Identifying Childhood Trauma:

An Interim Report on Trauma Screening and Referral Practices

A Report of the Childhood Trauma Task Force

DECEMBER 2021

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

About the Childhood Trauma Task Force

The Massachusetts 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

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Members of the Childhood Trauma Task Force

Member Name	Appointing Organization
Maria Mossaides	Child Advocate, Chair
Representative Carolyn Dykema^	House of Representatives (Speaker of the House Appointee)
Representative Timothy Whelan^	House of Representatives (Minority Leader Appointee)
Senator Adam Gomez^	Senate (Senate President Appointee)
Senator Patrick O'Connor^	Senate (Minority Leader Appointee)
Thomas Capasso^ **Rachel Wallack***	Juvenile Court
Rick St. Onge	Massachusetts Probation Service
Dr. Yvonne Sparling	Department of Youth Services
Commissioner Linda Spears **Laura Brody**	Department of Children and Families
Michelle Botus* **Andrea Goncalves-Oliveira***	Department of Mental Health
Nicole Daley*	Department of Public Health
Stacy Cabral^	Executive Office of Education
Claudia Dunne	Committee for Public Counsel Services
Kate Lowenstein	Citizens for Juvenile Justice
Tammy Mello	Children's League of Massachusetts
Dawn Christie	Parent of a child who has been subject to juvenile court jurisdiction
* **Abstained from voting on this report** ^ **Was not present to vote on this report**	

The Childhood Trauma Task Force is a Committee of the Juvenile Justice Policy and Data Board.

The CTTF is staffed by the Office of the Child Advocate:

Melissa Threadgill, Director of Strategic Innovation
Kristi Polizzano, Juvenile Justice Program Manager
Alix Rivière, PhD, Research and Policy Analyst
Gabriel Sultan, Research and Policy Analyst
Morgan Byrnes, Project and Research Coordinator

Definitions of Key Terms

Trauma: The CTTF has chosen to use the definition of individual trauma developed by the federal Substance Abuse and Mental Health Service Administration (SAMHSA) in 2014, as this is a commonly referenced definition that is meant to be used across multiple sectors:

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

When a child experiences a traumatic event or series of events, they may have a traumatic response, which could be acute or chronic. When the traumatic response persists, it can interfere with the child's development across a number of domains (e.g., social, emotional, physical, cognitive, and sexual), which may result in changes in the child's behavior or cognitive functioning. Common cognitive issues associated with trauma include problems with memory, attention, and emotional regulation. In addition, some children will experience physical symptoms such as headaches, stomachaches, and muscle pain. It is important to remember that no two children will react to the same potentially traumatic event in the same way.

For more information, see: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Racial Trauma: 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. The CTTF considers racial trauma and other forms of trauma that are the result of a set of circumstances to be included in the general definition above, but includes this definition for added context. For more information see: https://www.mhanational.org/racial-trauma

Secondary Traumatic Stress: 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

Adverse Childhood Experiences (ACEs): ACEs are potentially traumatic events that occur in childhood and which are, at the population level, linked to chronic health problems, mental illness, and substance use problems in adulthood. ACEs include experiencing violence, abuse, or neglect, witnessing violence, and having a family member attempt or die by suicide. ACEs also include aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with substance use problems, mental health problems, or instability due to parental separation or household members being imprisoned. For more information see: https://www.cdc.gov/violenceprevention/acestudy/index.html

Introduction

The Childhood Trauma Task Force (CTTF) was established by Chapter 69 of the Acts of 2018, *An Act Relative to Criminal Justice Reform*.[1] The membership is drawn from the membership of the Juvenile Justice Policy and Data Board (established by the same legislation) and is chaired and staffed by the Office of the Child Advocate (OCA).

Childhood Trauma Task Force Enabling Statute (MGL Chapter 18C, Section 14)

The Office of the Child Advocate

"…shall convene a childhood trauma task force made up of members of the juvenile justice policy and data board established pursuant to section 89 of chapter 119 to study, report and make recommendations on gender responsive and trauma-informed approaches to treatment services for juveniles and youthful offenders in the juvenile justice system. Said task force shall review the current means of (i) identifying school-aged children who have experienced trauma, particularly undiagnosed trauma, and (ii) providing services to help children recover from the psychological damage caused by such exposure to violence, crime or maltreatment. The task force shall consider the feasibility of providing school-based trainings on early, trauma-focused interventions, trauma-informed screenings and assessments, and the recognition of reactions to victimization, as well as the necessity for diagnostic tools. A priority shall be placed on juvenile or youthful offender's pathways into the juvenile justice system with the goal of reducing the likelihood of recidivism by addressing the unique issues associated with juvenile or youthful offenders including emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, family violence, household substance abuse, household mental illness, parental absence, and household member incarceration.

The childhood trauma task force shall annually report its findings and recommendations by December 31 to the governor, the house and senate chairs of the joint committee on the judiciary, the house and senate chairs of the joint committee on public safety and homeland security and the chief justice of the trial court."

In plain language, the CTTF is tasked with determining **how the Commonwealth can better identify and provide services to youth who have experienced trauma** and are currently involved with the juvenile justice system or at risk of future juvenile justice system involvement.

In its first two years, the CTTF focused on developing a statewide *Framework for Trauma-Informed and Responsive Organizations*.[2] The *Framework* was intended to provide a vision, direction, shared language, and concrete examples for child-serving organizations and agencies seeking to better serve children and families who may have experienced trauma. This Framework was published in the CTTF's 2020 report, "From Aspiration to Implementation: A Framework for Becoming a

[1] See: https://malegislature.gov/Laws/SessionLaws/Acts/2018/Chapter69

[2] Massachusetts Childhood Trauma Task Force. (2020). *Framework for Trauma Informed and Responsive Organizations in Massachusetts*. Office of the Child Advocate. https://www.mass.gov/doc/framework-for-trauma-informed-and-responsive-organizations-0/download

Trauma-Informed and Responsive Commonwealth" along with recommendations for supporting implementation of that framework.[3]

The primary recommendation of that report, the establishment of a *Center on Child Wellbeing and Trauma* to provide training and technical assistance to child-serving organizations, was realized in October 2021, when the Office of the Child Advocate launched such a center in partnership with the UMass Chan Medical School after receiving dedicated funding to do so in the FY22 state budget.

A Center on Child Wellbeing and Trauma

In October 2021, the Center on Child Wellbeing and Trauma (CCWT), a partnership between the Office of the Child Advocate and the UMass Chan Medical School, was launched.

The CCWT will support 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, which may include 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

Learn more at: https://childwellbeingandtrauma.org/

2021 and 2022 Focus: Trauma Screening and Referral Practices

In 2021, the CTTF returned to a prior topic of interest: **mechanisms for better identifying children who have experienced trauma and need services and support**. Over the course of the past year, the CTTF has launched an in-depth study of current means of identifying children who have experienced trauma, both here in Massachusetts and in other jurisdictions.

That study included:

- A review of the literature on mechanisms for identifying children who have experienced trauma, including a review of current recommendations from national organizations on this topic and perspectives from various professional and stakeholder groups.
- A review of a wide range of trauma screening tools currently in use in various settings.
- A review of emerging research on Positive Childhood Experiences (PCEs) and the role they can play in mitigating the impact of trauma, with special consideration to whether, and if so how, screening processes should identify PCEs as well as trauma.

[3] Massachusetts Childhood Trauma Task Force. (2020*). From Aspiration to Implementation: A Framework for Becoming a Trauma-Informed and Responsive Commonwealth*. Office of the Child Advocate. https://www.mass.gov/doc/cttf-2020-report-from-aspiration-to-implementation-a-framework-for-becoming-a-trauma-informed/download

- In-depth examinations of current practices and potentially promising trauma screening and referral models in a variety of settings:
    - K-12 education[4]
    - Pediatrics
    - Child Welfare
    - Juvenile Justice
    - First Responder settings

There are different ways to identify children who may have experienced trauma, including open-ended discussion with a child and/or their parents/caregivers, and child or caregiver self-reporting. However, an increasingly common mechanism is the use of a trauma screening tool, and so ***trauma screening practices*** **is a primary focus of this report.** Trauma screening – particularly *universal trauma screening* – is a more systematic approach to the identification of childhood trauma. A screening process can identify youth who might otherwise be missed and can be more objective (assuming the tool or process is well-designed).

The Importance of Creating Trauma-Informed and Responsive Systems

While this report urges a gradual and cautious approach to trauma screening in settings outside behavioral health, it should not be interpreted to suggest a lack of urgency with regards to identifying and better serving children who have experienced trauma.

As further described in *Why Focus on Trauma Identification?* below, there are striking gaps in our current means of identifying children who have experienced trauma and are in need of support. This is why the CTTF chose to spend its first two years on developing recommendations to support all child-serving organizations in becoming trauma-informed and responsive (TIR): because **if our systems are TIR, they will create environments in which adults are more likely to identify children who may have experienced trauma** (even in the absence of a specific universal screening process), and in which children who have experienced trauma can thrive and heal, regardless of whether adults in those systems are specifically aware of that trauma.

Trauma screening is a complex topic, and one in which research and practice are evolving quickly. Although conducting a trauma screening and/or assessment is currently a well-established (and generally non-controversial) best practice in behavioral health settings[5], this same consensus does not exist for conducting trauma screenings in other settings or contexts, such as schools or pediatrician offices. The questions of when trauma screening should occur, in which settings, under what circumstances, by which kinds of professionals, and using which tools are all topics of continued debate, both locally and nationally.

[4] The CTTF also researched trauma screening practices in early education settings but was not able to find examples of early education organizations conducting trauma screening in a formalized or systematized way. Instead, children exhibiting behavioral health symptoms in early education settings are more likely to be referred to a behavioral health specialist for a screening/assessment process, which may include a trauma screening.

[5] Substance Abuse and Mental Health Services Administration. (2014). Screening and Assessment. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4816.pdf

As a result, a gradual and data-driven approach to this issue is warranted. Careful consideration of pros and cons is necessary, and new practices should be tested and evaluated before they are expanded dramatically.

In this interim report, the CTTF seeks to document the current landscape of child trauma identification practices.

In Part I of this report, we discuss **trauma screening more generally**, including:

- Background information about trauma screening and definitions of key terms
- Special considerations, including:
    - Caregiver consent
    - The impact of culture, identity, and prior experiences of oppression
    - Screening for positive childhood experiences and incorporating a strength-based approach
- General best practices for implementing a trauma screening process

In Part II, we take a deeper dive into **trauma screening in particular settings**, beginning with more "general population" settings in which the prevalence of having been exposed to trauma is assumed to be lower (e. g., pediatrician offices and schools), and then moving to settings where the child's history of trauma exposure is more prevalent (e.g., child welfare and juvenile justice settings)

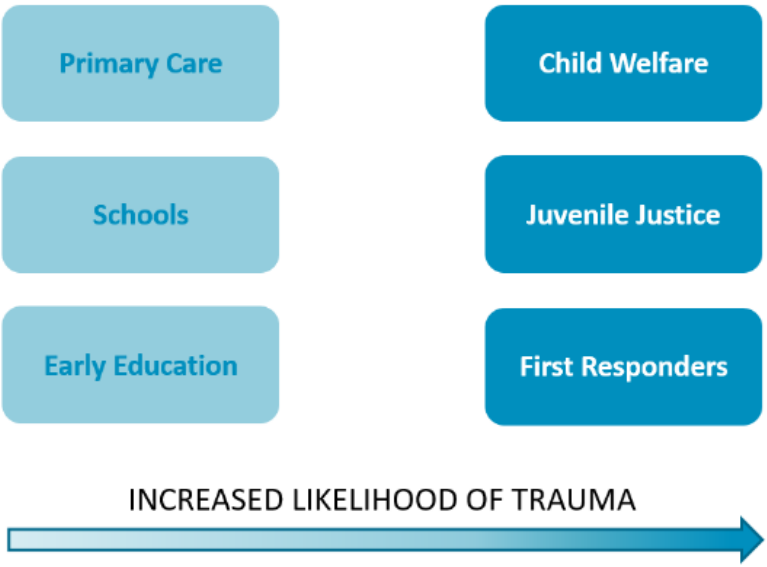

Figure 1: Trauma screening in particular settings, from "general population" settings with lower prevalence rates to settings with higher prevalence rates of trauma.

In 2022, using this document as a starting point, the CTTF will attempt **to develop consensus recommendations regarding what, if anything, the Commonwealth should do to incentivize, support and/or require specific child trauma identification practices in various setting**.

Why Focus on Trauma Identification?

As has been documented in prior CTTF reports[6], the experience of trauma in childhood is widespread. It is estimated that **a quarter of children in the United States will witness or experience a traumatic event before the age of four**.[7] A 2007 study estimated that by the age of

[6] Prior CTTF reports can be accessed at https://www.mass.gov/lists/childhood-trauma-task-force-cttf-reports-and-documents
[7] Briggs-Gowan, M. J., Ford, J. D., Fraleigh, L., McCarthy, K., & Carter, A. S. (2010). Prevalence of exposure to potentially traumatic events in a healthy birth cohort of very young children in the northeastern United States. *Journal of Traumatic Stress, 23*(6), 725–733. https://doi.org/10.1002/jts.20593

16, more than two-thirds of youth have experienced at least one potentially traumatic event.[8] For children involved in the child welfare and juvenile justice systems in particular, the experience of severe, repeated, and interpersonal trauma is extremely common.[9]

Some children – including Black and Latino children as well as children living in poverty – face more systemic injustices that are well beyond their making or control. Children experiencing such inequities are significantly more likely to experience potentially traumatic events, and to experience them more frequently – leading to even more inequities, which can be seen in our educational, health care, judicial and social service systems.[10] Further, the experience of systemic inequities can in of itself cause trauma: for example, experiencing racial bias, ethnic discrimination, racism and hate crimes – whether it is experienced directly or vicariously – can result in mental and emotional injury referred to as racial trauma.

No two children will react to the same traumatic event in the same way, and not all children who experience a potentially traumatic event will experience traumatic stress with lasting impacts on their development. Most children who experience trauma are able to heal and thrive, and many may not need a particular therapeutic intervention to do so. As is further discussed in *The Role of Positive Childhood Experiences*, below, there are a variety of experiences and supports that can buffer children from potentially traumatic experiences and help them develop strong relationships and emotional resilience.

Some children, however, would benefit from extra support. In some cases, this may simply be a doctor, social worker or school professional advising a parent/caregiver on effective practices for supporting a child who has experienced trauma; in other cases, connection with a therapeutic service like Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) or services of the DPH-funded Children Exposed to Domestic Violence programs may be most helpful.[11]

Unfortunately, it is not always obvious to the adults in a child's life that the child is experiencing the impacts of trauma and needs extra support. In some cases, a child's trauma response may manifest as behaviors that are viewed by the adults around them as disruptive or antisocial. These are the same types of behaviors that can result in trouble at school, substance use disorder, or involvement with law enforcement. Although engaging in some amount of risky, impulsive, or limit-testing behavior is common and developmentally appropriate for adolescents, children who have experienced trauma are still more likely to be excluded from school via a suspension or expulsion

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[8] Copeland WE, Keller G, Angold A, Costello EJ. (2007). Traumatic Events and Posttraumatic Stress in Childhood. Arch Gen Psychiatry. 2007;64(5):577-584.doi:10.1001/archpsyc.64.5.577 https://jamanetwork.com/journals/jamapsychiatry/fullarticle/482289

[9] Spinazzola, J., Habib, M., Knoverek, A., Arvidson, J., Nisenbaum, J., Wentworth, R., Hodgdon, H., Pond, A., & Kisiel, C. (2013). The heart of the matter: Complex trauma in child welfare. Center for Advanced Studies in Child Welfare. http://www.traumacenter.org/products/pdf_files/Complex_Trauma_in_Child_Welfare_S0002.pdf; Salazar, A.M., Keller, T.E., Gowen, L.K., Courtney, M.E. (2014). Trauma exposure and PTSD among older adolescents in foster care. *Social Psychiatry and Psychiatric Epidemiology*, *48*(4), 545-551. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4114143/; Dierkhising, C. B., Ko, S. J., Woods-Jaeger, B., Briggs, E. C., Lee, R., & Pynoos, R. S. (2013). Trauma histories among justice-involved youth: findings from the National Child Traumatic Stress Network. *European journal of psychotraumatology*,. https://doi.org/10.3402/ejpt.v4i0.20274

[10] 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

[11] The National Child Traumatic Stress Network. (2012). *Trauma Focused Cognitive Behavioral Therapy*. https://www.nctsn.org/sites/default/files/interventions/tfcbt_fact_sheet.pdf; The Commonwealth of Massachusetts. (n.d.). *DPH Domestic Violence Programs*. https://www.mass.gov/info-details/dph-domestic-violence-programs

and are more likely to come into contact with the juvenile justice system compared to the general population.[12]

These incidents all represent missed opportunities to support a child who has experienced trauma – which points to the need for our systems to do a better job identifying these children in the first place.

Improving trauma identification may also be an impactful way of addressing systemic racial and ethnic disparities. As noted above, Black and Latino children are more likely to experience traumatic events than white children – and, in particular, more likely to experience multiple traumatic incidents.[13] Black and Latino children are also significantly more likely to experience school exclusion or juvenile justice system involvement.[14] Implicit (or explicit) bias can impact the way an adult interprets a child's behaviors, what may be causing the behaviors, and what the appropriate response should be. If adults interacting with Black and Latino children were better equipped to identify behaviors as potentially resulting from trauma, including racial trauma, and the adults respond appropriately, it may result in fewer punitive responses and more responses designed to promote healing.

Finally, the more detailed our understanding of childhood trauma – its causes, its effects, and especially its prevalence and how that varies among populations – the greater our ability will be to identify effective "upstream" approaches to reduce the occurrence of trauma in the first place.

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[12] Morgan, E., Salomon, N., Plotkin, M., Cohen, R., (2014). The school discipline consensus report: Strategies from the field to keep students engaged in school and out of the juvenile justice system. Council on State Governments. Retrieved from http://knowledgecenter.csg.org/kc/system/files/The_School_Discipline_Consensus_Report.pdf

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

[14] See JJPAD's juvenile justice system data website: https://www.mass.gov/resource/massachusetts-juvenile-justice-system-data-and-outcomes-for-youth; See DESE's School and District Profiles: https://profiles.doe.mass.edu/statereport/ssdr.aspx

Part I: Trauma Screening: General Background

Trauma screening is a process of identifying an individual who may have experienced trauma. Typically, this is done by using a trauma screening tool, which is a brief set of questions designed to identify if "an individual has experienced one or more traumatic events, has reactions to such events, has specific mental or behavioral health needs, and/or needs a referral for a comprehensive trauma-informed mental health assessment."[15] It is, as the National Child Traumatic Stress Network (NCTSN) describes it, a "wide-net" process.[16]

Trauma screening tools do not necessarily need to be implemented by a clinician; many are designed to be administered via self-report (e.g., the youth or a family member answers a set of questions) and/or by another trained professional such as a medical professional, adjustment counselor or probation officer.

There is no one type of trauma screening tool, as trauma can manifest itself in many different ways depending on the child's personality, experience/history, developmental stage, and circumstances. As such, the CTTF includes in its definition of trauma screening tools any tool that measure any of the following:

- **Symptoms or behaviors** of traumatic stress or PTSD, such as having nightmares, avoiding reminders of traumatic experiences, feeling anxious, or demonstrating aggression or irritability. An example of a screening tool that measures trauma-related symptoms is the screening version of the Trauma Symptom Checklist for Children (TSCC-SF).[17]
- **Exposure to potentially traumatic incident(s)**, such as experiencing sexual, physical, or emotional abuse, witnessing violence or experiencing it firsthand, having a caregiver who went to jail/prison, or experiencing a natural disaster. An example of a screening tool that measures potentially traumatic incidents is the Juvenile Victimization Questionnaire, which evaluates exposure to various forms of violence.[18]
- **Developmental delays**, which might indicate a history of trauma.[19] In particular, young children who have experienced trauma might demonstrate important developmental delays, such as delayed verbal and social skills that can exhibit as learning disabilities.[20] An example of a screening tool that measures developmental delays is the Parents' Evaluation of Developmental Status (PEDS) Response Form.[21]

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[15] Peterson, S. (2017, December 11). *Screening and Assessment*. The National Child Traumatic Stress Network. https://www.nctsn.org/treatments-and-practices/screening-and-assessment
[16] Ibid.
[17] Briere, J. (n.d.). Trauma Symptom Checklist for Children. *TSCC*. Retrieved from https://www.parinc.com/Products/Pkey/461
[18] Hamby, S., Finkelhor, D., Turner, H., & Kracke, K. (2011). The Juvenile Victimization Questionnaire toolkit. Retrieved from http://www.unh.edu/ccrc/jvq/index_new.html.
[19] Gregorowski, C. & Seedat S. (2013, October). Addressing childhood trauma in a developmental context. *Journal of Child and Adolescent Mental Health 25*, 2, 105-118. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4104825/
[20] Peterson, S. (2018, February 1). *How Early Childhood Trauma is Unique*. The National Child Traumatic Stress Network. https://www.nctsn.org/what-is-child-trauma/trauma-types/early-childhood-trauma/effects
[21] PEDStest. (n.d.) *Parents' Evaluation of Developmental Status (PEDS) Response Form*. https://www2.columbusco.org/hdpolicies/Pediatric%20%20Policy%20Procedure/Pediatrics%20Tools/Well%20Child%20PEDS%20Response%20Forms.pdf

- **Risk factors,** which can exacerbate a child's trauma and provide some indication that the child might suffer (or be at risk of suffering) from trauma. For instance, as the CDC explains, inequitable conditions such as "living in under-resourced or racially segregated neighborhoods, frequently moving, and experiencing food insecurity can cause toxic stress."[22] An example of a screening tool that measures risk factors is the Safe Environment for Every Kid (SEEK), which asks caregivers questions about social determinants of health.[23]

A screening tool is different from:

- **An assessment**, which is a much longer process that includes a clinical interview, standardized measures, and/or behavioral observations. The goal of an assessment, which is a typical next step after a "positive" trauma screen, is to establish an in-depth understanding of the mental health and trauma conditions of an individual to refer them to appropriate services. An example of a trauma assessment tool is the Child Adolescent Needs and Strengths (CANS)-Trauma Comprehensive.[24]
- **Surveillance**, which uses de-identified/anonymous questionnaires to collect aggregate data. The data is then used to understand the prevalence of specific issues and inform policies, procedures, and/or services offered within a given setting (e.g., a school, community organization, state agency). An example of surveillance is the Youth Risk Behavior Surveillance System (YRBSS) conducted by local school districts throughout the nation and analyzed by the Center for Disease Control and Prevention and by state health departments.[25]

Developing a Screening Process: Who, What, When, Where, and How

Given the varied forms trauma screening tools can take, it is important for organizations or systems to decide *who* will be screened, *what* issues they want to identify within the children they serve, *when* and *where* a screening tool should be administered, *how* they want to identify the concerns, and *why* they want to screen for trauma.

This report will discuss setting-specific implications at greater length in Part II, but to give a few examples: a pediatrician might choose to screen younger patients for developmental delays, as the American Academy of Pediatrics recommends doing so for patients under thirty months old, while a family therapist might want to identify a young child's potentially traumatic experiences to gain insights into a family's functioning.[26] Similarly, a clinician might decide to screen for symptoms, as this might inform what type of trauma-based treatment is needed, while a social worker might

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[22] Center for Disease Control. (2021, April 6). *Violence Prevention*. Retrieved November 30, 2021, from https://www.cdc.gov/violenceprevention/aces/fastfact.html
[23] SEEK. (n.d.) SEEK Materials. Retrieved November 30, 2021, from https://seekwellbeing.org/seek-materials/
[24] Kisiel, C., Lyons, J.S., Blaustein, M., Fehrenbach, T., Griffin, G., Germain, J., Saxe, G., Ellis, H., Praed Foundation, & National Child Traumatic Stress Network. (2011). Child and adolescent needs and strengths (CANS) manual: The NCTSN CANS Comprehensive – Trauma Version: A comprehensive information integration tool for children and adolescents exposed to traumatic events. Retrieved from https://www.nctsn.org/measures/nctsn-cans-comprehensive-trauma-version-cans-trauma
[25] Center for Disease Control. (n.d). *Youth Risk Behavior Surveillance System (YRBSS): 2019 YRBS Results and Data*. https://www.cdc.gov/healthyyouth/data/yrbs/index.htm
[26] Mackrides, P. S., & Ryherd, S. J. (2011). Screening for developmental delay. *American family physician*, *84*(5), 544–549. https://pubmed.ncbi.nlm.nih.gov/21888305/

want to screen a youth for experiences in order to understand a child's triggers and make an informed out-of-home placement.

In particular, organizations must choose whether they would like to implement universal or selective screening processes to identify youth who might be experiencing trauma. **Universal screening** evaluates all individuals within a given population (e.g., students, medical patients, youth in foster care) for the purpose of identifying those possessing some target condition. For example, in some schools all youth are screened for both trauma and mental health symptoms. In comparison, **selective screening** only evaluates individuals that meet certain criteria or are believed to be at high-risk for target conditions. An example of this would be a school psychologist conducting a trauma screen on a child that has been referred by a teacher following disruptive behavior in the classroom.

Although this report focuses primarily on screening for children, it is worth noting that some argue that it is also – if not *more* – important to identify parents and caregivers' possible history of trauma as well.[27] As the NCTSN notes, parents' and caregivers' own trauma can "impair their ability to manage stress, their attachment and social functioning, and their executive functioning," all of which are necessary to create healthy bonds with their children, use appropriate discipline, and parent successfully.[28]

Organizations should also choose whether they would like to screen for youth's possible mental health issues in general or potential trauma-related issues specifically. This is complicated by the fact that:

- **Many symptoms in trauma and mental health screening tools are similar.** The Trauma Symptom Checklist for Children (TSCC) asks similar questions as the Patient Health Questionnaire (PHQ)-9, a mental health screener for depression.[29] For example, both tools ask about feelings of sadness and troubles with sleep and can help identify depression, which is both a mental health disorder and a symptom of trauma.
- **Traditional mental health screening tools** (e.g., PHQ-9) **do not always identify** youth who suffer from trauma. One study showed that 15% of youth likely to meet criteria for PTSD and 44% of youth who could possibly meet criteria for PTSD would not have been identified as needing trauma-specific treatment by traditional universal depression screening methods.[30]
- **Trauma is only one contributor to mental and behavioral health concerns**. As the Substance Abuse and Mental Health Services Administration (SAMHSA) explains, "individuals with severe mental illnesses report child trauma at a much higher rate than the

[27] See, for example, https://acestoohigh.com/2014/07/29/to-prevent-childhood-trauma-pediatricians-screen-children-and-their-parentsand-sometimes-just-parents/
[28] The National Child Traumatic Stress Network. (n.d.) Recommendations for Trauma-Informed Care Under the Family First Prevention Services Act. NCTSN. Retrieved from https://www.nctsn.org/sites/default/files/resources/special-resource/recommendations_for_trauma_informed_care_under_the_family_first_prevention_services_act.pdf
[29] Spitzer, R., Willams, J., & Kroenke, K. (n.d). Patient Health Questionnaire-9. American Psychological Association. https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf
[30] Selwyn, C. et al. (2019, February). Recognizing the hurt: Prevalence and correlates of elevated PTSD symptoms among adolescents receiving mental/behavioral health services in primary care. *Psychological Services 16*, 1 58-66. https://doi.org/10.1037/ser0000322

general population."[31] As such, it can be argued that screening for mental health may indicate possible trauma history. At the same time, there are other non-trauma related contributors to less-than-optimal mental and behavioral health, including conditions of social isolation, poverty, or discrimination. Trauma can also contribute to problems with a child's physical health.[32]

- **Most people who experience trauma do not develop a severe mental health condition as a result.**[33] Screening children for trauma experiences as part of a mental health screen could have the effect of identifying children who do not actually need a therapeutic intervention – which at best could be a misallocation of scarce therapeutic resources, and at worst could be harmful to the child and/or their family.

Given the above, many organizations advocate for using tools that screen for *both* trauma symptoms/behaviors *and* a history of traumatic experiences, and for looking at the combination of these factors in determining any next steps. The National Child Traumatic Stress Network (NCTSN), for instance, argues that trauma screening should include "two critical elements: exposure to potentially traumatic events/experiences, including traumatic loss, and traumatic stress symptoms/reactions."[34] As Part II of this report demonstrates, many organizations have taken this stance as they developed their own trauma screening tools.

Finally, a common concern regarding the use of trauma-screening tools is the extent to which this can cause distress for children and their families. Research suggests, however, that asking about traumatic experiences and providing individuals the opportunity to talk about them can, in of itself, be therapeutic. As described in a toolkit written to help home visiting staff talk about adverse childhood experiences with families:[35]

> *"There is data to support the effectiveness of the question '**How have these experiences affected you?'** This is how the providers at San Diego Kaiser Permanente, site of the original ACEs research, were taught to respond to learning their patient's ACE score. The researchers learned that patients responded well and did not go into crisis; subsequent visits for unnecessary care were reduced by about 50% over the next year. Being heard is powerful medicine."*

Special Considerations: Caregiver Consent

Due to the sensitive nature of asking a child about potentially traumatic events or issues with which they might be struggling, child-serving organizations must obtain parents' or caregivers'

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[31] Substance Abuse and Mental Health Services Administration. (2018, May). Serious Mental Illness and Trauma: A Literature Review and Issue Brief. U.S. Department of Health and Human Services. https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/samhsa-smi-and-trauma-lit-review-and-issue-brief.docx

[32] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8

[33] National Institute of Mental Health. (n.d.) *Post-Traumatic Stress Disorder*. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

[34] The National Child Traumatic Stress Network's Trauma Screening. (n.d.). *What is a Trauma Screening Tool or Process?* https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-screening

[35] Start Early. (2020, August 27). *NEAR@Home Toolkit: A Guided Process to Talk About Trauma and Resilience in Home Visiting*. https://www.startearly.org/post/nearhome-toolkit-a-guided-process-to-talk-about-trauma-and-resilience-in-home-visiting/

permission to administer trauma screenings. There are two types of consent organizations can seek:

- **Active consent,** which can be defined as the "explicit permission, signed by parent [or caregiver], that explains the scope of the assessment, the risks associated with the assessment, as well as information about what will be done with the assessment results."[36] Active consent is more logistically difficult to obtain, as organizations must collect the necessary documentation to proceed with the screening process.
- **Passive consent**, on the other hand, is when "information is shared with parents regarding the scope of the assessment, the risk associated with the assessment, and information about what will be done with the assessment," but instead of having parents/caregivers give written consent, parents must "opt out" of the assessment in writing if they so choose. This increases participation, as the onus of refusing consent is on the youth's parent or caregiver.

Issues of consent can also be tricky for youth in certain situations, such as youth who are in the custody of the Department of Children and Families, youth who are homeless, youth being cared for by a relative or friend who does not have legal custody, and in situations where a youth may want to participate but the parent/caregiver does not want them to.

While passive consent can help ensure that an organization can identify trauma in as many youth as possible, its use is highly debated. Indeed, some professionals point out that it is ethically questionable.[37] For instance, the Defending Childhood State Policy Initiative explains in its *Guidance for Trauma Screening in Schools* (2016) that passive consent might be less ethical "particularly in communities with high populations of illiteracy or non-English speaking families." Therefore, they recommend that schools use active parental/caregiver consent.[38] At the same time, some organizations go to great length to ensure that passive consent is well informed and give parents multiple opportunities (e.g., in-person meetings, information packets with stamped, pre-addressed reply postcards, phone calls) to understand the implications of screening for trauma or mental health and opt out of the process.[39]

Special Considerations: The Impact of Culture, Identity, and Prior Experiences of Oppression

There are a variety of ways in which culture and identity, as well as the on-going impacts of structural inequities, can impact trauma screening, and the CTTF recognizes that any recommendations on this topic must include a careful consideration of the specific impact they may have on historically marginalized communities.

These considerations include:

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[36] Oyen, K. (2019). Effective Prevention and Response in Schools. *The Center for the Prevention of Child Maltreatment (CPCM) in South Dakota*. https://www.sdcpcm.com/wp-content/uploads/2019/12/Universal-Screenings-in-Schools-Final.pdf

[37] Jason, L.A., Pokorny, S. and Katz, R. (2001), Passive versus active consent: A case study in school settings. J. Community Psychol., 29: 53-68. https://doi.org/10.1002/1520-6629(200101)29:1<53::AID-JCOP4>3.0.CO;2-6

[38] Eklund, K. & Rossen, E. (2016). *Guidance for Trauma Screening in Schools: A product of the defending childhood state policy initiative*. Delmar, NY: The National Center for Mental Health and Juvenile Justice. https://www.nasponline.org/x37269.xml

[39] Chartier, M., Stoep, A. V., McCauley, E., Herting, J. R., Tracy, M., & Lymp, J. (2008). Passive versus active parental permission: implications for the ability of school-based depression screening to reach youth at risk. *The Journal of school health*, *78*(3), 157–186. https://doi.org/10.1111/j.1746-1561.2007.00278.x

- **How a given individual or community's culture might impact the process:** Research shows that culture shapes how people react to trauma, how they think about the traumatic event, and what supports they look for and find helpful.[40] One study found, for instance, that there are "qualitative differences between individuals from Caucasian, African American, and Hispanic groups in terms of interpretations of traumatic events and self-reported PTSD symptoms."[41] Other researchers have noted that some communities "persistently encounter traumatic circumstances," which might lead to certain forms of trauma becoming "normalized".[42] Any trauma-screening process must take into account the different ways a child and family's culture may impact how they describe their experiences and reactions, as well as what supports they may find useful. The ability to seek out or engage in any type of support or service requires a level of trust that may not exist for the individual or family – especially people who have lived with consistent injustices.

- **The extent to which a given screening tool is appropriate for individuals of different races, cultures and identities:** As SAMHSA notes, "instruments that have been normed for, adapted to, and tested on specific cultural and linguistic groups should be used. Instruments that are not normed for the population are likely to contain cultural biases and produce misleading results. Subsequently, this can lead to misdiagnosis, overdiagnosis, inappropriate treatment plans, and ineffective interventions. Thus, it is important to interpret all test results cautiously and to discuss the limitations of instruments with clients from diverse ethnic populations and cultures."[43]

  It is also important to note that currently available trauma screening tools rarely measure racial trauma, despite the increased evidence of the psychiatric and emotional consequences of racism and racial discrimination.[44]

- **The impact that prior experiences of oppression may have on family consent and service engagement:** It is important to note that many children and families have personally experienced discrimination from a variety of systems/system-actors, and/or are aware of a long history of discrimination within these systems, from health care to school to the child welfare and juvenile systems. As a result, they may be distrustful of individuals working in those systems, which can impact their willingness to consent to a screening process, or to engage fully in screening or services.

- **The way in which implicit bias in adults administering a screening could impact the process:** Adults working in child-serving systems come with their own personal biases,

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[40] Marsella, Anthony J. "Ethnocultural Aspects of PTSD: An Overview of Concepts, Issues, and Treatments." *Traumatology: An International Journal* 16.4 (2010): 17-26. https://www.ncbi.nlm.nih.gov/books/NBK207188/

[41] Trepasso-Grullon, E. (2012) Differences Among Ethnic Groups in Trauma Type and PTSD Symptom Severity. *Columbia Graduate Student Journal of Psychology*. https://www.tc.columbia.edu/publications/gsjp/gsjp-volumes-archive/gsjp-volume-14-2012/25235_Trepasso-Grullon_PTSDEthnicity.pdf

[42] Marsella, Anthony J. "Ethnocultural Aspects of PTSD: An Overview of Concepts, Issues, and Treatments." *Traumatology: An International Journal* 16.4 (2010): 17-26. http://indigenouspsych.org/Discussion/forum/Marsella.Traumatology.pdf

[43] Substance Abuse and Mental Health Services Administration. (2014). Trauma-Informed Care in Behavioral Health Settings. U.S. Department of Health and Human Services. https://www.ncbi.nlm.nih.gov/books/NBK207201/

[44] Williams, Monnica & Printz Pereira, Destiny & DeLapp, Ryan. (2018). Assessing Racial Trauma with the Trauma Symptoms of Discrimination Scale. Psychology of Violence. 8. 735-747. 10.1037/vio0000212. ; https://www.researchgate.net/publication/328010708_Assessing_Racial_Trauma_With_the_Trauma_Symptoms_of_Discrimination_Scale ; Carter, R., Forsyth, J., (2009). A Guide to the Forensic Assessment of Race-Based Traumatic Stress Reactions. *Journal of the American Academy of Psychiatry and the Law Online March 2009*, 37 (1) 28-40. http://jaapl.org/content/37/1/28

some of which they may not be consciously aware – either at all, or in times of stress. This can make the adult fail to recognize that youth and families may bring different, equally valid values and perspectives to a decision, some of which may be rooted in differences in background, upbringing, experiences, or culture. The adult conducting the screening may struggle to differentiate between decisions that are actively harmful, and those that are simply not the same decision the adult would have made.

Given the above considerations, and as further discussed in *Requirements for Effective Implementation of Trauma Screening,* below, it is critical that child-serving organizations understand cultural implications of trauma in the communities they serve and engage in thoughtful discussion of what trauma means, its prevalence, and how it can affect children, youth, and adults across various demographic groups and identities.

Special Considerations: Positive Childhood Experiences and Strength-Based Approaches

While there is widespread agreement that childhood trauma can have an adverse impact on health and mental health, focusing only on trauma and adverse childhood experiences fails to address the powerful impact that *positive childhood experiences*, particularly a strong foundational relationship between a child and their caregivers, can have in mitigating the impacts of trauma and supporting healing. To account for this, trauma screening practices should be rooted in a strengths-based framework[45] rather than a deficit-based approach, to develop a more holistic view of the child and their family.[46]

Research on Positive Childhood Experiences

An extensive and growing body of research on child development, and in particular development in children dealing with adversity, points to the importance of positive childhood experiences, including strong attachment to a parent or caregiver, feeling safe and protected by an adult in one's home, feeling supported by friends, having a sense of belonging and connection with a larger group (e.g. school, faith-based organization, team, social club), and having a relationship with a non-parent adult who takes genuine interest in the child.[47]

Key positive childhood experience can have profound effects on a child's development and health outcomes by driving healthy development and, importantly, mitigating the long-term effects of adverse childhood experiences (ACEs). Research shows that these experiences help:[48]

- Promote children's long-term health and wellbeing
- Enable children to form strong relationships and meaningful connections

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[45] A strengths-based framework is one that focuses on a child's strengths, protective factors, and resiliency factors, as opposed to focusing on the gaps, challenges or services that need to be implemented to fix a problem. Examples of strengths-based frameworks include Positive Youth Development, which is an approach employed by many child-serving agencies and organizations in Massachusetts, and has a significant body of research behind it demonstrating its efficacy in improving social and emotional outcomes for youth. See: Youth.gov "Positive Youth Development" https://youth.gov/youth-topics/positive-youth-development

[46] The National Child Traumatic Stress Network. (n.d.). *What is Trauma-Informed Mental Health Assessment and Why is it Important?* https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-informed-mental-health-assessment

[47] Bethell, C., Jones, J., Gombojav, N., Linkenbach, J., & Sege, R. (2019). Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample: Associations Across Adverse Childhood Experiences Levels. *JAMA pediatrics*, *173*(11), e193007. https://doi.org/10.1001/jamapediatrics.2019.3007

[48] Burstein, D., Yang, C., Johnson, K. *et al.* Transforming Practice with HOPE (Healthy Outcomes from Positive Experiences). *Maternal Child Health J* 25**,** 1019–1024 (2021). https://doi.org/10.1007/s10995-021-03173-9

- Cultivate positive self-image and self-worth
- Provide a sense of belonging
- Build skills to cope with stress in healthy ways

A 2019 study looking at health-related risk behaviors and chronic health conditions found that the more positive childhood experiences (PCEs) an individual has, the lower their likelihood for depression and poor mental health in adulthood:[49]

- Individuals reporting six to seven PCEs had a **72% lower chance** of reporting depression or poor mental health as an adult when compared with those reporting zero to two PCEs.

- Individuals reporting three to five PCEs had a **52% lower chance** of reporting depression or poor mental health as an adult when compared with those reporting zero to two PCEs.

Even for children with several adverse childhood experiences, having positive experiences can reduce negative outcomes. As the graph shows, even with four or more adverse childhood experiences, positive childhood experiences **serve as a protective factor** and reduce adult depression.[50]

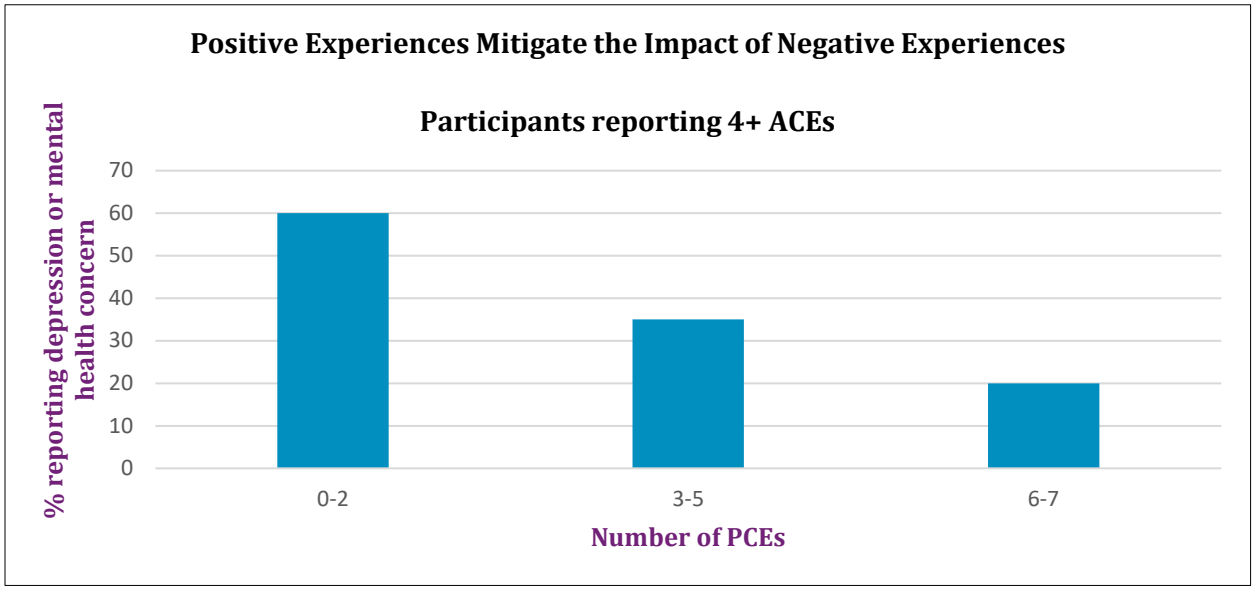

Figure 2: Positive Experiences Mitigate the Impact of Negative Experiences

Trauma Screening and PCEs

Despite our increasing understanding of the significant role PCEs can play in mitigating the impacts of trauma, many system practices – including many trauma screening processes – tend to focus primarily on the negative.

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[49]Bethell, C., Jones, J., Gombojav, N., Linkenbach, J., & Sege, R. (2019). Positive Childhood Experiences and Adult sub and Relational Health in a Statewide Sample: Associations Across Adverse Childhood Experiences Levels. *JAMA pediatrics*, *173*(11), e193007. https://doi.org/10.1001/jamapediatrics.2019.3007

[50] Ibid

PCEs are not static, however: child-serving organizations have the opportunity to provide positive childhood experiences and/or support parents and caregivers in doing so. This suggests there would be a benefit to creating more holistic screening processes that look at *both* adverse and positive experiences and identify ways of building on child and family strengths.

There are currently only a few validated screening tools for PCEs.[51] However, as noted in the next section, there can be other opportunities within a screening and referral process to identify and honor child and family strengths, particularly within processes that involve a one-on-one conversation with the child and/or their family.

Requirements for Effective Implementation of Trauma Screenings

As detailed in Part II of this report, organizations in various sectors – from schools to pediatrics to child welfare – have successfully implemented trauma screening processes. Many have also experienced challenges and pitfalls along the way and have "lessons learned" as a result.

In this section, we detail *general* best practices for implementing trauma screening processes based on a review of the national literature as well as on discussions with individuals and organizations with expertise in this arena. Considerations specific to particular settings or sectors are included in Part II, as relevant. The CTTF also recommends any organization considering implementing a trauma screening practice to review the CTTF's 2020 *Framework for Trauma Informed and Responsive (TIR) Organizations* for general advice on creating a "TIR" atmosphere.[52]

Child/Youth and Family Engagement

Any effective trauma screening process begins with effective child/youth and family engagement. This includes[53]:

- **Explaining the purpose of the screening tool** and the process: why the organization is asking the child or the family this information, how the information being gathered will be used, how it could benefit the child and their family to participate in the screening, and who will have access to the information in the future. This should include a discussion of what information is confidential and what could be reported and to whom, including what would trigger a mandatory report of abuse/neglect under state law.

- **Addressing language barriers** by ensuring information is available in the primary languages of the community served and providing the screening tools in additional

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[51] Narayan, A. J., Rivera, L. M., Bernstein, R. E., Harris, W. W., & Lieberman, A. F. (2018). Positive childhood experiences predict less psychopathology and stress in pregnant women with childhood adversity: A pilot study of the benevolent childhood experiences (BCEs) scale. *Child abuse & neglect*, *78*, 19–30. https://doi.org/10.1016/j.chiabu.2017.09.022; Merrick, J., & Narayan, A. (2020). Assessment and screening of positive childhood experiences along with childhood adversity in research, practice, and policy, *Journal of Children and Poverty*, 26:2, 269-281, DOI: 10.1080/10796126.2020.1799338

[52] Massachusetts Childhood Trauma Task Force. (2020). *Framework for Trauma Informed and Responsive Organizations in Massachusetts.* Office of the Child Advocate. https://www.mass.gov/doc/framework-for-trauma-informed-and-responsive-organizations-0/download

[53] Adapted from The National Child Traumatic Stress Network. (n.d.). *What is a Trauma Screening Tool or Process?* https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-screening

languages whenever possible.

- **Having a two-way conversation with the youth and their family** about trauma and its effects and giving them the opportunity to ask questions about the screening tool, how it will be used and any concerns they may have. This can also help create a feeling of safety and transparency for the child and their family, which is an important aspect of trauma-informed practice and may be of particular importance if a traumatic event occurred recently.

- **Providing opportunities for the child and/or family to identify strengths**, highlighting the child's capacity to recover, and reinforcing actions that promote positive childhood experiences (e.g., identifying and reinforcing positive parenting techniques, engaging the child in pro-social activities).

- **Engaging the youth or family in a conversation about the results of the screening** and any next steps that are recommended. This may include discussing the impact that trauma can have on a child, identifying options for additional assessment or service referrals, and providing information on how to interact with children in trauma-informed and responsive ways as well as how to effectively advocate for the services and supports their child needs.

- **Thanking the child/family** for completing the trauma screening tool or process, and explaining that most feelings, responses, or reactions the child may be having to trauma are normal and expected. As needed, offer the parents/caregivers support for the secondary trauma they may experience themselves as they deal with their child's trauma. This support may help the parent/caregiver to differentiate expected reactions from unhealthy reactions that require further assessment – and can help the parent/caregiver who is personally triggered by their child's trauma.

Staff Engagement & Training

It is also important to engage with staff implementing a trauma screening process to gain their buy-in and ensure the process is implemented with fidelity.

Training for staff implementing a trauma screening process should include:

- **General training on trauma,** as detailed in the CTTF's *Framework,* including how trauma can manifest differently at each developmental stage as well as with children of differing sexes, gender identities, sexual orientations, races, cultures, and abilities.[54]

- **Instruction on how to effectively discuss trauma with both the child and their caregiver,** including how to use a strengths-based approach (see "Special Considerations: Positive Childhood Experiences" above), how to work with the family as a co-equal partner, how to converse without making assumptions that suggest the staff member would make a judgment regarding the answers, and how a child or family's culture or prior experience of

[54] See the Center on Child Wellbeing and Trauma's Organization's Create a Trauma-Informed and Responsive Workforce: https://childwellbeingandtrauma.org/taking-action/action-steps/step-2-create-a-trauma-informed-and-responsive-workforce/

trauma, as well as a staff member's own implicit bias, may influence this process (as further discussed above).

- If a specific trauma screening tool or tools are being used, **specific instructions on how the tool is to be used** (e.g., how to gather information appropriately and sensitively, how to avoid retraumatization in the screening process, how the tool scoring function works).

- **Information on next steps based on the results of the tool,** which may include a referral for a full assessment and/or connections to specific services.

- **How staff can identify secondary traumatic stress** (STS) that may come from their experiences administering a trauma screening, practices for prevention of STS, and strategies for coping – including how to discuss these issues with a supervisor.

Established Referral and Follow-Up Processes

The purpose of a trauma screening process is to identify children in need of additional support – but there is no point in incurring the costs (to the child, to the family, and to the organization) of implementing a trauma screening if nothing is then done with this information. In other words: trauma screening and a solid referral process go hand-in-hand, and **a screening should not be done if there is not an established process for what comes next.** This does not mean organizations or staff should not ever ask questions because they do not feel equipped to handle the answers, however. Instead, it is a call for organizations to develop strong referral processes before or concurrently to developing a screening process.

An effective referral process includes:

- **A mechanism for connecting the child with immediate help** (e.g., a mobile crisis team) if the screening reveals serious, acute symptoms, such as suicidality.

- **Smooth connections to a more detailed assessment process** if the screening process indicates one is necessary. This assessment process could be completed in-house, or the organization may need to make a referral to a mental health organization that can provide this service. In either case, the individual conducting the screening should know how to help the family arrange this next step and facilitate the warm referral process as necessary.

- **Established relationships with community-based organizations that can offer follow-up services**, including local mental health professionals and Family Resource Centers. It can be particularly helpful to include agencies/organizations that can offer low- or no-cost services among those resources, and to ensure that referral agencies have the capacity to serve the child/family in their primary language.

- **A system for following-up with the youth and their family** as appropriate to ensure they are receiving the support they want and need and helping them overcome barriers to accessing services to the extent possible.

Data Collection and Continuous Quality Improvement

There are a variety of considerations regarding collecting data on the screening results. First and foremost, the organization must have a process for protecting the confidentiality of any personal/private information about a child or family.

Beyond that, it can be very helpful to collect and analyze anonymized, aggregated data (to the extent possible given the need to protect confidentiality) to help inform on-going implementation and any process improvements:

- **Data on the prevalence of trauma in a given population of children** can help organizations better understand the histories and needs of the population they serve and inform policy and programmatic decisions.

- **Data on the types of trauma and traumatic symptoms experienced by children screened** can help organizations better identify service needs, which could inform internal programmatic offerings and/or the need to develop or expand certain referral relationships and prevention programs.

Part II: Trauma Screening in Specific Settings

Trauma screenings can, and do, take place in a wide variety of settings. Most commonly, they are conducted as part of larger behavioral health assessment. For example, a therapist working with a child presenting with anxiety or depression may conduct a trauma screening to identify if a traumatic experience may be an underlying cause of the symptoms the child is experiencing.

Conducting a trauma screening and/or assessment is currently a well-established (and generally non-controversial) best practice in behavioral health settings. Less well-established, however – and in some cases, more controversial – is the practice of conducting a trauma screening in other settings, such as schools or pediatric offices. In other contexts – such as with children involved in the child welfare or juvenile justice systems – conducting a trauma screen or assessment may be an established practice in some circumstances, but the practice is not universal.

As noted in the introduction, this is an *interim* report, and the goal is to establish the "lay of the land" before making formal recommendations. As such, this section of the report will focus on describing trauma screening in settings and contexts where it is not currently common, including:

- Arguments *for* conducting a trauma screening in a given setting/context
- Cautions, considerations and/or arguments *against* conducting a trauma screening in a given setting/context
- A description of *current practices in Massachusetts in this sector*, as best as the CTTF has been able to identify
- A *spotlight* on one or more trauma screening programs currently operational in this setting or context

We begin with trauma screening in more "general population" settings, in which the prevalence of exposure to trauma is expected to be lower (e.g., pediatric offices and schools), and then move to settings/contexts where trauma exposure is known to be more prevalent (e.g., child welfare and juvenile justice settings).

Trauma Screening in K-12 Schools

Over the past two decades, there has been an increasing interest in, and understanding of, the negative impact that trauma can have on a child's school experience, including:

- **Learning and academic performance:** Acquiring the necessary skills to read, write, engage in discussion, or solve complex problems requires "attention, organization, comprehension, memory, the ability to produce work, engagement in learning, and trust."[55] Unfortunately, many children who have experienced trauma struggle in these domains: responses to trauma often include hyperactivity, lack of focus, difficulty problem-solving, and lack of sleep, which can worsen other issues.[56]

[55] Cole, S., Greenwald-O'Brien, J., Gadd, M.G., Ristuccia, J., Wallace, D. L., Gregory, M. (2005). *Helping Traumatized Children Learn.* Massachusetts Advocates for Children. https://traumasensitiveschools.org/wp-content/uploads/2013/06/Helping-Traumatized-Children-Learn.pdf

[56] Center for Early Childhood Mental Health Consultation. (n.d.) *Trauma Signs and Symptoms*. Georgetown University Center for Child and Human Development. Retrieved from https://www.ecmhc.org/tutorials/trauma/mod3_1.html

- **Classroom behavior:** Children who suffer from trauma can adopt challenging behaviors (e.g., aggression, withdrawal) as a coping mechanism, leading to conflict in the classroom. As experts note, many of these behaviors "originate from the same problems that create academic difficulties: the inability to process social cues and to convey feelings in an appropriate manner."[57]
- **Relationship with peers and school staff**: Some youth who have suffered trauma may become withdrawn and isolate from their friends and teachers. Others may become verbally and/or physically aggressive. Because trauma can lead individuals to have "distorted perceptions of the intentions, feelings, and behaviors of others," traumatized youth might develop conflictual relationships with peers and authority figures, such as educators and school staff.[58]

> *"I could see the math teacher's mouth moving in the classroom but couldn't hear a thing. It was as if I were in a soundless chamber. She was smiling and clearly talking, I just couldn't process a word of it. I had been an excellent math student, but the day she told me I was "spacey" and unfocused was the day I stopped connecting to math. My grades dropped and they took me out of the advanced classes."*
>
> Teenager suffering from trauma, as quoted in *Helping Traumatized Children Learn* (2005) by the Trauma and Learning Policy Initiative

Detecting that a child has experienced trauma can be a critical first step in connecting them to appropriate behavioral health services that may help improve learning, classroom behavior, and their relationships with others, as well as their own overall well-being. As a fundamental principle, this concept is relatively uncontroversial.

There are, however, differences of opinion on whether *schools* should take specific steps to identify children who have experienced trauma, and, if so, how best to do that.

As described in Figure 3, there are a number of approaches to trauma screenings that K-12 schools can take. In this section, we will describe:

- General arguments in favor of systematic screening for trauma in schools (whether it is through a Universal or Multi-gate Approach)
- Arguments against systematic screening for trauma in schools (in other words, adopting a Selective or Referral/No Screening approach)

[57] Cole, S., Greenwald-O'Brien, J., Gadd, M.G., Ristuccia, J., Wallace, D. L., Gregory, M. (2005). *Helping Traumatized Children Learn.* Massachusetts Advocates for Children. https://traumasensitiveschools.org/wp-content/uploads/2013/06/Helping-Traumatized-Children-Learn.pdf

[58] Rogosch, F.A., and Cicchetti, D. (1994). "Illustrating the Interface of Family and Peer Relations through the Study of Child Maltreatment." *Social Development*, 3: 291–308, cited in TLPI Vol 1.

We will also discuss current practice in Massachusetts, as well as spotlight promising practice in the Methuen Public School District.

Arguments For Systematic Trauma Screening in K-12 Settings

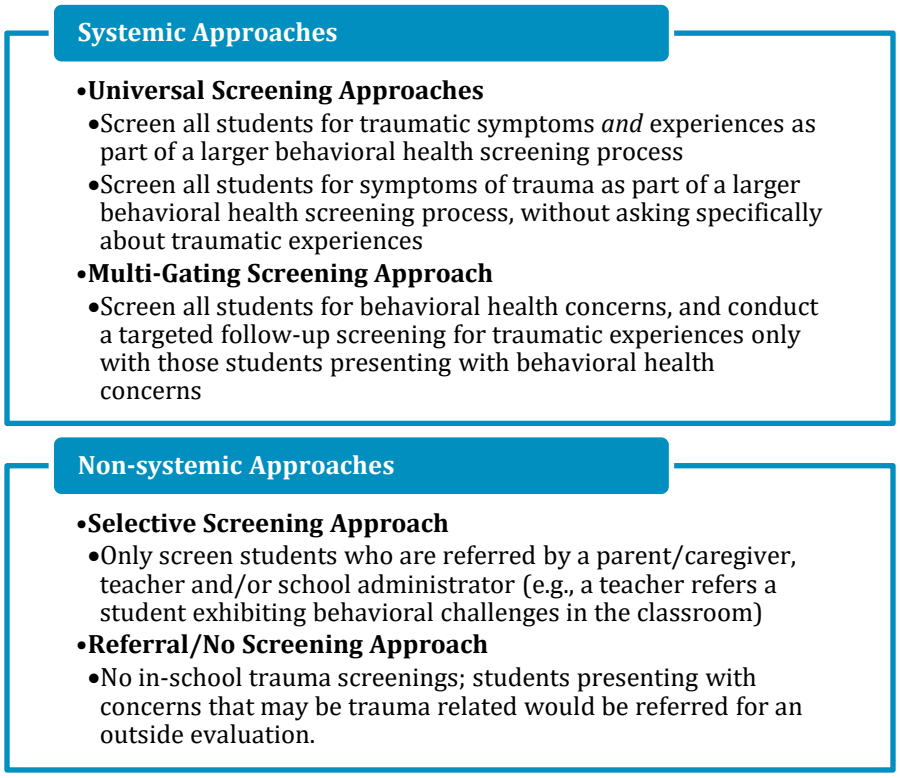

Figure 3: Approaches to trauma screenings in a K-12 setting

It is difficult to disentangle arguments in favor of trauma screening in schools from arguments in favor of mental/behavioral health screening. This is at least partially because universal emotional or behavioral health screening of any sort in schools is still relatively rare: for example, a 2014 study estimated that **only 13% K-12 schools throughout the U.S. conduct schoolwide emotional or behavioral screening**.[59] Although this number has likely increased since that study was conducted, it is still far from a universal practice in Massachusetts or across the nation.

It would not make theoretical or practical sense for a school to conduct a trauma screening but not a larger behavioral health screening, which means **a push to conduct trauma screenings in schools is, almost by definition, a push to conduct behavioral health screenings more generally.**

Given the prevalence of mental health issues and trauma among students, many national professional organizations – including the National Association of School Psychologists and SAMHSA – recommend that schools conduct regular and widespread mental health screening, which may include screening for traumatic symptoms and/or experiences. Proponents of screening in K-12 settings argue that:

[59] Bruhn et al. (2014). A preliminary investigation of emotional and behavioral screening practices in K-12 schools. *Education and Treatment of Children 37,* 4, 611-634. https://www.jstor.org/stable/44683940

- **Schools are where the kids are:** K-12 schools are the single best place to reach the largest percentage of childen and youth. Although many schools are historicaly understaffed when it comes to school social workers, adjustment counselors, and psychologists,[60] the sheer volume of students and schools means that mental health professionals working in schools make up "the largest cadre of primary providers of mental health services for children."[61] Most students who receive mental health services do so in school.[62] Schools can be a particularly efficient and effective setting to reach youth who otherwise lack access to appropriate mental health services, whether due to a shortage of local providers, systematic barriers (e.g., insurance, transportation, behavioral supports, language access,), or inadequate services in the community. Of particular note, access to school-based mental health services has been shown to reduce racial disparities in service access.[63]

Proponents of Screening Youth for Mental/Behavioral Health and/or Trauma in Schools Include:

- The National Center for Mental Health and Juvenile Justice, under the Defending Childhood State Policy Initiative, argues that the "need for thorough and accurate assessment of trauma, including screening and assessment measures has grown in recent years" in its *Guidance for Trauma Screening in Schools* (2016).
- The National Association of School Psychologists' position paper on **Mental and Behavioral Health Services for Children and Adolescents** notes that "Proactive screening and early intervention for young children and families are therefore crucial in order to prevent more debilitating problems and reduce the costs associated with identifying and treating more serious disabilities."
- The Substance Abuse and Mental Health Services Administration (SAMHSA), who, in collaboration with the National Research Council and the Institute of Medicine published in 2019 *Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools*.

School can also be a more convenient place for youth to receive services, which can increase likelihood of treatment completion. For example, a study of children's mental health care following Hurricane Katrina found that 91% of students referred to school-based trauma intervention

[60] Pearrow, M., Berkman, T., Walker, W., Gordon, K., Whitcomb, S., Scottron, B., Kurtz, K., Priest, A., & Hall, A. (2020). Behavioral health capacity of Massachusetts public school districts: Technical report. https://www.umb.edu/birch/research_evaluation

[61] 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

[62] Barrett, S. Eber, L., & Weist, M. (2012). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. University of Oregon. https://www.sdcoe.net/student-services/student-support/Documents/School%20Mental%20Health%20and%20School%20Wide%20PBIS.pdf; 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

[63] Lyon, A. R., Ludwig, K. A., Stoep, A. V., Gudmundsen, G., & McCauley, E. (2013). Patterns and Predictors of Mental Healthcare Utilization in Schools and other Service Sectors among Adolescents at Risk for Depression. *School mental health*, *5*(3), 10.1007/s12310-012-9097-6. https://doi.org/10.1007/s12310-012-9097-6

completed treatment compared to only 15% of students referred to clinic-based treatment, even though both treatments were offered at no cost to families.[64]

- **Screening can identify students who are struggling with trauma or other behavioral health issues that were previously unknown to school staff and/or who are not connected to appropriate services.** Selective identification practices can miss students. For example, a 2014 study that compared elementary-aged students who went through a behavioral and emotional risk screening to current identification practices in schools found that just over 60% of students identified by a screening measure were not previously identified by the school as needing support.[65]

  In particular, many internalizing behaviors, such as anxiety or social withdrawal, often go unnoticed or are viewed as less problematic, while externalizing behaviors, such as aggression, oppositionality, or hyperactivity are more easily recognized by school staff.[66] Internalizing behaviors may also be even more difficult to detect in young children who might not have the verbal skills to describe their feelings.[67] A 2020 study suggests that implementation of a universal screening and intervention program can be particularly effective at increasing positive outcomes for students with internalizing behaviors.[68]

  Even when selective screening practices do appropriately identify students in need of help, the identification may come later than would be ideal, when the symptoms have become more severe and more difficult to treat. This has been described as a "wait-to-fail" model, as compared to a more pro-active systematic screening approach.[69]

- **Selective screening processes can be biased:** Systems that rely on the adults around a child to notice that there is a problem and make a referral can create opportunities for bias. For example, a teacher may be less aware of the internalizing behaviors of some students than others, or more likely to automatically assume some children have experienced trauma compared to others based on demographics.

  As one example, a Boston-based study of the role racial and ethnic demographics play in identifying student mental health issues suggests that educator-based referrals could be more racially biased. Boston Public Schools uses the Behavior Intervention Monitoring Assessment System-2 (BIMAS-2) for educators to assess students' behavioral concerns, which includes externalizing and internalizing concerns, difficulties with attention and/or executive functioning,

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[64] Jaycox, L. et al. (2010, April). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress 23,* 2, 223-231. https://doi.org/10.1002/jts.20518
[65] Eklund, K., & Dowdy, E. (2014). Screening for behavioral and emotional risk versus traditional school identification methods. *School Mental Health: A Multidisciplinary Research and Practice Journal, 6*(1), 40–49. https://doi.org/10.1007/s12310-013-9109-1
[66] Stormont, M., Herman, K. C., & Reinke, W. M. (2015). The Overlooked Children: How Teachers Can Support Children with Internalizing Behaviors. *Beyond Behavior*, *24*(2), 39–45. https://doi.org/10.1177/107429561502400206
[67] Tandon, M., Cardeli, E., & Luby, J. (2009). Internalizing disorders in early childhood: a review of depressive and anxiety disorders. *Child and adolescent psychiatric clinics of North America*, *18*(3), 593–610. https://doi.org/10.1016/j.chc.2009.03.004
[68] Battal, J., Pearrow, MM., & Kaye, AJ. (2020). Implementing a comprehensive behavioral health model for social, emotional, and behavioral development in an urban district: An applied study. *Psychol Schs.* 2020; 57: 1475– 1491. https://doi.org/10.1002/pits.22420
[69] Dowdy, E., Furlong, M., Raines, T.C., Bovery, B., Kauffman, K., Kamphaus, R., Dever, B., Price, M., & Murdock, J. (2015). Enhancing school-based mental health services with a preventative and promotive approach to universal screening for complete mental health. Journal of Educational and Psychological Consultation, 25(2/ 3), 178-197. DOI: 10.1080/10474412.2014.929951

as well as social and academic strengths. A recent study on how the racial demographics of a school impact disproportionality in teacher assessments using BIMAS-2 found that:[70]

- Black students were rated in higher risk-level categories more than expected. For example, Black students were more likely to be referred for mental health services for externalizing problems and inattentive symptoms.
- The proportion of Black students and teachers (compared to White) in a school impacts the BIMAS-2 scores of Black students. Indeed, Black students at schools with fewer Black teachers were rated worse on the behaviors scale. The study hypothesized that this may be a result of a cultural mismatch between students and teachers, and/or indicate insufficient teacher training.

The Boston study, which has not yet been published, has limitations, and further study is ongoing. Still, it serves as a reminder of the many ways bias, both explicit and implicit, can impact subjective decision-making and the need to consider the way it may impact the likelihood of students receiving the services and supports they need.

- **Students are routinely screened for other important health issues.** Hearing and vision are two of the most frequently conducted physical health evaluations in schools, as they can affect students' learning.[71] Proponents of mental health and/or trauma screening argue that identifying *mental* and *emotional* health concerns is as important as *physical* health issues and, as such, schools should screen for all domains of children's health.
- **Screening data can produce school-level data to help inform school decision-making.** Although the primary purpose of screening is to identify students in need of support, systematic screening can also produce data that education professionals can use to:
    - Better understand the prevalence of students experiencing specific symptoms or who have been exposed to trauma, which can in turn help the school secure additional resources to support these children and develop prevention programming.
    - Identify the highest priority need areas for prevention and intervention (e.g., a school might discover that anxiety is the symptom facing the largest swath of students and decide to implement a therapeutic program targeted toward anxiety).

As noted above, screening for trauma should take place within a larger behavioral health screening process. That said, not all behavioral health screening tools are designed to identify youth who have experienced trauma. Therefore, it is important to note that there are **arguments specifically in favor of screening for traumatic experiences.** Namely, as described in Part I, traditional mental health screening tools do not always identify youth who suffer from trauma, and youth who have experienced traumatic events can often benefit from additional support even if they are not currently experiencing acute mental health symptoms. For these reasons, the National Child Traumatic Stress Network argues that trauma screening should include "two critical elements:

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[70] Massachusetts Childhood Trauma Task Force. (2021, May 3). *Childhood Trauma Task Force* [PowerPoint slides]. Office of the Child Advocate. https://www.mass.gov/doc/cttf-may-3-2021-meeting-presentation/download

[71] Healthy Children. (n.d.) *Health Screening at School*. https://www.healthychildren.org/English/ages-stages/gradeschool/school/Pages/Health-Screenings-at-School.aspx

exposure to potentially traumatic events/experiences, including traumatic loss, and traumatic stress symptoms/reactions."[72]

Arguments Against Systematic Trauma Screening in K-12 Settings

While there is widespread agreement that, in certain circumstances, a trauma screening or assessment process can be helpful in connecting students with the most appropriate services, there is not universal agreement that schools should conduct *systemic* screenings for trauma, and in particularly systemic screenings for exposure to potentially traumatic events. Arguments against systemic trauma screening in school include:

- **There are better ways to use scarce resources:** Schools have very different financial, staffing, and structural capacities. As such, it is critical for schools to identify what their priorities are and how they can best support students who have experienced trauma or struggle with mental health issues. Given limited resources, some argue that other efforts should be prioritized over systemic screening for trauma.

  For example, at an April 2019 Childhood Trauma Task Force meeting, Michael Gregory of the Trauma and Learning Policy Institute (TLPI) at Massachusetts Advocates for Children argued schools should instead focus on establishing a trauma-sensitive culture where students have "established nurturing, respectful, caring relationships with trusted adults."[73]

  Similarly, a task force set up to study universal trauma screening in schools in South Dakota recommended that schools broaden community prevention education to change the community's culture around trauma, implement school staff/stakeholders training to obtain buy-in, and screen all students for internalizing and externalizing behaviors *before* screening those with identified behavioral issues for trauma.[74]

- **Selective screening processes are sufficient:** Forgoing systemic screening does not necessarily mean forgoing screening all together. Schools that wish to have a process in place to identify youth who may have experienced trauma could opt for selective screening, whereby certain students who have met certain criteria indicating they might have experienced trauma or mental health challenges are selected to be screened. One advantage of using a selective screening approach is that it requires fewer resources (e.g., time, funding, staff) than a universal screening approach, allowing scarce resources to be targeted for students who are most at risk.

  The decision to refer a student for trauma screening can be based on school staff's observation. Appropriate training can help ensure that mental health school staff and educators are better able to notice if a student might be showing common trauma responses, such as lack of focus, aggressive or disruptive behavior, or change in academic performance.

- **Concerns regarding stigma and confidentiality:** Some have also raised concerns regarding the confidentiality of information that children provide, and the potential for children who

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[72] The National Child Traumatic Stress Network. (n.d.). *What is a Trauma Screening Tool or Process*? https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-screening

[73] Massachusetts Childhood Trauma Task Force. (2021, April 10). *Childhood Trauma Task Force* [PowerPoint slides]. Office of the Child Advocate. https://www.mass.gov/doc/cttf-april-10th-meeting-presentation/download

[74] Oyen, K. (n.d.) Universal Trauma Screening in Schools. The Center for the Prevention of Child Maltreatment at USD. Retrieved from https://www.sdcpcm.com/schools/

disclose traumatic events, in particular, to be stigmatized or treated differently by the school district in a way that could be detrimental to that child. For example, at the same April 2019 presentation, Mr. Gregory of TLPI argued that "because of the high potential for stigma, screening for *experiences* is more problematic than identifying *clusters of symptoms* in students who are exhibiting observable difficulties at school."[75]

What's Currently Happening in Massachusetts?

There is no master list available of schools that have implemented any sort of universal behavioral health screening process, much less a screening process specific to trauma. Based on conversations with practitioners, the Childhood Trauma Task Force estimates, that in Massachusetts:

- Most if not all schools are currently screening students for substance use concerns using SAMHSA's "Screening, Brief Intervention and Referral to Treatment" (SBIRT) process. Use of the SBIRT process in public schools in Massachusetts is mandated by law under the 2016 STEP (Substance Use Treatment, Education and Prevention) Act.

- Many schools currently screen for suicidal ideation using a screener such as the Signs of Suicide (SOS) tool. The SOS tool is available to middle and high schools at no cost via the Department of Public Health's Suicide Prevention Program.[76]

- Several schools are implementing screening tools that assess a student's social/emotional/behavioral functions more broadly. For example, the Boston Public School District – the largest school district in the state – currently uses a screening tool to assess student's social, emotional, and behavioral functions (the BIMAS-2).

- Use of screening tools specifically for depression and anxiety is growing, although this is still not a widespread practice.

- The CTTF is currently aware of only two school districts – Methuen and Arlington – that administer a screening tool specific to trauma (the UCLA COVID-19 Brief Trauma Screen).

[75] Massachusetts Childhood Trauma Task Force. (2021, April 10). *Childhood Trauma Task Force* [PowerPoint slides]. Office of the Child Advocate. https://www.mass.gov/doc/cttf-april-10th-meeting-presentation/download

[76] See: https://www.mass.gov/service-details/massachusetts-department-of-public-health-offers-schools-access-to-sos-signs-of

What About Trauma Screening in Early Education?

Throughout the U.S., organizations in early childhood settings seem to prioritize a trauma-informed culture over systematic identification of childhood trauma. In fact, our research has not revealed any programs or initiatives that uses universal trauma screening in early childhood settings such as daycares or Home Visiting Programs (HVP) to identify children who have experienced from trauma. This is likely because:

- Using screening tools on young children is difficult. Not only must professionals often relying on interpretation of symptoms for preverbal children, but very few screening tools have been validated for this population.
- Early childhood trauma is often rooted in the caregiving relationship, which is especially critical for child's development in the early years. As such, focusing on identifying parental mental health or trauma-related issues and the child-caregiver relationship makes more sense for very young children.

Trauma Smart, an evidence-based program implemented in Head Start classrooms across the nation, is an example of an early childhood program that has consciously opted to create a trauma-informed school environment to support young children who might have experienced trauma rather than systematically screen for trauma. Developed in Kansas City, MO, the model brings together teachers, administrative/support staff, and family members to ensure everyone in a child's life understands trauma responses and the impact of trauma. If any adult suspects the child might have experienced trauma, both the child and their caregivers are supported by trauma-informed clinical services and other necessary supports (e.g., assistance with food or housing).

While the program's mental health specialists use the Childhood Trust Events Survey to gain insights into events that could have led to the child's trauma (if they are referred to therapeutic services), the program prefers using other measures to assess and ensure they are trauma-informed, such as the Classroom Assessment Scoring System (CLASS), the Attitudes Related to Trauma Informed Care (ARTIC), as well as parent/teacher post-training tests and ongoing focus groups and feedback from stakeholders.

Based on feedback from practitioners, the CTTF understands that there has recently been a significant increase in interest from schools in implementing a universal behavioral health screening practice, due to increasing concerns about student's mental health in the wake of the COVID-19 pandemic. As a result, the above numbers may have increased this school year.

There are a variety of efforts currently underway to support schools interested in implementing behavioral health screening processes:

- In October 2021, the Department of Elementary and Secondary Education (DESE) released a competitive grant opportunity for schools interested in (among other things) piloting a universal mental health screening process for students in kindergarten to grade 12.

- Given the increased interest in this topic, the UMass BIRCh Project recently released a 7-module training for schools on use and implementation of universal screening, which is freely available at https://www.umb.edu/birch/online_learning.

- Additionally, the Rennie Center, the Massachusetts School Mental Health Consortium, and BRYT (Bridge for Resilient Youth in Transition) have recently teamed up with the Department of Elementary and Secondary Education on a new initiative, Thriving Minds. Among other things, Thriving Minds will provide training to schools on building comprehensive school mental health systems, including sessions on implementation of behavioral health screening tools. The Thriving Minds team is also partnering with the Center on Child Wellbeing and Trauma to offer training and coaching support specific to trauma, including implementation of trauma screening tools.

Spotlight: Methuen Public Schools' "Start Small, Build Off Success" and Data-Driven Approach[77]

The Methuen Public School system (MPS) provides an example of a school district that has built out its capacity to conduct evidence-based universal mental health screenings of students over time, as part of an overall effort to expand the mental health services and supports for Methuen students. Methuen took a step-by-step approach to implementing mental health screening starting in the 2015-2016 school year.

To decide which behavioral health screener to use, Methuen school leaders analyzed data from their 2013-2015 counseling logs, data from their school district's Youth Risk Behavioral Survey as well as a survey of all school mental health staff to better understand the most prevalent problems they were addressing with students as well as what students reported to be the most pressing issues. Results revealed that while externalizing behaviors posed issues in the classroom, many students suffered from internalizing concerns such as anxiety and depression that needed to be addressed. The School Health Assessment and Performance Evaluation (SHAPE) System is a web-based system to monitor and evaluate a district's implementation of a comprehensive school mental health system (CSMHS). SHAPE houses a variety of resources, including a screening and assessment library, that Methuen used to select multiple screeners – namely, the PHQ-9 for depression and GAD-7 for anxiety

Methuen's Critical Components of Universal Mental Health Screening Implementation:

1.Developing a team to support screening

2. Generating buy-in from school and community stakeholders

3. Providing professional development and technical assistance to ensure MH staff readiness

4. Selection of the population to screen

5.Selection of a screening measure

6. Design and adoption of consent procedures

7. Planning for the administration of screening

8. Data collection, analysis, and warehousing considerations

9.Conducting a coordinated follow up to address the needs of identified students

[77] Crocker, J. (2021, May 3). *Childhood Trauma Task Force* [PowerPoint slides]. Office of the Child Advocate. https://www.mass.gov/doc/cttf-may-3-2021-meeting-presentation/download

for grades 9-12 and the RCADS for anxiety and depression in grades 5-8 – to obtain a comprehensive view of their student population's needs.

MPS began by piloting these screening tools on a small scale with individual students and incrementally scaled up the population being screened, moving from individual screening to classroom, grade level, and, eventually, whole school screening. Over time, and as the utility of this approach became more evident to them, they have expanded the practice to the point at which they have implemented it districtwide annually.

This gradual approach enabled the leaders of this initiative to work through logistical challenges, such as:

- How to transition from paper-based screenings to web-based screenings to facilitate data collection and analysis.
- Who was best placed to administer screenings. Initially, school mental health staff administered them, but the district eventually shifted to teachers of advisory and tech courses to accommodate large-scale, computer-based efforts.
- How to collect consent from parents and guardians. Over time, the district shifted from active to passive consent after determining that the former was too logistically difficult to implement and yielded fewer opportunities for widespread identification of mental health issues. Additionally, school leaders wanted to put mental health screening on par with physical health screenings, for which passive consent was used.

Mental health staff receive screening data within twenty minutes of completion of the screening (which are self-report by the students), allowing for immediate follow-up for students who have elevated scores (e.g., suicidal ideation or intent to self-harm). Methuen has documented screening follow-up protocols, which include meeting with the student to discuss the results and asking additional questions to aid in determining the appropriate next steps. The school staff also contact the parents/guardians to discuss the results of the screening. Based on the results of these conversations, students may be referred to a variety of services, including school-based individual or group therapy. Crisis teams are also placed on call in advance of a screening in case those services are necessary.

Screening with Equity in Mind

Methuen Public Schools strived to center equity in screening implementation by considering the following factors:

- What is the cultural background of our students, and do the screening measures we have chosen match our student population's needs and beliefs?
- If I use this measure, will ALL students be able to access it? Is it available in multiple languages? If not, how will we plan for translation?
- As we pilot screening, is our sample of students reflective of our population?

The utility of using a systematic mental health screening process was immediately visible to school leaders, as data from the first year showed a 63% increase in the identification of students eligible for mental health services. The school has found that **screening allows the school to pro-actively identify emerging concerns and connect students to preventative services earlier, which in turn reduces the likelihood that students will develop more serious mental health problems and reduce instances of crisis.**

Having implemented a data-driven system catered to the needs of students and capacity of its staff, Methuen was able to smoothly integrate a trauma screening tool during the COVID-19 pandemic. Data from this additional screening revealed that a significant number of students experienced trauma during the pandemic: 37.7% of students at Methuen High School had elevated scores on the UCLA COVID-19 Brief Trauma Screen during the 2020-2021 academic year. These results later informed Methuen's recent development of a three-year strategic plan that bolsters and augments their existing comprehensive school mental health system by emphasizing the need to address trauma in the district's schools.

Trauma Screening in Pediatric Health Settings

Given the known links between childhood trauma and long-term physical health, pediatric practices are commonly considered as settings in which universal or selective trauma screenings could take place.[78] As with K-12 education settings, there is continued debate about the appropriate role that pediatricians should play and which approach would be most effective.

A decade ago, there was considerably less attention to and recognition of PTSD in children – much less signs of trauma that do not rise to the level of PTSD – by pediatricians. For example, a 2008 study of 597 pediatricians in Massachusetts revealed that only 18% of pediatricians within a pediatric primary care clinic reported feeling as if they had "adequate knowledge" of childhood PTSD.[79] Further, a 2010 study at two mental health programs for youth in Pennsylvania demonstrated that clinicians were missing the diagnosis of PTSD about 90% of the time.[80]

Although similar studies have not, to the best of the CTTF's awareness, been replicated recently, it seems very likely that pediatrician *awareness* of trauma has increased dramatically in the past ten years given the increased focus on the topic both in society at large and, in particular, within pediatrics. In 2012, for example, the American Academy of Pediatrics issued a policy statement about the impact of toxic stress on brain development and longer-term health outcomes. The policy statement highlights the role of a pediatrician in early identification of developmental concerns as well as providing interventions that reduce external threats to healthy brain growth, including trauma.[81] This policy statement was focused on the importance of trauma prevention and the role of pediatricians in addressing toxic stress in a child's life.

It is only in recent years, however, that there has been a concerted and more widespread movement within pediatrics focused on the role of pediatricians in identifying and diagnosing trauma (recognition) and making referrals for services as necessary (response). In 2019, the state of California launched the statewide ACEs Aware initiative to train and provide payments to Medi-

[78] For more information on the impact of toxic stress on individual's long-term health outcomes see CTTF 2019 report (p.13); Massachusetts Childhood Trauma Task Force. (2019). *Next steps for addressing childhood trauma: Becoming a trauma-informed and responsive Commonwealth*. Office of the Child Advocate. https://www.mass.gov/doc/next-stepsfor-addressing-childhood-trauma-becoming-a-trauma-informed-and-responsive/download

[79] Banh, M. K., Saxe, G., Mangione, T., & Horton, N. J. (2008). Physician-reported practice of managing childhood posttraumatic stress in pediatric primary care. *General Hospital Psychiatry, 30*(6), 536–545 https://psycnet.apa.org/record/2008-16054-010

[80] Miele, D., & O'Brien, E.J. (2010). Underdiagnosis of posttraumatic stress disorder in at risk youth. *Journal of Traumatic Stress, 23*(5), 591-598. https://doi.org/10.1002/jts.20572

[81] Garner, A. S., Shonkoff, J. P., Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, & Section on Developmental and Behavioral Pediatrics (2012). Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*, *129*(1), e224–e231. https://doi.org/10.1542/peds.2011-2662

Cal (the California version of MassHealth) providers to use an Adverse Childhood Experiences (ACEs) questionnaire as a means of detecting toxic stress risk.[82] This policy has provoked considerable controversy, however, primarily due to concerns about the appropriateness of screening for traumatic *experiences* rather than *symptoms* in pediatric settings, and the limited research on the specific tool chosen by California. (This topic is further discussed in *Screening for Trauma Symptoms or Events in Pediatric Health Settings? The Controversy around Using the ACEs Questionnaire,* below.)

In 2021, the American Academy of Pediatrics endorsed a different approach, issuing a policy statement and clinical report in August 2021 that recommended that health organizations "commit to becoming trauma-informed system[s]of care and integrate clinical practice of TIC into all services" and "expand and improve system-wide strategies for identification and treatment of all children and adolescents affected by traumatizing experiences."[83]

The AAP policy statement and clinical practice guide did not specifically recommend that all pediatricians universally screen patients for trauma, but instead described a variety of approaches, from clinical observation/conversation to selective screening to universal screening, that pediatricians might opt to establish in their practice. That said, it is important to note that the AAP policy statement did call on federal and state governments to "**mandate coverage for TIC services by government and private payers, including screening,** diagnosis, office-based management, counseling, case management, community collaboration, and home visiting."

Similarly, in October 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association joined together to declare a "National State of Emergency in Children's Mental Health", noting that they are "caring for young people with soaring rates of depression, anxiety, trauma, loneliness, and suicidality that will have lasting impacts on them, their families, and their communities." As part of that declaration, they called for policymakers at all levels of government to "promote and pay for trauma-informed care services that support relational health and family resilience."[84]

In this section, we will discuss:

- General arguments in favor of systematic screening for trauma in pediatric settings
- Cautions about and arguments against systemic screening for trauma in pediatric setting
- The controversy over the use of the ACES questionnaire in California
- A description of the current landscape with regards to trauma screening in pediatric settings in Massachusetts

We also highlight a promising model first implemented in Utah and currently being implemented in a number of settings, the Utah Pediatric Integrated Post-Trauma Services (PIPS) program.

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[82] See: https://www.acesaware.org/

[83] Duffee, J., Szilagyi, M., Forkey, H., Kelly, E. T., & Council on Community Pediatrics, Council on Foster Care, Adoption, and Kinship care, on Child Abuse and Neglect, Committee on Psychosocial Aspects of Child and Family Health. (2021). Trauma-Informed Care in Child Health Systems. *Pediatrics*, *148*(2), e2021052579. https://doi.org/10.1542/peds.2021-052579

[84] American Academy of Pediatrics. (n.d.). *A declaration from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association*. https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/

Arguments in Favor of Screening for Trauma in Pediatric Health Settings

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

- **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 and their pediatrician's office several times each year.[85] When working in collaboration with community stakeholders, physicians are especially well-equipped to support children and families living in poverty or under-resourced communities.[86]
- **Identifying children who suffer from toxic stress is part of trauma-informed care.** In the past few decades, the growing understanding of the impact of trauma on the brain and body has led to a push to integrate trauma-informed care in healthcare practices writ large. In line with this approach, some argue that identifying youth who suffer from trauma can be efficiently done by systematically screening children using validated tools.[87] In August 2021, as outlined in Figure 4, the American Academy of Pediatrics (AAP) defined the identification of trauma-related signs and symptoms by screening and surveillance as one of the three core components of Trauma-Informed Care

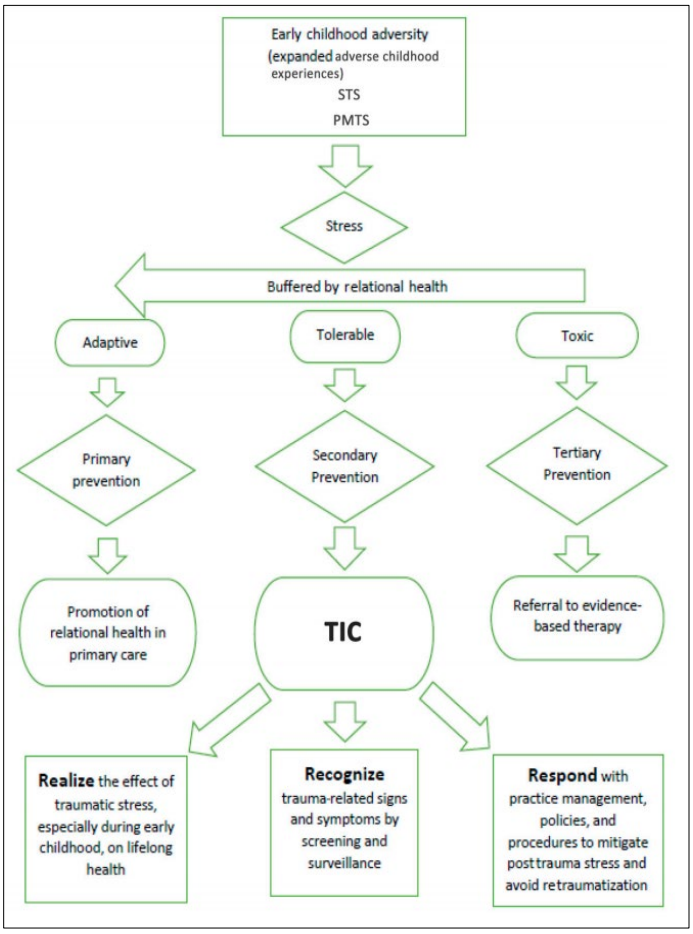

Figure 4: AAP Pediatric Approach to Trauma-Informed Care (TIC)

[85] 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

[86] Plax, K., Donnelly, J., Federico, S. G., Brock, L., & Kaczorowski, J. M. (2016). An Essential Role for Pediatricians: Becoming Child Poverty Change Agents for a Lifetime. *Academic pediatrics*, *16*(3 Suppl), S147–S154. https://doi.org/10.1016/j.acap.2016.01.009 ; Rushton, F. E., Jr, & American Academy of Pediatrics Committee on Community Health Services (2005). The pediatrician's role in community pediatrics. *Pediatrics*, *115*(4), 1092–1094. https://doi.org/10.1542/peds.2004-2680

[87] 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 ; Hornor G. (2015). Childhood trauma exposure and toxic stress: what the PNP needs to know. *Journal of pediatric health care: official publication of National Association of Pediatric Nurse Associates & Practitioners*, *29*(2), 191–198. https://doi.org/10.1016/j.pedhc.2014.09.006; Aldridge, M., Goode, Z., Garbus, L., DeSousa, L., Fioroni, T., Oropeza-Diaz, Y., Delgado, K., Friderici, J., & Crlin, S. Aldridge, M., Goode, Z., Garbus, L., DeSousa, L., Fioroni, T., Oropeza-Diaz, Y., Delgado, K., Friderici, J., & Crlin, S. (2015). Developing a Toxic Stress Screening Protocol and Referral System in a Large Inner-City Pediatric Practice: An Update from Longitudinal Data Collection. American Academy of Pediatrics. Retrieved from https://aap.confex.com/aap/2015/webprogrampress/Paper29985.html

(TIC).[88]

- **Within integrated healthcare systems, screening for trauma at the pediatrician's provides an opportunity for immediate links to behavioral health care.** In line with a national push for more holistic approaches to wellbeing across child-serving sectors, primary care providers are increasingly collaborating with behavioral health specialists to ensure "the establishment of a comprehensive treatment plan to address the biological, psychological and social needs of the patient."[89] In integrated healthcare settings, pediatricians are ideally placed to identify youth who have experienced trauma and immediately refer them to professionals who can provide the necessary clinical and social supports to the youth and their family. Of note, this model addresses one of the main challenges of screening for trauma, that is, the need for appropriate referrals and timely treatment once a youth has been identified as needing trauma services.
- **Health care providers have a role to play in dismantling the trauma-to-prison pipeline.** Challenging behaviors are normal reactions to abnormal, violent, or life-threatening events. Yet, as the high prevalence of youth in the juvenile justice system demonstrates, youth who suffer from trauma are often punished for their reactions to what happened to them. Some medical providers have therefore argued that pediatric care providers should use "an ecological approach to understand and dismantle the trauma-to-prison pipeline" by advocating for a trauma-informed approach, including "standardized, holistic trauma screening to identify children who would benefit from referrals to mental and behavioral health services or evidence-based trauma treatment.[90]

Cautions About and Arguments Against Screening in Pediatric Health Settings

As with trauma screening in K-12 educational settings, cautions about and arguments against trauma screening in pediatric settings focus primarily on prioritization: how should pediatricians used their limited time with patients, and what systemic reforms are necessary before implementation of a universal screening practice becomes advisable? These arguments include:

- **Trauma screening should only be implemented within a trauma-informed care framework:** Just as professionals in education settings caution that schools must establish trauma-informed environments, policies, and practices before implementing trauma screening systems, professionals in the medical field warn that trauma screening should only be implemented within a trauma-informed care framework. The American Academy of

[88] Duffee, J., Szilagyi, M., Forkey, H., Kelly, E. T., & Council on Community Pediatrics, 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 in Child Health Systems. *Pediatrics*, *148*(2), e2021052579. https://doi.org/10.1542/peds.2021-052579
[88] 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
[89] See the American Psychological Association's Integrated Health Care: https://www.apa.org/health/integrated-health-care
[90] Sinko, L., He, Y., & Tolliver, D. (2021). Recognizing the Role of Health Care Providers in Dismantling the Trauma-to-Prison Pipeline. *Pediatrics*, *147*(5), e2020035915. https://doi.org/10.1542/peds.2020-035915

Pediatrics' (AAP) holistic approach to identifying trauma advocates for the use of screening tools to take place *in conjunction with* the following clinical strategies and skills:[91]

- Knowledge about trauma and its potential lifelong effects
- Support for the caregiver-child relationship to build resilience and prevent traumatic stress reactions
- 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)

The AAP does not outright argue for the broad use of universal trauma screening among pediatricians and primary care providers. Instead, in a policy issued in August 2021, it has taken a more cautious approach to **identifying childhood trauma by defining detection as involving "both surveillance and screening**." The AAP defines surveillance as the general observation of all those who may be affected by the suffering of the child (e.g., the child itself, family members, social workers, first responders). Surveillance is also less formal than screening and can be conducted at every visit.

In its policy statement and clinical report, the AAP therefore leaves the possibility for providers in pediatric settings to decide which model to opt for: a selective screening approach, where providers, through observation and conversation, identify youth who might benefit from being screened for trauma symptoms, or a universal screening approach, where providers establish trauma screening for all their patients.[92]

- **Pediatric visits are short; trauma screenings may not be the best use of time for all patients.** The AAP currently recommends that children receive "well-child" visits – visits in which a pediatrician conducts a variety of health-related screenings and assessments, as opposed to a visit about a specific symptom or illness – on a set schedule, starting with every few months when a child is first born, and settling into a once a year from age three onward.[93] The length of the visit may vary based on the pediatrician, the child, and the child's age, but these visits are typically fairly short in length. A 2011 survey found, for example, that a third of parents reported that their child's last well-child visit lasted 10 minutes or less, and nearly half spent 11 to 20 minutes.

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[91] Forkey, H., Szilagyi, M., Kelly, E. T., Duffee, J. (2021, August). Trauma-Informed Care. *Pediatrics 148*, 2. https://pediatrics.aappublications.org/content/pediatrics/148/2/e2021052580.full.pdf

[92] Duffee, J., Szilagyi, M., Forkey, H., Kelly, E. T., & Council on Community Pediatrics, 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 in Child Health Systems. *Pediatrics*, *148*(2), e2021052579. https://doi.org/10.1542/peds.2021-052579

[92] 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

[93] Healthy Children (n.d.). *AAP Schedule of Well-Child Care Visits*. https://healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx

Given the large number of screenings and assessments a pediatrician may want to do in that short amount of time, some argue that screening children for trauma – and, in particularly screening *all* children for trauma as compared to only those children for which there is some indication of trauma due to a parent or caregiver's report or symptoms a child is displaying – is not a good use of limited time.

Currently, the U.S. Preventative Services Task Force (USPSTF), which makes recommendations about the effectiveness of specific preventive care services for patients without obvious related signs or symptoms based on a systematic review of available evidence of the benefits and harms of a given service, does not recommend that pediatricians universally screen children for trauma.[94]

The Importance of Trust

As discussed in "Requirements for Effective Implementation of Trauma Screenings," above, **trust is critical to the successful use of trauma screening** processes in any child-serving setting. A recent study of low-income parents' perspectives on how pediatricians could screen for social determinants of health highlights that parents "could only share information about sensitive topics in the context of a trusting relationship." However, many parents were reluctant to open up to their pediatrician out of "concerns about being judged and discriminated against, about fitting discussions of complex topics into short appointments, and that they wouldn't get help even if they did share sensitive information." In particular, parents worried that divulging information would lead to scrutiny from child welfare agencies.

The parents surveyed for this study recommended that pediatricians seeking to build the trust needed to conduct a sensitive screening process should:

- Approach discussions respectfully, without shaming
- Choose the right moment to ask about social needs
- Don't ask in front of the children
- Signal confidentiality, where approach, and be transparent about what would trigger a report to child welfare.
- Do not ask just for the sake of asking – follow up with services and supports when necessary
- Make clear that screening is standard protocol

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/

[94] See U.S. Preventive Services Website: https://www.uspreventiveservicestaskforce.org/uspstf/

Screening for Trauma *Symptoms* or *Events* in Pediatric Health Settings? The Controversy around Using the ACEs Questionnaire

While "trauma screening" has thus far been defined broadly, the medical field has centered much of its conversation on this topic on the difference between screening for trauma-related *symptoms* (i.e., PTSD) or *events* (i.e., potentially traumatic experiences or Adverse Childhood Experiences (ACEs)).

The debate between screening for symptoms or events was pushed to the forefront by California's statewide ACEs Aware initiative to train and provide payments to Medi-Cal providers to use an Adverse Childhood Experiences (ACEs) questionnaire as a means of detecting toxic stress risk (effective January 2020). The questionnaire, called the Pediatric ACEs and Related Life-Events Screener (PEARLS), was developed by the University of California San Francisco and contains two sections. The first asks about the ten most commonly established ACEs (see *Definitions of Key Terms* on page 5), while the second—optional—section inquiries about other adverse experiences (e.g., witnessing violence or experiencing discrimination) as well as common social determinants of health (e.g., housing or food-related issues).[95]

ACEs Aware by the numbers in 2020:

- Over 15,000 providers trained and 97% of participants plan to implement changes in their practice or already reinforced their current practice.
- Over 155,000 screenings conducted. Of 130,000 unique Medi-Cal beneficiaries screened for ACEs, 6% had ACE scores of 4 or more.

ACES Aware. (2021, March). Fact Sheet: ACES Aware in California. Aces Aware. Retrieved from *https://www.acesaware.org/wp-content/uploads/2021/03/ACEs-1-Page-Fact-Sheet-FINAL-2-25-21_a11y.pdf*

Proponents of using ACEs questionnaires (PEARLS or other) in pediatric primary care settings argue the following:

- **Screening children and parents/caregivers for ACEs in pediatric settings is an effective prevention strategy.** A study of 151 infants at a community medical clinic found that almost half (47%) of patients who were screened using an ACEs questionnaire were identified as being at "intermediate risk" for trauma and the majority (77%) of referred families accepted prevention services.[96] These prevention services include housing and food supports, parenting education, and mental health supports for caregivers. The potential of ACEs questionnaires to prevent child maltreatment or childhood trauma by providing caregivers with needed supports has also led some providers to screen parents—rather than children—for childhood adversity.[97]

[95]See the Pediatric ACEs and Related Life-events Screener (PEARLS): https://www.dhcs.ca.gov/provgovpart/Documents/PEARLS_FAQ_1.15.19.pdf

[96] Kia-Keating, M., Barnett, M. L., Liu, S. R., Sims, G. M., & Ruth, A. B. (2019). 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.1236

[97] The Children's Clinic in Portland, Oregon, provides a good example of the use of screening for parental ACEs to increase parents and caregivers' understanding of childhood trauma, how it can affect their parenting, and provide them and their children with the supports they need. https://www.oregon.gov/oha/HPA/dsi-tc/Documents/CCI-poster-Gillespie.pdf

- **The ACE score, combined with other assessments, identifies the possibility of toxic stress.** As Dr. Nadine Burke Harris, the California Surgeon General who helped launch ACEs Aware, notes, "although the ACE score alone is an imperfect proxy for toxic stress, a complete ACE screening involves clinical assessment, including for protective factors and ACE-associated health conditions. Together, these indicators inform assessment of toxic stress risk."[98]
- **The widespread use of ACEs questionnaires can spur a better understanding of childhood trauma among caregivers and professionals.** Using the questionnaire can facilitate a conversation between medical providers and families about trauma, the connection between mental and physical health, and how childhood adversity can impact parenting. Additionally, beyond identifying individuals (both young and adult) who might have experienced traumatic events, the science behind ACEs is also of much use to educate providers.[99]
- **ACEs data can inform public policy.** California's statewide initiative provides a rare opportunity to collect data to understand the prevalence and impact of childhood adversity among a broad and diverse population as well as successes/challenges in referral and treatment services.[100]

> *"Awareness of ACEs is valuable to public health, but is insufficient to meet the needs of children and families who have been exposed to trauma and adversity."*
>
> National Child Traumatic Stress Network. (2021). *Beyond the ACEs Score: Perspectives from the NCTSN on child trauma and adversity screening and impact.* *https://www.nctsn.org/sites/default/files/resources/special-resource/beyond-the-ace-score-perspectives-from-the-nctsn-on-child-tauma-and-adversity-screening-and-impact.pdf*

Many pediatric providers instead advocate for the use of screening tools that identify trauma *symptoms*—rather than *events*—which form the basis for a Post-Traumatic Stress Disorder (PTSD) diagnosis.[101] Those who raise concerns regarding the use of ACEs to screen youth for trauma argue that:

- **ACEs do not necessarily equate trauma or toxic stress.** Many children experience scary or dangerous events, but only some will become traumatized. The danger to one's health therefore does not come from the experience itself, but the impact it can have on one's mental and physical health. As Dr. Heather Forkey of UMass Medical School explained in her presentation to the Childhood Trauma Task Force in July 2021, toxic stress is defined as the "excessive or prolonged activation of stress response systems in the absence of buffering

[98] Harris N. B. (2020). Screening for Adverse Childhood Experiences. *JAMA*, *324*(17), 1788–1789. https://doi.org/10.1001/jama.2020.16452
[99] Gordon, J. (2021, May 26). Criticizing ACEs in peer reviewed professional journals impairs child abuse treatment [blog post]. *ACEs in Pediatrics.* *https://www.pacesconnection.com/g/aces-in-pediatrics/blog/criticizing-aces-in-peer-reviewed-professional-journals-impairs-child-abuse-treatment*
[100] Anda, R. F., Porter, L. E., & Brown, D. W. (2020). Inside the Adverse Childhood Experience Score: Strengths, Limitations, and Misapplications. *American journal of preventive medicine*, *59*(2), 293–295. https://doi.org/10.1016/j.amepre.2020.01.009
[101] 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

protection from adult caregivers."[102] As such, only considering adverse experiences without identifying buffers that promote resilience or identifying trauma *symptoms* is not an effective strategy to support children who suffer from trauma.

- **ACEs questionnaires are too simplistic.** As the NCTSN notes, "not all ACEs are created equal."[103] Indeed, experiencing the divorce of one's parents is not the same as being repeatedly maltreated by one's caregiver. Additionally, many factors influence whether a child who has experienced a scary, dangerous, or life-threatening event will suffer from it afterwards. A child's developmental stage, history of previous traumatic events, support of loving caregivers, positive childhood experiences, as well as the frequency, intensity, or chronicity of exposure all affect how a child will respond to the event. All of these factors also have important implications for referral and treatment. As such, many experts warn that the ACEs questionnaire is not an adequate tool to identify childhood trauma in primary care settings.[104]
- **ACEs questionnaires are too narrow.** The 10-item list of adverse experiences from the original ACEs study "captures a narrow experience of childhood adversity" as it excludes many other potentially traumatic events, such as traumatic grief, medical trauma, natural or manmade disasters, kidnapping, serious accidents, forced displacement, or community violence.[105] The PEARLS screening tool's second section, which is not consistently used by pediatricians in California, includes a slightly broader range of potentially traumatic experiences, such as discrimination or grief, but omits many other potentially traumatic events.
- **The PEARLS screening tool has not (yet) been validated.** Robert Anda, co-author of the original ACEs study, warns that "the ACE score is not a standardized measure of childhood exposure to the biology of stress" and should not be used as a diagnostic screening tool.[106] A validation study for the PEARLS screening tool is currently underway.[107]
- **There are no proven interventions based on one's ACEs score.**[108] California providers using the PEARLS screening tool are encouraged to ask for de-identified results of an individual's ACEs score (rather than list individual adverse experiences) to reduce the fear and anxiety parents may have when answering questions relating to their private lives. Yet, without understanding the specific event, appropriate referral for services is difficult if not

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[102] Forkey, H. (2021, July 19). *Childhood Trauma Task Force* [PowerPoint slides]. Office of the Child Advocate. https://www.mass.gov/doc/cttf-july-19-2021-meeting-presentation/download

[103] The National Child Traumatic Stress Network. (n.d.) *Beyond the ACE Score: Perspective from the NCTSN on Child Trauma and Adversity Screening and Impact*. https://www.nctsn.org/sites/default/files/resources/special-resource/beyond-the-ace-score-perspectives-from-the-nctsn-on-child-tauma-and-adversity-screening-and-impact.pdf

[104] Anda, R. F., Porter, L. E., Brown, D. W. (2020). Inside the Adverse Childhood Experiences score: Strengths, limitation, and misapplications. *American Journal of Preventive Medicine.* https://doi.org/10.1016/j.amepre.2020.01.009

[105] The National Child Traumatic Stress Network. (n.d.) *Beyond the ACE Score: Perspective from the NCTSN on Child Trauma and Adversity Screening and Impact*. https://www.nctsn.org/sites/default/files/resources/special-resource/beyond-the-ace-score-perspectives-from-the-nctsn-on-child-tauma-and-adversity-screening-and-impact.pdf

[106] Anda, R. F., Porter, L. E., Brown, D. W. (2020). Inside the Adverse Childhood Experiences score: Strengths, limitation, and misapplications. *American Journal of Preventive Medicine. 59*(2), 293–295. https://doi.org/10.1016/j.amepre.2020.01.009

[107] Thakur, N., Hessler, D., Koita, K., Ye, M., Benson, M., Gilgoff, R., Bucci, M., Long, D., & Burke Harris, N. (2020). Pediatrics adverse childhood experiences and related life events screener (PEARLS) and health in a safety-net practice. *Child abuse & neglect*, *108*, 104685. https://doi.org/10.1016/j.chiabu.2020.104685

[108] Campbell, T. L. (2020). Screening for Adverse Childhood Experiences (ACEs) in Primary Care: A Cautionary Note. *JAMA*, *323*(23), 2379–2380. https://doi.org/10.1001/jama.2020.4365

impossible. A child who has witnessed a shooting in his community will need different treatment than one who has been repeatedly sexually abused by a caregiver, regardless of whether their ACE score is the same.

- **The ACEs questionnaire is a poor predictor of future health outcomes at the individual level**. The original ACEs study, conducted in the late 1990s, demonstrated that, in the aggregate, individuals with high scores suffered more mental and physical health issues later in life. Further studies confirmed these results, yet also demonstrated that at the individual child level, "ACE scores had poor accuracy in predicting an *individual's* risk of later health problems." As such, "targeting interventions based on ACEs screening is likely to be ineffective in preventing poor health outcomes" at the individual level.[109]

What's Currently Happening in Massachusetts?

Massachusetts does not have a statewide policy on the use of trauma screening in pediatric health settings. Further, no inventory of current practices in pediatric settings exists. Although some pediatricians – particularly those that are part of an integrated health care system – may screen some children for trauma, the CTTF is not currently aware of any general pediatrics practice that screens *all* children for traumatic symptoms and/or experiences.

The state *does* currently have a policy on conducting behavioral health screenings more generally (i.e., not trauma-specific) for children enrolled in MassHealth. Since 2009, MassHealth providers have been required and reimbursed to conduct behavioral health screenings at well-child visits. Spurred by the class-action lawsuit known as Rosie D., the state developed the Children's Behavioral Health Initiative (CBHI) to ensure that MassHealth-enrolled children with significant behavioral health needs would be identified using validated screening tools and referred to appropriate services.[110] This policy change led to a substantial increase in screening practices; in 2007, only 4% of well child visits among children receiving MassHealth included a formal behavioral health screen, while this was the case in 74% of visits in 2012.[111]

The screening tools currently approved for use by MassHealth providers do not screen for trauma specifically, although it is possible that an issue identified via a broad behavioral health screener could, through conversation between a pediatrician and a child's caregiver, result in referral for a more comprehensive assessment that may identify trauma as a factor.[112] Research has shown, however, that behavioral health screens are not always sufficient to identify trauma in children. For example, a 2019 study found that, among adolescents receiving mental/behavioral health services in primary care, 15% of youth likely to meet criteria for PTSD and 44% of youth who could possibly meet criteria for PTSD would not have been identified as needing trauma-specific treatment by traditional universal depression screening methods.[113]

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[109] Baldwin, J. R., Caspi, A., Meehan, A. J., Ambler, A., Arseneault, L., Fisher, H. L., Harrington, H., Matthews, T., Odgers, C. L., Poulton, R., Ramrakha, S., Moffitt, T. E., & Danese, A. (2021). Population vs Individual Prediction of Poor Health from Results of Adverse Childhood Experiences Screening. *JAMA pediatrics*, *175*(4), 385–393. https://doi.org/10.1001/jamapediatrics.2020.5602

[110] Rosie D. (n.d.). *About Rosie D*. http://www.rosied.org/page-67061 ; CBHI News. (2009). CBHI News. The Executive Office of Health and Human Services. Retrieved from https://www.bmchp.org/-/media/a012b255cdba40889946be4809fe3afd.ashx

[111] Savageau, J. et al. (2016, November). Behavioral health screening among Massachusetts children receiving Medicaid. *Journal of Pediatrics 178*, 261–267. https://pubmed.ncbi.nlm.nih.gov/27546203/

[112] For a list of approved MassHealth screening tools see: https://www.mass.gov/info-details/learn-about-the-approved-masshealth-screening-tools

[113] Selwyn, C. et al. (2019, February). Recognizing the hurt: Prevalence and correlates of elevated PTSD symptoms among adolescents receiving mental/behavioral health services in primary care. *Psychological Services 16*, 1 58-66. https://doi.org/10.1037/ser0000322

Spotlight: Utah PIPS's Care Process Model for Pediatric Traumatic Stress

The Utah PIPS's Care Process Model for Pediatric Traumatic Stress (CPM-PTS) provides an example of how the use of universal trauma screening in pediatric care settings can help identify children experiencing traumatic symptoms who would not otherwise have been identified. Developed through a collaboration of the Department of Pediatrics at the University of Utah and Intermountain Healthcare's Primary Children's Hospital, this roadmap and decision support document helps providers identify children with traumatic stress in pediatric settings (e.g., well-child visits, mental health related visits) and connect them to evidence-based trauma treatment providers.[114]

The CPM-PTS lays out the following steps for providers to take:

1. **Screen youth for trauma exposure and symptoms** using the Pediatric Traumatic Stress Screening Tool. The screening tool was developed by combining the UCLA Brief Screen for trauma exposure & symptoms of traumatic stress as well as the last question of the PHQ-9 to assess suicidality. The tool has a parent version (children 6-10) and an adolescent version (11 and older), is available in English or Spanish, and can be completed on paper or electronically. For children younger than five, the CPM suggests using the Safe Environment for Every Kid (SEEK) questionnaire to assess risk of maltreatment by identifying possible psychosocial problems families might be facing.
2. **Analyze the results and follow a three-step approach:** providers are advised to report child maltreatment if necessary, respond to suicide risk by using the C-SSRS assessment tool if necessary, and stratify a treatment approach.
3. **Stratify treatment based on score, child functional impairment, and shared decision-making**. The care process model provides an algorithm for the pediatric health provider to follow, including when to refer youth to a mental health specialist or trauma-based treatment. The PIPS team can also help providers identify resources in their areas and has clinicians available for consultation when needed.
4. **Provide a brief in-office intervention,** which can include sleep education, medication, breathing exercises, and tips for improving caregiver-child communication and interactions.
5. **Follow-up after 2-4 weeks and 4-6 months** by using the same screening tool to evaluate how youth is responding to treatment.

The full Care Process Model is a thoughtfully written 41-page document laying out foundational knowledge on childhood trauma, resources about the screening tools used, descriptions of in-office interventions, tips on how to use a strength-based approach, and resources for both patients and providers.

Data collected following implementation of the CPM-PTS has been very positive. Of note, the Utah PIPS team presented at a Childhood Trauma Task Force meeting the following findings:

[114] See Utah PIPS Website: https://utahpips.org/ ; Forkey, H. (2021, July 19). *Childhood Trauma Task Force* [PowerPoint slides]. Office of the Child Advocate. https://www.mass.gov/doc/cttf-july-19-2021-meeting-presentation/download

- The CPM-PTS has been validated to reveal trauma exposure, traumatic stress symptoms, and suicidality in children seen in pediatric settings.
- CPM-PTS reveals traumatic stress symptoms in routine well child visits that would otherwise have been missed, especially in youth endorsing thoughts of suicide or self-harm.
- CPM-PTS helps triage youth at high risk for PTSD, so that if there are limited trauma-specific services in an area, children who need the most support are prioritized.
- In addition to successfully identifying children who suffer from trauma, CPM-PTS participates in improving providers' trauma-informed care.

The CPM-PTS model has been implemented in eleven primary care clinics in Utah and is also widely used in the state's Children Justice Centers (the Massachusetts equivalent of Children's Advocacy Centers). Over 17,500 children have been screened in Utah at 19 Children Justice Centers and 11 Primary Care clinics. Additionally, in recent years the CPM-PTS model has spread to 39 other sites in eight different states and continues to grow.

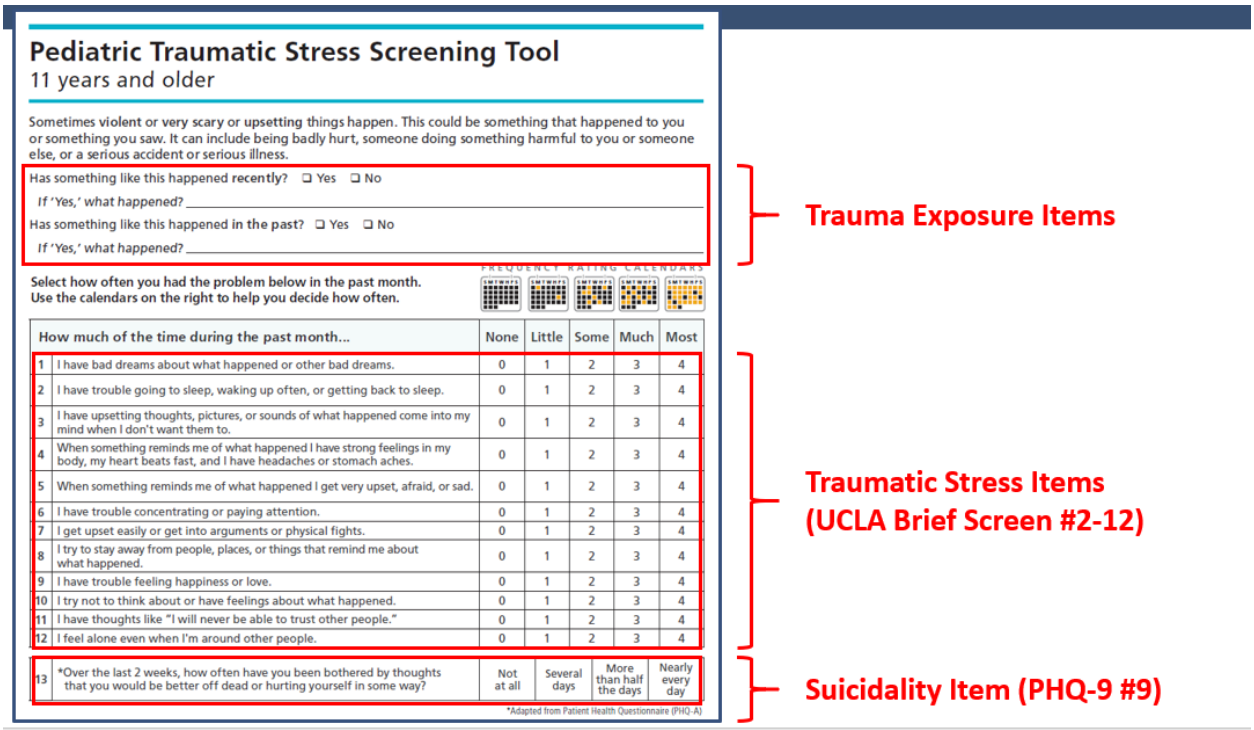

Figure 5: Pediatric Traumatic Stress Screening Tool (PIPS)

Trauma Screening in Child Welfare

Given the mandate of child welfare agencies to protect youth who have been maltreated, it is not surprising that trauma is highly prevalent among children involved with child protective services. In addition to the trauma a child may have experienced due to abuse or neglect, parents involved with the child welfare system often have their own histories of traumatic events and experience

with the child welfare system as children, which can impact the child-caregiver relationship.[115] Finally, experience with the child welfare system itself can be traumatic.[116]

Research has repeatedly demonstrated the high prevalence of trauma among children in the child welfare system—especially among those placed in foster care. These studies also demonstrate that age, gender, and type of traumatic exposure all affect a child's risk of developing trauma symptoms. For example:

- A study of adolescents in out-of-home child welfare placements in three Midwestern states found that youth in foster care were twice as likely to have been exposed to trauma as a "general population" sample of youth.[117]
- A study of youth who had been placed in foster care found that 30% of respondents met lifetime diagnostic criteria for PTSD, compared with 7.6% of a general population sample with similar demographics.[118]
- A study of children and youth (age 0-21) in foster care referred for treatment at a National Child Traumatic Stress Network treatment site found that 70% of the sample reported at least two of the traumas that constitute complex trauma, and 11.7% of the sample reported all five types.[119]

Age—or more specifically developmental stage—is of particular interest when discussing trauma screening in child welfare settings, given that:

- **Young children are disproportionately represented in the child welfare system**. In MA, children under six represent 37% of children (0-17) in an out-of-home placement, with children 0-2 representing 20% of all children in out-of-home placements.[120]
- **Young children don't have the verbal or emotional skills to describe their feelings and/or potentially traumatic experiences**. As experts point out, "very young children who are pre-verbal or early in their language, cognitive, and socioemotional development cannot report their symptoms, they must convey their internal emotional experiences through cues or behavior that can range from subtle to extremely intense and that can be difficult to interpret and to differentiate from normal reactions or from other early childhood disorders."[121]

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[115] The National Child Traumatic Stress Network. (n.d.) Birth Parents with Trauma Histories and the Child Welfare System. NCTSN. Retrieved from https://www.nctsn.org/sites/default/files/resources//birth_parents_with_trauma_histories_child_welfare_resource_parents.pdf

[116] The National Child Traumatic Stress Network. (n.d.) Recommendations for Trauma-Informed Care Under the Family First Prevention Services Act. NCTSN. Retrieved from https://www.nctsn.org/sites/default/files/resources/special-resource/recommendations_for_trauma_informed_care_under_the_family_first_prevention_services_act.pdf

[117] Salazar, A. M., Keller, T. E., Gowen, L. K., & Courtney, M. E. (2013). Trauma exposure and PTSD among older adolescents in foster care. *Social psychiatry and psychiatric epidemiology*, *48*(4), 545–551. https://doi.org/10.1007/s00127-012-0563-0

[118] Pecora PJ, White CR, Jackson LJ, Wiggins T. Mental health of current and former recipients of foster care: A review of recent studies in the USA. *Child & Family Social Work.* 2009;14(2):132–146. https://doi.org/10.1111/j.1365-2206.2009.00618.x

[119] Greeson, J. K., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake, G. S., 3rd, Ko, S. J., Gerrity, E. T., Steinberg, A. M., Howard, M. L., Pynoos, R. S., & Fairbank, J. A. (2011). Complex trauma and mental health in children and adolescents placed in foster care: findings from the National Child Traumatic Stress Network. *Child welfare*, *90*(6), 91–108. https://pubmed.ncbi.nlm.nih.gov/22533044/

[120] Massachusetts Department of Children and Families. (2020). *Annual Report FY2020*. Massachusetts Department of Children and Families. https://www.mass.gov/doc/dcf-annual-reportfy2020/download

[121] Fraser, J. G. et al. (2019). 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*, 399-409. https://doi.org/10.1007/s40653-018-0240-x

- **Very few screening tools have been validated for use in child welfare settings for young children.** However, a recent study on the effectiveness of two validated trauma screening tools for use on infants and toddlers receiving child welfare services in Massachusetts found that the very brief Young Child PTSD (YCP) Screen can detect signs of possible traumatic stress in very young children and identify children in need of further assessment.[122]

Yet it is critical to identify trauma among young children in child welfare, as children under the age of three are particularly vulnerable because the caregiver-child attachment relationship is central to their development and future wellbeing. In the first year of their lives, babies' brains double in size and, by age three, their brains grow to about 80% of adult size.[123] When infants are exposed to traumatic situations and use all their regulatory skills to cope, they lose opportunities for socio-emotional learning during critical periods of their brain development.[124] Research has effectively shown, for instance, that witnessing domestic violence between the ages of twelve and eighteen months impacts brain development and can lead to speech delays at three or four years.[125]

Given the impact of trauma in early childhood and the overrepresentation of young children in child welfare, it is important to be able to detect if young children involved with child protective services have experienced trauma and are suffering from toxic stress to refer them to appropriate treatment and inform services for the family.

In this section, we will discuss:

- Arguments in favor of systematic screening for trauma in children involved in the child welfare system.
- Cautions about and considerations regarding trauma screening in child welfare settings
- A description of the current landscape with regards to trauma screening in child welfare programs in Massachusetts

Finally, we will spotlight two programs – in Connecticut and Louisiana– that have implemented trauma screening practices in child welfare settings.

Arguments in Favor of Screening for Trauma in Child Welfare

The National Child Traumatic Stress Network, which was created by Congress in 2000 to raise the standard of care and increase access to services for children and families who experience or witness traumatic events, recommends trauma screening for all children in child welfare programs.[126] As further discussed in the *Spotlight* section below, child protective services agencies across the nation have begun to implement trauma screenings at intake as a systematic means to identify children who might suffer from trauma.

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[122] Ibid.
[123] The Urban Child Institute. (n.d.). *Baby's brain begins now: Conception to Age 3.* http://www.urbanchildinstitute.org/why-0-3/baby-and-brain
[124] Schore A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1-2), 201-269. https://psycnet.apa.org/record/2001-16734-007
[125] Newell, L. (2015). Gray matter reduction and speech delays in three and four year-old children from witnessing domestic violence between 12 and 18 months of age. Kaplan University. ProQuest Dissertations Publishing, 2015. 1591077. https://www.proquest.com/openview/b8e69a4e9c54a33157aeabd2dc69a86b/1.pdf?pq-origsite=gscholar&cbl=18750
[126] The National Child Traumatic Stress Network. (n.d.) Recommendations for Trauma-Informed Care Under the Family First Prevention Services Act. NCTSN. Retrieved from https://www.nctsn.org/sites/default/files/resources/special-resource/recommendations_for_trauma_informed_care_under_the_family_first_prevention_services_act.pdf

Screening youth for trauma symptoms and experiences at intake or in the beginning stages of a case can help in the following ways:

- **Improve early identification and support appropriate referrals to treatment and services that are specific to the child's needs**. The type of trauma experienced, the age of the child, or the symptoms trauma elicits have implications for the type of treatments children with trauma could benefit from. For instance, a young child with an attachment disorder might benefit from Child Parent Psychotherapy, while an adolescent suffering from complex trauma with severe PTSD might benefit more from Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).[127] Additionally, screening children could inform professionals about additional resources the family might benefit from, such as help with housing/shelter, food, or educational support.
- **With proper supports, identifying trauma and discussing the impact with caregivers can help improve family functioning and avoid out-of-home placements**. Identifying trauma in children, discussing the impact of trauma on children's behaviors as well as parenting, and providing families with trauma-specific supports can help keep families together. Conducting a trauma screening can also help destigmatize conversations about trauma with a family and help the child and family feel listened to. One of the goals of the Louisiana Child Welfare Trauma Project (discussed below), which implemented universal trauma screening in the state's child protective services agency, was to "attend more to the trauma-related psychiatric problems of children in child welfare systems" to "help strengthen biological families."[128]
- **Inform case management.** In its recommendations for trauma-informed screening and functional assessment in child welfare, the NCTSN explains that information gleaned from screening and assessment helps the caseworker "understand the parent, child and family's unique strengths and challenges, while also providing direction on how to work with them in a tailored and individualized manner that incorporates their trauma-related needs, both initially and over time."[129] Repeating screenings at recurrent intervals is particularly useful to gauge how the child and/or family is responding to treatment and if the family needs more/different supports.

[127]Barto, B., Bartlett, J. D., Von Ende, A., Bodian, R., Noroña, C. R., Griffin, J., Fraser, J. G., Kinniburgh, K., Spinazzola, J., Montagna, C., & Todd, M. (2018). The impact of a statewide trauma-informed child welfare initiative on children's permanency and maltreatment outcomes. *Child abuse & neglect*, *81*, 149–160. https://doi.org/10.1016/j.chiabu.2018.04.023.

[128] Scheeringa, M. S. & Mai, T. A. (2018). *Louisiana Child Welfare Trauma Project (LCTP): Background, implementation, and results*. Retrieved from https://www.michaelscheeringa.com/uploads/1/2/0/2/120202234/lctp_background_implementation_and_results.pdf

[129] The National Child Traumatic Stress Network. (n.d.) Recommendations for Trauma-Informed Care Under the Family First Prevention Services Act. NCTSN. Retrieved from https://www.nctsn.org/sites/default/files/resources/special-resource/recommendations_for_trauma_informed_care_under_the_family_first_prevention_services_act.pdf

- **Facilitate more stable and appropriate placements**. A main goal of Colorado Child Welfare Resiliency Project (CWRP), which implemented universal trauma screening in 2015, was to place youth in less restrictive placement settings. CWRP hypothesized that by identifying and treating the trauma "that underlies youth behavioral problems rather than the behavior itself, youth can be more effectively served in the community rather than in more restrictive settings." Data from all seven counties participating in CWRP revealed successful reductions in congregate care placements.[130] Additionally, screening youth can help inform a better match between foster parents and children in need of out-of-home placements.
- **Collect aggregate data to inform policy and funding.** While individual data from trauma screening can inform referral for treatment and case management, collecting aggregate data on the prevalence of specific types of trauma can help child welfare agencies compare the different needs and challenges of children in different areas of the state. Additionally, this can inform community needs for specific types of treatment and services. Finally, child welfare agencies and community stakeholders can use this data to justify the need for more funding to support trauma-informed practices.

"A routine screen for a Hispanic child revealed they suffered from trauma associated with a dog attack. Unfortunately, the only Spanish-speaking foster family in the county had a dog of a similar breed as the one that had attacked the child. This information helped both the family and the child prepare: the dog was crated and dressed up with a costume, the child was shown pictures and videos of the pet being kind beforehand, and eventually, the child grew to love the dog so much they slept in the same bed."

Staff at Project Broadcast (spotlighted below) discuss the importance of trauma screening for successful out-of-home placements.

Cautions and Complications Regarding Screening in Child Welfare

Discussions about screening for trauma in child welfare settings is different in important ways from the debate on screening in K-12 and pediatric settings. Because there is widespread acknowledgement that a significant portion of the children involved with the child welfare system have experienced trauma, there is little to no debate about whether or not this would be an appropriate setting to conduct screenings (e.g., no concern regarding stigma). Similarly, while in K-12 and pediatric settings, there are legitimate concerns about how trauma screening fits in with the other priorities in those settings (e.g., academics; identification of other important health concerns), that is not the case in child welfare: connecting children who have experienced trauma with services and supports as necessary is an important functions of the child welfare system.

Instead, **the primary barrier to implementation of trauma screening in child welfare settings is resources:** child welfare staff are stretched thin already, and ensuring they have the appropriate

[130] Rizzo, C. et al. (2019, July-August). Implementing trauma screening and trauma assessment in child welfare: The journey of seven Colorado counties. *Child Welfare 98*, 4. Retrieved from https://go.gale.com/ps/i.do?id=GALE%7CA656271045&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=00094021&p=AONE&sw=w&userGroupName=mlin_oweb&isGeoAuthType=true

training and support to implement a trauma screening process is a significant undertaking. Some also argue that given the rates of prevalence in this population of children, a screening process may be an unnecessary step, as staff can safely assume that all children they work with have experienced trauma and should work with them accordingly (including referring the children for a more comprehensive assessment if the case worker deems it necessary.)

Although there is not strong *opposition* to the idea of trauma screening in this setting, there are implementation considerations specific to the child welfare system (in addition to the very real concerns about workload). In particular, research demonstrates that the prevalence of intergenerational trauma among families involved with child protective services might pose significant barriers to be addressed through implementation:

- **Children and caregivers don't always agree on youth's traumatic experiences.** Studies have shown that there can be significant discrepancy between child and caregiver reports of the trauma experienced by youth, which in turn can lead to youth having difficulty recovering from trauma.[131] This holds true in child welfare settings, where studies have demonstrated that parents' own trauma histories, as well as mental health challenges, substance use, familial/community stressors, or fear of disclosing specific events can influence their interpretation and report of their child's symptoms.[132] Of note, one study among families involved in child welfare demonstrates that the discrepancy increases with greater child psychopathology.[133] As such, some experts advocate for youth and caregiver reports to be systematically combined, as each report different sets of information that is useful to identify trauma.[134]
- **Child welfare agencies should also identify parents and caregivers' possible history of trauma.** Parents' and caregivers' own trauma can "impair their ability to manage stress, their attachment and social functioning, and their executive functioning," all of which are necessary to create healthy bonds with their children, use appropriate discipline, and parent successfully.[135] For that reason, the NCTSN advocates for the need to identify parental trauma in child welfare settings and help caregivers understand how intergenerational trauma can be an obstacle to health family functioning and/or reunification.[136]

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[131] Oransky, M., Hahn, H., & Stover, C. S. (2013). Caregiver and youth agreement regarding youths' trauma histories: implications for youths' functioning after exposure to trauma. *Journal of youth and adolescence*, *42*(10), 1528–1542. https://doi.org/10.1007/s10964-013-9947-z ; Shemesh, E., Newcorn, J. H., Rockmore, L., Shneider, B. L., Emre, S., Gelb, B. D., Rapaport, R., Noone, S. A., Annunziato, R., Schmeidler, J., & Yehuda, R. (2005). Comparison of parent and child reports of emotional trauma symptoms in pediatric outpatient settings. *Pediatrics*, *115*(5), e582–e589. https://doi.org/10.1542/peds.2004-2201

[132] Fraser, J. G. et al. (2019). 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*, 399-409. https://doi.org/10.1007/s40653-018-0240-x

[133] Scheeringa. M. S. (2020). The Diagnostic Infant Preschool Assessment-Likert Version: Preparation, Concurrent Construct Validation, and Test–Retest Reliability. *Journal of Child and Adolescent Psychopharmacology* 30:5, pages 326-334. https://doi.org/10.1089/cap.2019.0168

[134] Scheeringa, M. S., Wright, M. J., Hunt, J. P., & Zeanah, C. H. (2006). Factors affecting the diagnosis and prediction of PTSD symptomatology in children and adolescents. *American Journal of Psychiatry*, 163(4), 644–651. https://doi.org/10.1176/ajp.2006.163.4.644

[135] The National Child Traumatic Stress Network. (n.d.) Recommendations for Trauma-Informed Care Under the Family First Prevention Services Act. NCTSN. Retrieved from https://www.nctsn.org/sites/default/files/resources/special-resource/recommendations_for_trauma_informed_care_under_the_family_first_prevention_services_act.pdf

[136] The National Child Traumatic Stress Network. (n.d.) Birth Parents with Trauma Histories and the Child Welfare System. NCTSN. Retrieved from https://www.nctsn.org/sites/default/files/resources//birth_parents_with_trauma_histories_child_welfare_resource_parents.pdf

What's Currently Happening in Massachusetts?

Massachusetts does not currently have a universal trauma screening system in place for children involved with the child welfare system. Instead, on a case-by-case basis, the Department of Children and Families (DCF) will refer children to providers that may conduct a trauma screening or assessment and provide trauma-responsive interventions as indicated.

Examples of this include:

- DCF case workers regularly partner with the LINK-KID system run by the Child Trauma Training Center at UMass, which can help connect a child with an appropriate therapeutic service.
- The Central Massachusetts Children's Trauma Center, operated by LUK, Inc, provides trauma-informed services and treatment for children who have experienced trauma related to abuse and neglect, domestic violence, and other causes. Many children are referred to the CMCTC from DCF and will receive a full assessment and connections to services as indicated.
- The Foster Children Evaluation Services program at UMass Medical provides services to children in foster care settings. Among other services, the staff at FaCES provide developmental, mental health and trauma screenings, and referrals to appropriate services as necessary. FaCES also works to coordinate in-home support for caregivers to help address the needs of children exposed to trauma.

Spotlight 1: Louisiana Child Welfare Trauma Project (LCTP)

LCTP was developed as a partnership between Tulane University and the Louisiana Department of Children and Family Services (DCFS) between 2013-2017 as part of a Children's Bureau grant to support trauma-informed child welfare systems across the nation.[137] During these five years, LCTP:

- **Developed a screen for traumatic experiences and symptoms** called the Trauma and Behavioral Health Screen (TBH), which includes both traumatic events and symptoms. The LCTP team defined seven criteria they believed were critical to identifying trauma in children (see textbox) and developed the tool to fit caseworkers' high caseloads and time constraints.
- **Implemented the TBH screen across Louisiana** by training over 600 DCFS caseworkers to use the screen within 30 days of intake and to be repeated every six months as long as a case is open to ensure treatment and services are working for the youth and family. The training was tailored to fit the needs of busy caseworkers and high staff turnover by being short (1h-1h30 per session) and by having the trainer travel to the caseworkers to avoid them losing too much work time. LCTP integrated the training and use of the screen within DCFS policy to ensure successful implementation across the state. TBH training is also

[137] All of the information in this section—unless noted otherwise—comes from Scheeringa, M.S., & Mai, T.A. (2018). Louisiana Child Welfare Trauma Project (LCTP): Background, Implementation, and Results. Tulane University, New Orleans, LA. Retrieved from https://www.michaelscheeringa.com/uploads/1/2/0/2/120202234/lctp_background_implementation_and_results.pdf

mandatory for foster parent training. To establish continuity in training content, LCTP also developed a PowerPoint presentation as well as videos for DCFS to use.

- **Expanded trauma-specific treatment capacity** by providing initial training to 335 clinicians on Cognitive Behavioral Therapy (CBT) for PTSD (a 12-session treatment for youth 7-18). Of the initial cohort of clinicians who received the one-day training, 13% (n=45) achieved Advanced Training and 11% (n=38) achieved Basic Training. LCTP also undertook a "mystery shopper project" to document for the first time the true state of mental health services access for youth in Louisiana's child welfare system. This project revealed that only a quarter (25.5%) of the 2,643 providers publicized by Medicaid insurance networks were willing and able to accept patients. The LCTP team estimates that "this is approximately seven times lower than national recommendations for access to mental health care."

LCTP's 7 Criteria for an Effective Child Welfare Trauma Screen

- Covers a wide range of traumatic events beyond child maltreatment (e.g., disasters, accident, animal attack, witnessing violence, medical trauma)
- Covers at least 10 PTSD symptoms
- Covers symptoms of co-morbid items (e.g., depression, anxiety, oppositional defiant disorder) for a full picture and to inform changes in youth's mental health over time
- Is brief to ensure it could be completed consistently (i.e., contain 30-40 items)
- Is self-administered by youth and/or caregiver for the most economical use of time and resources, greater completion, and avoid bias of caseworker
- Applies to all age groups to avoid multiple forms for caseworker
- Is free to remove a barrier for underfunded child welfare systems

The implementation of universal screening and training at DCFS and the collection and analysis of data during the Louisiana Child Welfare Trauma Project was not without its challenges:

- LCTP staff noted that **without the commitment of DCFS leadership the project would not have been successful**, especially because the agency allocated staff to act as liaisons and facilitate implementation.
- There was a large **gap between theory and case practice**. Although youth were supposed to be universally screened at intake, by the end of the project only 50% of TBH screens were completed for newly opened cases and only 29% were completed for repeat screening.
- The project revealed **challenges in access to evidence-based treatments** (due to a limited culture of using EBTs throughout the state, the inflexibility of Medicaid networks to try new strategies, and difficulty recruiting clinicians willing or able to learn and provide trauma-focused EBTs.

Spotlight 2: Development and Implementation of the Child Trauma Screen in Connecticut

In 2011, the state of Connecticut launched a seven-year effort to shift the child welfare system to be trauma-informed. That process, which was a collaborative effort between the Connecticut Department of Children and Families (DCF), the Child Health and Development Institute of Connecticut (CHDI), the Yale Child Study Center, the Consultation Center at Yale, family advocates and community providers, had a number of core activities, including the development and implementation of the **Child Trauma Screen (CTS)**. (See box at right for more on CONCEPT).[138]

CONCEPT Core Activities (2011-2018)

1) Training and support for child welfare staff to understand childhood trauma and how to support children and families who have experienced trauma
2) Trauma screening to identify children who may be suffering from trauma and in need of specialty services
3) Dissemination of **Trauma-focused Cognitive Behavioral Therapy** (TF-CBT), to 13 community provider agencies
4) Dissemination of the **Child and Family Traumatic Stress Intervention** (CFTSI) to 10 community provider agencies
5) Improving collaboration between child welfare staff and community providers of evidenced-based practices
6) **Supporting wellness and reducing secondary traumatic stress reactions** among child welfare staff

The CTS was designed to be a "very brief, empirically-derived screen for child traumatic stress that can be administered by trained clinical and non-clinical staff, including intake staff, child welfare workers, juvenile probation officers, clinicians, medical providers, and school personnel."[139] The tool, which is supported by three peer-review studies, looks at both traumatic events/experiences as well as reactions to those events (i.e. symptoms of trauma).[140] It is meant to help identify children who may be suffering from trauma exposure and need more comprehensive assessment or treatment.

The CTS was implemented by the CT DCF over time. Currently, it is used as part of a multidisciplinary evaluation of a child three years or older, which takes place thirty days prior to a child being removed from a home. Staff who implemented the CTS and responded to feedback forms indicated that:[141]

- 82% felt the CTS enhanced their understanding of the child's needs at least half the time
- 46% identified new traumatic exposures in a child they were not aware of, and 73% identified new symptoms
- The information from the screen lead to changes in case services plans 36% of the time
- Youth and caregivers expressed relatively low levels of discomfort with the tool

[138] Child Health and Development Institute of Connecticut, Inc. (n.d.) *CONCEPT (The Connecticut Collaborative on Effective Practices for Trauma)*. https://www.chdi.org/our-work/mental-health/trauma-informed-initiatives/concept/
[139] Child Health and Development Institute of Connecticut, Inc. (n.d.) Information about the Child Trauma Screen (CTS). CHDI. Retrieved from https://www.chdi.org/index.php/download_file/view/1099/902/
[140] Child Health and Development Institute of Connecticut, Inc. (n.d.). *Child Trauma Screen.* https://www.chdi.org/our-work/mental-health/trauma-informed-initiatives/ct-trauma-screen-cts/
[141] Lang, J. (2021, September 13). *Trauma Screening in Child Welfare (and Beyond)* [PowerPoint slides]. Child Health and Development of Connecticut, Inc. https://www.mass.gov/doc/dr-jason-lang-ct-presentation-trauma-screening-child-welfare/download

- The tool took on average 8.9 minutes to administer, and 4.1 out of 5 staff felt it was worth the time spent.

A subsequent case review, which compared children who were screened with a matched sample, also found that children screened for trauma were:[142]

- More likely to have a documentation about trauma reactions in their case plan
- More likely to be recommended and referred for trauma-focused mental health services
- More likely to be referred for other mental health services

In addition to being used in the child welfare system, the CTS is also used in Connecticut with:

- All youth involved in the juvenile justice system at intake
- All youth receiving care coordination services
- All youth receiving mobile crisis services
- A limited number of schools and pediatric primary care practices

Trauma Screening Practices in the Juvenile Justice System

As with the child welfare system, the experience of trauma is pervasive in the juvenile justice system. Recent scholarship shows that over 80% of youth involved in the juvenile justice system reported experiencing childhood trauma.[143] Youth who experience traumatic events may experience mental health, substance abuse, and behavioral challenges, all of which put them at risk for juvenile justice system involvement.[144] Additionally, juvenile justice system involvement is often traumatizing in its own right: arrests, detention, removal from one's family and community, and court proceedings have all been shown to be significant sources of trauma, and often compounds preexisting trauma.[145]

There is, at this point, significant support for screening youth who are involved in the juvenile justice system who have been adjudicated delinquent (functionally equivalent to "found guilty of a crime" in adult court)**, particularly those in an out-of-home placement, to help inform service planning and supports.** Proponents of universal trauma screening in courts and

[142] Ibid.
[143] The National Child Traumatic Stress Network. (n.d). *Essential Elements.* https://www.nctsn.org/trauma-informed-care/trauma-informed-systems/justice/essential-elements
[144] Cénat, J. M., & Dalexis, R. D. (2020). The Complex Trauma Spectrum During the COVID-19 Pandemic: A Threat for Children and Adolescents' Physical and Mental Health. *Psychiatry research*, *293*, 113473. https://doi.org/10.1016/j.psychres.2020.113473 ; Buffinton, K., Dierkhising, C., & Marsh, S. (2012). Ten Things Every Juvenile Court Judge Should Know About Trauma and Delinquency. National Council of Juvenile and Family Court Judges. Retrieved from https://www.ncjfcj.org/wp-content/uploads/2012/02/trauma-bulletin_0.pdf
[145] Wyrick, P., Atkinson, K. (2021). Examining the Relationship Between Childhood Trauma and Involvement in the Justice System. National Institute of Justice. Retrieved from https://nij.ojp.gov/topics/articles/examining-relationship-between-childhood-trauma-and-involvement-justice-system

juvenile justice agencies include the National Child Traumatic Stress Network,[146] the National Council of Juvenile and Family Court Judges,[147] and the Coalition for Juvenile Justice.[148]

In these settings, the question is less about whether screening should occur, and more about practice adoption, as **implementing trauma screening practices in juvenile justice settings is a substantial undertaking and requires an investment of resources to accomplish.**

Opinions are more mixed on whether youth who have not yet been adjudicated delinquent should be screened for trauma, and in particular on whether and how this information should be considered in adjudication and disposition decision-making. As one article summarizes, "Empirical research is mixed on this issue, with some studies demonstrating the mitigating role played by the presence of trauma exposure and others demonstrating the tendency of trauma history to raise additional risk-related concerns, with trauma history, in effect, acting as an aggravating factor."[149] For this reason, defense attorneys representing youth tend to support a more selective approach to trauma screening and assessment prior to adjudication.

This section focuses on current trauma screening practices in various Massachusetts juvenile justice organizations, with particular considerations for each of those settings included in the respective subsection.

Trauma Screening in Massachusetts' Juvenile Court (Pre-Adjudication)

The Juvenile Court currently screens youth for trauma selectively, rather than universally. Screenings and assessment are conducted by the Juvenile Court Clinics at the discretion of the presiding judge in the youth's case.

The Juvenile Court Clinic System (JCC) is the primary provider of mental health evaluations for the Juvenile Court Department. The Court Clinic system is jointly administered the Department of the Trial Court and the Department of Mental Health (DMH).[150]

JCC evaluations can only be initiated by court order and do not occur automatically. This means that a JCC evaluation cannot take place unless a youth has a matter pending before the Juvenile Court.[151] The parties to a juvenile matter may request a referral to the JCC in open court or by written motion. The presiding judge may also make a referral of their own volition.

When a referral is ordered, a JCC clinician conducts a comprehensive forensic evaluation. JCC clinicians possess masters' or doctoral level qualifications and have completed a specialized training program which focuses on the forensic adequacy of evaluations and how to craft pragmatic recommendations to assist the youth and their family while simultaneously protecting public safety

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[146] Kerig, P., Ford, J., & Olafson, E. (2014). The National Child Traumatic Stress Network. Retrieved from https://www.nctsn.org/sites/default/files/resources//assessing_exposure_to_trauma_and_posttraumatic_stress_symptoms_in_juvenile_justice_population.pdf

[147] Stoffel, E., Korthase, A., & Gueller, M. (2019). Assessing Trauma for Juvenile and Family Courts. National Council of Juvenile and Family Courts. Retrieved from https://www.ncjfcj.org/wp-content/uploads/2019/07/NCJFCJ_Assessing_Trauma_Final.pdf

[148] See Coalition for Juvenile Justice's Trauma Website: https://www.juvjustice.org/our-work/safety-opportunity-and-success-project/national-standards/section-i-principles-responding-8

[149] Zelechoski, A. D. et al (2021, October). Trauma assessment in juvenile justice: Are we asking the right questions in the right way? *Journal of Aggression, Maltreatment & Trauma, 30*(3), 324-346. https://doi.org/10.1080/10926771.2020.1832167

[150] The actual staffing mechanism of JCCs varies by county. DMH staffs the JCCs in Berkshire and Suffolk County courts directly with DMH-employed clinicians. All other JCCs are operated by contracted vendors which are overseen by and report to DMH. All JCC clinicians are required to complete a specialized training program administered by DMH and UMass Medical School.

[151] Email communication between OCA staff and Bridget Nichols (DMH), 9/28/2021.

interests. Evaluation timelines vary based on location, staffing, exigent circumstances, and caseload.[152]

The evaluation itself is conducted according to the *JCC Report Writing Guidelines*. All evaluations include at least one full interview with the child and the child's parents or guardian(s).[153] Clinicians may employ trauma-specific tools such as the *Trauma Screening Checklist* at their discretion and/or may obtain such information through the interview process.

All full evaluations include a screening for adverse childhood experiences (ACEs) that informs the clinician's ultimate findings, report, and recommendations.

After the clinician completes a full assessment, they prepare a full forensic report for the court. The clinician may also refer families to services and provide recommendations for management and intervention to minimize the likelihood of further court involvement. In some cases, the court may provide funds for a third-party evaluation to replace or supplement a JCC assessment.

It is unclear what percentage of juvenile cases receive a referral to the JCC each year. However, in FY20, there were 3,596 Child Requiring Assistance petitions, and 4,806 delinquency filings. The Department of Mental Health reported 1,330 JCC referrals in FY20. Most of these referrals were related to a CRA or delinquency case, although a small number were related to a Care & Protection case. [154] This suggests that only a small percentage of CRA and delinquency cases – perhaps 15-20% – receive a behavioral health assessment.

Committee for Public Counsel Services Screening Practices (Pre-Adjudication)

Every youth with a delinquency matter in the court is entitled to a lawyer. Youth may have private counsel, but more often youth have a court-appointed attorney through Massachusetts' public defender agency—the Committee for Public Counsel Services (CPCS) through their Youth Advocacy Division (YAD). CPCS/YAD does not currently have in-house trauma screening services or a policy for when third party trauma screening should be sought. YAD attorneys—with support from staff social workers—frequently request screenings by JCC clinicians when they deem it to be in their client's best interest. YAD attorneys also routinely seek third party evaluations of their clients when necessary.

Massachusetts Probation Service (MPS) Trauma Screening Practices (Post-Adjudication)

Currently, MPS does not administer any form of trauma screening tool, although individual Probation Officers may discuss traumatic experiences or symptoms with youth as part of the intake assessment process.

All youth who are placed under the supervision of the Massachusetts Probation Service (MPS) undergo an intake assessment. Intake assessments are conducted by a probation officer and consist of at least one interview and a review of the child's court record. Intake interviews are designed to clarify and identify potential concerns. Probation officers regularly consult with the JCC during the

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[152] JCCs may be ordered to complete emergency evaluations to determine if a youth needs urgent admission to a psychiatric hospital.
[153] Private communication between OCA staff and Bridget Nichols (DMH), 9/28/2021.
[154] The Juvenile Justice Policy and Data Board. *2020 Annual Report*. Office of the Child Advocate. https://www.mass.gov/doc/jjpad-board-2020-annual-report-0/download

intake process. Probation officers may also refer a youth to outside resources for additional evaluations or services at their discretion.

Youth who are adjudicated delinquent (the equivalent of being found "guilty" in adult court) and placed on Risk-Need Probation are required to complete a risk assessment to help probation officers determine how frequently they meet with youth per the MPS supervision standards. The OYAS is a risk-need screen used for evaluating the likelihood of re-offending and potential needs of the youth, but does not explicitly screen for trauma.[155] Probation officers are not instructed to screen for trauma or to use any trauma assessment tools, however, they may discuss traumatic experiences or responses with the youth at their discretion. Many Juvenile Probation Officers have undergone training on trauma and its impacts through a partnership with the Child Trauma Training Center at UMass Medical School or through other trauma-focused trainings offered by the department's Massachusetts Training and Operation Center.

Department of Youth Services Trauma Screening Practices (Pre- and Post-Adjudication)

The Department of Youth Services works with youth who are being detained (pre-trial) or who have been committed (post-adjudication.) The practices and services differ based on the youth's status (detained or committed.)

All youth – detained and committed – receive a mental health screening upon first entering a DYS facility using the MAYSI-2 (Massachusetts Youth Screening Instrument-Version 2) rapid behavioral health screening. This tool helps to determine if the youth requires urgent interventions or further emergency screening.[156] It is comprised of 52 'yes or no' questions which can be administered and scored in the span of 15 minutes, and was designed to assist juvenile justice facilities in identifying special mental health needs among 12-17 year-olds.[157] The MAYSI-2 screens for signs of depression, suicidal/self-harm ideation, substance abuse, psychosis, aggression, and PTSD. If a youth produces a high MAYSI-2 score, the youth is 'flagged', indicating that the youth may need to be placed on suicide watch, transferred to a psychiatric hospital, or kept away from others.[158]

The MAYSI-2 also has a Traumatic Experiences scale. While this scale does not assess a clinical condition like PTSD, it does identify youth who may have had greater exposure to potentially traumatizing events.[159] It is intended to serve as a "red flag" for further assessment, and the questions it asks regarding events and symptoms are limited due to the brief nature of the instrument.[160]

Youth who are committed to DYS receive comprehensive mental health screening assessment. This assessment takes place over a 35-to-40-day period and is led by a clinician with masters' or doctoral level qualifications and the assigned DYS caseworker. The clinical assessment team conducts extensive interviews with the youth, their families, and all other relevant parties

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[155] Latessa, E. (2009). The Ohio Youth Assessment System: Final Report. University of Cincinnati. Retrieved from https://www.uc.edu/content/dam/uc/ccjr/docs/reports/project_reports/OYAS_final_report.pdf
[156] DYS has emergency screening teams on call 24 hours a day to respond to mental health emergencies in its facilities.
[157] Kathleen, L. (2014). *MAYSI-2 Administration and Referral Protocol Template Instructions*. Spark Public Policy Institute.
[158] Private communication between OCA staff and Yvonne Sparling (DYS), 10/1/2021
[159] See the National Youth Screening & Assessment Partners' MAYSI-2 Scales and Their Use: http://www.nysap.us/maysi2/scales.html
[160] Kerig, P. K. et al. (2011). Assessing the sensitivity and specificity of theMAYSI-2 for detecting trauma among youth in juvenile detention *Child Youth Care Forum 40*, 345-362. DOI 10.1007/s10566-010-9124-4

identified by the team. Youth are also provided with ACEs screenings, Philadelphia ACEs screenings (if relevant), PTSD screenings, Childhood and Adolescent Needs and Strengths (CANS) assessments, and any other behavioral health assessment deemed to be necessary by the attending clinician.[161] The ACE screening (Adverse Childhood Experiences Questionnaire) consists of 10 'yes or no' questions which measure specific types of childhood trauma.[162] The Philadelphia ACE Survey is an add-on to the ACE screening which measures community-level adversity such as exposure to violence, discrimination, or bullying.[163] The CANS assessment is intended to identify children and adolescents with serious emotional disturbances. The CANS assessment is a comprehensive evaluation of behaviors, family issues, community factors, developmental disabilities, social functioning, emotional functioning, trauma, substance use, and other indicators of a child's mental health profile. The assessment is 24 pages long and must be administered and scored through an extensive interview process conducted by a clinical professional.[164]

After the assessment period is complete, the assessing team produces a comprehensive report that outlines the factors which influence a youth's behavior and provides recommendations for future placement and treatment. Trauma is explicitly included as a factor in this report, and treatment for trauma, PTSD, and other resulting behavioral responses is available for all youth in DYS custody for whom it is deemed necessary by the clinical team.

Trauma Screening Following Traumatic Events

The prior sections of this report focus on trauma screening in *systems* that are set up to work with youth – K-12 education, pediatrics, child welfare, and juvenile justice. A different approach that has been implemented in some areas of the country is to focus on establishing a screening & referral process following a *traumatic event in which a child is involved,* such as a child who has witnessed an act of serious violence or a drug overdose. These programs involve collaboration between law enforcement and child-serving professionals, who are called to a scene (i.e., following a violent episode or overdose) and identify that a child is present.

Proponents of this approach point to the following:

- Research on experiencing or witnessing fatal or life-threatening events suggest the importance of paying attention to peritraumatic symptoms (i.e., symptoms that occur immediately after the event), as they are often predictive of later PTSD as well as high levels of PTSD symptomatology.[165]

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[161] Private communication between OCA staff and Yvonne Sparling (DYS), 10/1/2021
[162] Schulman, M., & Maul A. (2019). *Screening for Adverse Childhood Experiences and Trauma*. Center for Health Care Strategies. Retrieved from https://www.chcs.org/media/TA-Tool-Screening-for-ACEs-and-Trauma_020619.pdf
[163] See the Philadelphia ACE Survey: https://www.philadelphiaaces.org/philadelphia-ace-survey
[164] See the Massachusetts CHILD AND ADOLESCENT NEEDS AND STRENGTHS: https://www.mass.gov/doc/cans-five-through-20-with-sed-determination/download
[165]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). 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), e594–e600. https://doi.org/10.4088/JCP.11m07348 ; Bui, E., Brunet, A., Allenou, C., Camassel, C., Raynaud, J. P., Claudet, I., Fries, F., Cahuzac, J. P., Grandjean, H., Schmitt, L., & Birmes, P. (2010). 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 ; Peltonen, K. et al. (2017). Peritraumatic dissociation predicts posttraumatic stress disorder symptoms via dysfunctional trauma-related memory among war-affected children. *European Journal of Psychotraumatology 8*. https://doi.org/10.1080/20008198.2017.1375828

- The American Academy of Pediatrics similarly advocates for the identification of trauma symptoms shortly after the event took place to triage emergency.[166]

The CTTF has not identified any specific opposition to this approach. Instead, as in child welfare, adoption of the practice is a matter of resources.

In addition to discussing current practices in Massachusetts, this section highlights two different police first responder programs that have demonstrated success in identifying youth suffering from trauma using screening tools and referring them and their families for services that could help them recover from their experiences.

What's Currently Happening in Massachusetts?

As with K-12 schools, each town or city police department has its own approach, and there is no master list available of police departments that have implemented trauma-specific behavioral health approaches.

However, the CTTF is aware that an increasing number of police departments in Massachusetts are developing partnerships with clinicians or social workers, where law enforcement officers are trained on when to call a social worker to come to the scene to help, for example, with a mental health crisis. In some cases, these departments may also call a social worker to a scene when they have identified a child that has witnessed a traumatic event.

For example, the Police Action Counseling Team (TEAM), which is a partnership between MGH Chelsea and the Chelsea Police Department, trains officers to identify children (and sometimes other vulnerable persons) at the scenes of police calls where they are victims of or witnesses to violence or other trauma. The goal of PACT interventions is to lessen the impact of traumatic experiences on the health and mental health of these children. The social workers provide on-site, developmentally appropriate interventions and psychoeducation to help children express their feelings and concerns, through outlets such as drawing and the use of puppets, to manage symptoms of trauma. The team assists child victims and their families in finding constructive means to reestablish stability after a traumatic event. These swift interventions aim to facilitate children's active participation in their own well-being, promote resilience and to increase parental knowledge of potential responses to trauma as well as its longer-term effects.

Additionally, the Child Witness to Violence Project, which is run under the auspices of the Department of Developmental and Behavioral Pediatrics at Boston Medical Center, provides services to children who have witnessed an act of significant violence. Referrals to CWVP come from a variety of sources, including the police, health and mental health providers, Head Start and other early childhood programs, schools, attorneys, domestic violence shelters, court-sponsored victim programs and families themselves. The program specifically notes that they are not first responders, however.

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[166] 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

Spotlight 1: The Child Development-Community Policing (CD-CP) Program: Spotlight on Charlotte-Mecklenburg County, NC

The Child Development-Community Policing (CD-CP) program ensures that mental health professionals are on call 24/7 to assist law enforcement at a scene involving children (birth to 17) who are victims or witnesses to violence.[167]

The model originated as a partnership between the Yale Child Study Center in Connecticut and the New Haven Police Department in 1991. Charlotte-Mecklenburg County, North Carolina initiated their CD-CP program in 1996 as a pilot project in a few select locations, expanding to the entire city of Charlotte and other towns in the county by 2016. It is the largest CD-CP program in the nation and, in 2004, was designated as the Southeast Regional Training Center of the National Center for Children Exposed to Violence at Yale University to provide technical assistance and consultation for other communities wishing to implement the program.

In FY21, the program served 6,432 families, reaching 10,231 children.

The program has the following key components:

Partnership & Collaboration: The program features strong collaboration between the Mecklenburg County Public Health department and local police departments at all levels (executive, management, and operations). A core value of the program is that no child should have to wait for the best possible trauma-informed police response and coordinated clinical care; as they put it, "the partnership IS the intervention."

Identification: A majority (72% in FY19) of children contacted by the CD-CP program are screened using 1 or more trauma screening tool, most notably the Acute Trauma Questionnaire, which looks at early emerging symptoms after a traumatic experience. They also developed a proprietary ANS (Autonomic Nervous System) measure for immediate indicators of emerging trauma response, to be used by a clinician within 12 hours of a critical incident.

Acute Trauma Interventions: Staff are trained to provide a child and their family with specific short interventions designed to support relaxation and grounding. The goal is to "put on the breaks" after a traumatic experience.

Referral and Treatment: CD-CP established strong referral pathways for children who have witnessed or experienced a traumatic event. In addition to short-term trauma intervention provided by the CD-CP staff, as needed children and/or guardians are provided with referrals for longer-term therapy and supports. The program will provide specialized referrals when possible; for instance, the program refers LGBTQ youth to professionals offering trauma-based treatment with experience working with this cohort group. The CD-CP staff also make linkage to other services (e.g., connection to housing or food supports) as needed.

Training, interdisciplinary collaboration and data analysis are also key components of program administration:

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[167] 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

- Thousands of police officers have received training on child development, the impacts of child trauma, ACES, and resilience strategies, focusing on the officer's role and co-taught by police-clinician teams. Clinicians also participate in police ride-alongs to better understand the role, duties, and responsibilities of law enforcement.

- A multi-disciplinary team holds a monthly program conference to plan additional clinical, child protection, and police interventions as well as address any other needs of referred families.

- The program collects and analyzes data yearly to inform program needs. For instance, noting that around 15% of families referred to CD-CP are Spanish-speaking, the program has designated 2 of their 17 clinicians as "floaters" (unattached to a specific precinct) who can respond to calls throughout the county and partner with Spanish-speaking officers.

Spotlight 2: Defending Childhood Initiative: Spotlight on Children Who Witness Violence Program in Cuyahoga County, OH.

In 2010, the Department of Justice launched the Defending Childhood Initiative (DCI) to address children's increasing exposure to violence as victims and witnesses. The initiative, which initially awarded grants to eight cities, counties, and reservations throughout the country, aims to prevent children's exposure to violence, mitigate the negative impact of exposure to violence, and spread knowledge about effective strategies as well as challenges officials face when implementing such programs.[168]

The programs established in Cuyahoga County, Ohio demonstrate effective identification, referral, and treatment for children who witness violence and use of the DCI grant to build upon an existing program. The Children Who Witness Violence (CWWV) Program was developed in 1999 to provide intervention services for youth in the immediate aftermath of a crisis. Within thirty minutes following a referral by law enforcement, a mental health professional contacts the family to check their availability and willingness to receive mental health support services as well as help with safety planning, family education, and information about community services and supports (e.g., for food, clothing, shelter).

Thanks to a DCI grant, Cuyahoga County was able to expand its reach and provide more systematic supports for children (0-17) suffering from trauma as a result of exposure to violence in the home, at school, and in the community. The program does so by:

- **Identifying** impacted children in child-serving systems (child welfare, juvenile court, behavioral health agencies) through two locally developed DCI screening tools—one for children 0-7 and one for children 8-17. Between 2012 and 2015, over 23,000 children were screened for exposure to violence and trauma.
- **Referring** the child for a more in-depth assessment of trauma exposure to determine if the child can function socially, academically, and in family relationships. Using the information gathered from the diagnostic assessment and assessment tools, a clinician provides a

[168] See Defending Childhood Initiative: https://www.futureswithoutviolence.org/children-youth-teens/defending-childhood-initiative/

mental health diagnosis, if warranted. Between 2012 and 2015, over 1,000 children were referred for a full assessment—about 4.4% of children initially screened.

- **Providing treatment** to the youth, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), which is prefaced by a "linkage appointment" to introduce the child/family to the new counselor to ensure a smooth transition and continuity of services. Between 2012 and 2015, 870 children were referred for treatment (85% of children assessed; 3.7% of children screened).

Conclusion and Next Steps

The purpose of this report was to document the current landscape with regards to child trauma identification practices.

In 2022, using this document as a starting point, **the CTTF will attempt to develop consensus recommendations regarding what, if anything, the Commonwealth should do to incentivize, support and/or require specific child trauma identification practices in various setting**.

Before we begin that process, the CTTF requests feedback on this interim report that may help us as we move to the "recommendations" phase of our process. In particular, we ask for responses to the following questions:

- We have attempted to document the **"pros" and "cons"** of various screening approaches in different sectors as best we understand them. Have we missed any?

- Similarly, we have attempted to note all important **cautions and considerations** with regards to trauma screening in various sectors. Have we missed any?

- We document our best understanding of **what "current practices" are in Massachusetts** with regards to trauma screening in various sectors. Are there current practices in Massachusetts that we missed or otherwise misrepresented?

- In this document, we "spotlight" certain trauma screening practices in different sectors, in Massachusetts and elsewhere. This is not meant to be an exhaustive list. Still, we would welcome hearing from **practitioners who have implemented a trauma screening practice about your experiences.** Do you have an experience you would like to share with us?

We welcome all feedback, which can be submitted via email to Melissa.Threadgill@mass.gov, Director of Strategic Innovation at the Office of the Child Advocate.