (n.d.). What is a trauma screening tool or process? The National Child Traumatic Stress Network. https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-screening

- Length of the screener: How much time do staff members have with individual children and families?
- Administration: Does the screener need to be administered by staff or is it filled out by the child and/or their caregiver?
- Expenditure: Is the screening instrument available online for free or is it proprietary? (While many screening tools are free, some developed for specific populations or those that are more clinically oriented are often proprietary)

Resources

Many well-established organizations have developed resources to help child-serving professionals select the screening instrument that best fits their needs. Some instruments were developed with specific sectors in mind, while others can be used by child-serving organizations across sectors. While this document categorizes resources by sector, individual screeners can be used in a wide variety of settings and organizations are encouraged to look at multiple resources to identify their preferred instrument.

Cross-Sector Resources

National Child Traumatic Stress Network

The SAMHSA-funded organization is a go-to resource for child-serving professionals and organizations incorporating trauma-informed and responsive practices and policies in their day-to-day work. As part of its guidance, the NCTSN developed a library of resources on trauma screening (e.g., reports, webinars, toolkits, fact sheets).[140]

In particular, the website hosts an All Measures Reviews database that can be searched for information on any screening tool, including an overview of the tool, information on how to administer it, alternative version of the instrument, a description of psychometric properties and, for many of the instruments, a list of pros and cons.[141]

Additionally, the NCTSN website includes lists of screening tools best suited for specific populations (e.g., "Trafficking Screening Tools," "Recommended Screening Tools for CACs").[142]

UMass Medical School Law & Psychiatry Program

This 2016 review of 11 trauma screening tools for children and adolescents was developed by Dr. Amy Wevodau at UMass Medical School and lists validated instruments that take less than 20 minutes to administer.[143]

The 76-page document lists three types of screening tools:

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[140] The National Child Traumatic Stress Network. (n.d.). NCTSN resources. NCTSN.org https://www.nctsn.org/treatments-and-practices/screening-and-assessment/nctsn-resources
[141] The National Child Traumatic Stress Network. (n.d.). Measure reviews. NCTSN.org. https://www.nctsn.org/treatments-and-practices/screening-and-assessments/measure-reviews
[142] The National Child Traumatic Stress Network. (n.d.). Trafficking screening tools. NCTSN.org. https://www.nctsn.org/resources/trafficking-screening-tools ; The National Child Traumatic Stress Network. (n.d.). Recommended screening tools for CACs. NCTSN.org. https://www.nctsn.org/resources/recommended-screening-tools-cacs
[143] Wevodau, Amy. (2016, January). Review of trauma screening tools for children and adolescents. Available on National Youth Screening & Assessment Partners. http://www.nysap.us/Review%20of%20Trauma%20Screening%20Tools%20for%20Children%20&%20Adolescents.pdf

- Instruments that screen for degree and/or type of exposure to events that have the potential to be traumatizing
- Instruments that screen for symptoms of PTSD
- Instruments that screen for a broader range of symptoms often associated with trauma.

The document provides details on each instrument discussed, including the purpose of the screener, administration procedures, the target population, and training requirements.

Michigan.gov Health and Human Services

As part of its efforts to address trauma, the Michigan Department of Health and Human Services created a short list of trauma screening tools developed by reputable national or academic organizations. The tools included measure adverse childhood events, trauma-related symptoms as well as children's outlook on hope in the face of adversity.

Trauma ScreenTIME

Trauma ScreenTIME is a training and resource website developed by the Child Health and Development Institute in collaboration with NCTSN and SAMHSA.

In addition to providing free, online modules to learn about screening in general, this resource helps child-serving professionals select the right instrument and learn how to analyze results. At the end of the third module, ScreenTIME provides a summary of 19 trauma and adversity screening tools, including some that focus on children's experiences of racism and discrimination, bullying, homelessness, food insecurity, and adverse experiences on the Internet.

Is the ACEs Questionnaire an Appropriate Trauma Screener?

The Adverse Childhood Experiences (ACEs) questionnaire was originally developed for a large-scale study of childhood trauma and its impact in adulthood. In its *Interim Report*, the CTTF laid out the many arguments against the use of ACEs questionnaires to assess children's risk of toxic stress, namely that these questionnaires:

- Are too simplistic and narrow in scope
- Have not been validated by studies
- Do not lead to specific interventions based on scores
- Are poor predictors of health outcomes at the individual level

Recently, the American College of Preventive Medicine has also come out against using ACEs questionnaires as trauma screening tools.

Child Welfare Resources

The Children's Bureau Child Welfare Information Gateway offers resources to help child welfare organizations select a trauma screening tool as well as highlights a couple of instruments, including the Child Trauma Screen used for all children in out-of-home placements in Connecticut.[144]

The Child Trauma Screen is a brief, validated screener for children 6-17 that enquires about five potentially traumatic experiences and asks five questions on trauma-related symptoms—taking into account the frequency and acuity of these trauma reactions.[145]

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[144] Child Welfare Information Gateway. (n.d.). Trauma screening instruments in child protection. Children's Bureau. https://www.childwelfare.gov/topics/responding/iia/screening/trauma-screening-instruments/

[145] Lang, J. & Connell, C. (2021). Child trauma screen. International Society for Traumatic Stress Studies. https://istss.org/clinical-resources/child-trauma-assessments/child-trauma-screen-(cts)

Other child welfare agencies across the U.S. have used Michigan's CTAC Trauma Screening Checklist, a one-page, comprehensive checklist that helps pinpoint emotions, behaviors, attachment concerns, and school problems the child may be experiencing.[146] With two versions (for children 0-5 and 6-18), this screener is particularly attuned to the potential impact trauma can have on the developmental characteristics of young children.

Pediatric Primary Care Resources

The American Academy of Pediatrics (AAP) recently updated its Bright Futures Toolkits of screening instruments and tools commonly used by pediatric primary care providers.[147] The screeners listed are not limited to medical settings and many are used in various child-serving sectors.

While Bright Futures does not include screening tools specifically about trauma, the list includes instruments that assess domains correlated to a heightened risk of toxic stress, including maternal depression, behavioral/social/emotional development, depression, suicide risk, and substance use.

Additionally, the Bright Futures Toolkits includes links to screening tools that assess Social Determinants of Health, including the Safe Environment for Every Kid (SEEK) questionnaire and the Survey of Well-being of Young Children (SWYC), both of which are validated, comprehensive assessments of young children's wellbeing and environments available in multiple languages and used by child-serving professionals across sectors.[148]

Screening for Resilience

As this report notes, child-serving organizations should adopt a strength-based approach when identifying trauma. This can be done by highlighting Positive Childhood Experiences (see p. 21 of this report and pp. 18-20 of the *Interim Report*) while engaging with the child and their family.

Organizations can also opt to use a screening tool highlighting children's resilience and hope, such as:

- The Children's Hope Scale
- The Child & Youth Resilience Measure

To identify symptoms and behaviors associated with trauma, the Utah Pediatric Integrated Post-trauma Services (PIPS) program developed and validated a Pediatric Traumatic Stress Screening tool for children 6-18 as part of their Child Traumatic Stress Care Process Model (CPM).[149] The CPM was created to provide guidance and structure to providers interested in using screening as a way of identifying children who might be experiencing toxic stress. The AAP highlighted this screening tool in its 2021 policy recommendations on trauma-informed care.

Education Resources

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[146] Children's Trauma Assessment Center. (n.d.). Resources. Western Michigan University. https://wmich.edu/traumacenter/resources-0

[147] American Academy of Pediatrics. (2022, June). Bright Futures toolkit: Links to commonly used screening instruments and tools. AAP Publications. https://publications.aap.org/toolkits/resources/15625/Bright-Futures-Toolkit-Links-to-Commonly-Used?searchresult=1

[148] Safe Environment for Every Kid. (n.d.). Home. The SEEK Project. https://seekwellbeing.org/ ; Tufts Medical Center. (n.d.). The Survey of Well-being of Young Children. https://pediatrics.tuftsmedicalcenter.org/The-Survey-of-Wellbeing-of-Young-Children/Parts-of-the-SWYC/Family-Questions

[149] Pediatric Integrated Post-trauma Services. (n.d.). Child traumatic stress care process model. UtahPIPS. https://utahpips.org/cpm/

The School Health Assessment and Performance Evaluation (SHAPE) System helps schools improve their mental health systems by providing technical assistance and free resources to organizations educating children from preschool to high school. As part of their resources, SHAPE System's screening and assessment library hosts a searchable database of free or low-cost screening instruments that fits a school's needs.[150]

[150] School Health Assessment and Performance Evaluation System. (n.d.). The SHAPE System. National Center for School mental Health. https://www.theshapesystem.com/