Childhood Trauma Task Force

April 4, 2022

1pm-3pm

Agenda

- Welcome & Introductions
- Approval of March Meeting Minutes
- Discussion of CTTF 2022 Work Plan
- Review of General Recommendations for Trauma Screening
- Presentation and Discussion of Trauma Screening in Child Welfare

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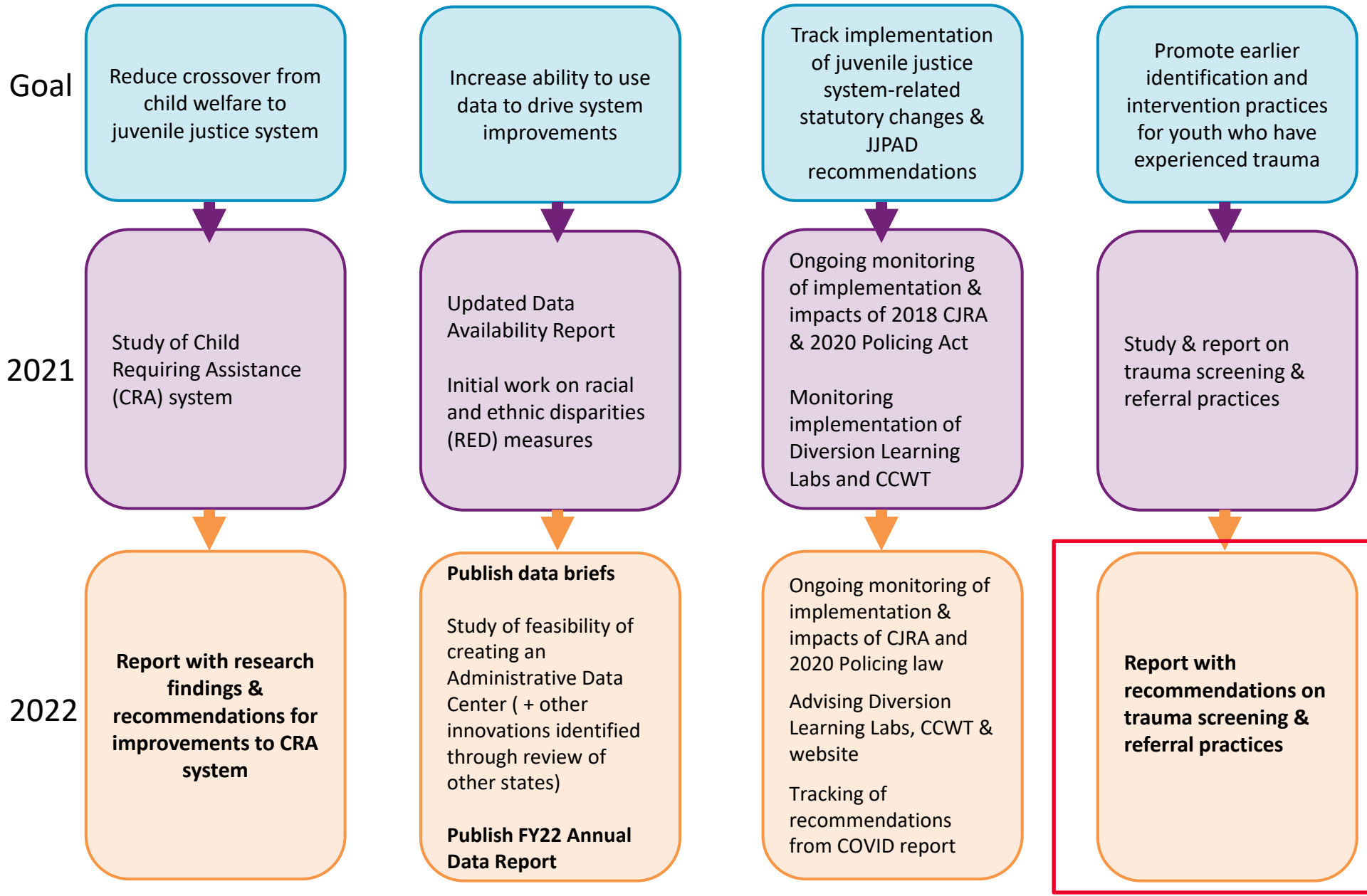
JJPAD 2022 Work Plan



CTTF 2022 Work Plan

April
- Review of draft General Recommendations for Trauma Screening
- Trauma Screening in Child Welfare

May
- Review of draft recommendations for trauma screening in Child Welfare
- Trauma Screening in Juvenile Justice and First Responder settings

June
- Review of draft recommendations for screening in Juvenile Justice + First Responder settings
- Trauma Screening in Early Childhood Settings and Education

July
- Review of draft recommendations for trauma screening in Early Childhood Settings and Education
- Trauma Screening in Pediatrics

Sept.
- Review of full draft report (including trauma screening in Pediatrics)

Oct.

Vote on *Recommendations for Trauma Screening* Report

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GENERAL REQUIREMENTS AND SUPPORTS FOR EFFECTIVE TRAUMA SCREENING IMPLEMENTATION

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Recommendation #1: Organizations Developing and Implementing a Screening and Referral Process Should Do So in a Trauma-Informed and Responsive Way

- Trauma screening and referral, if not implemented in a trauma-informed and responsive way, is not effective—and can in fact be harmful

- Organizations should implement "TIR Principles" when establishing a screening/referral process:
  - Family & community engagement
  - Caregiver consent
  - Cultural competency & prior experiences of oppression

- Operationalizing screening and referral processes in a TIR way requires efforts in multiple domains of an organization:
  - Leadership & staff buy-in
  - Training
  - Strong referral/follow-up
  - Feedback loop

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Recommendation #2: Trauma Screening and Referral Processes Should Incorporate a Strength-based Approach

- Being Trauma-Informed and *Responsive* requires focusing on children/families' positive experiences, existing support systems, and healthy strategies they have adopted
  - "strength-based," "healing-centered," or "asset-based"

- Studies show that adopting a strength-based approach positively impact's children's development and long-term health
  - See the work of HOPE at Tufts Medical Center

- Examples of how organizations can incorporate a strength-based approach in trauma screening/referral:
  - Incorporate questions about Positive Childhood Experiences in the interview process
  - Use a screening tool measuring resilience
  - Refer children/families to programs and services committed to a strength-based approach
  - Refer children/families to programs and services they have expressed interest in

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Recommendation #3: The State Should Support Organizations Who Wish to Implement Trauma Screenings

The Center on Child Wellbeing and Trauma (CCWT) is well equipped to support organizations wishing to implement trauma screening. Increasing its funding would enable the CCWT to provide:

1. Training and Technical Assistance
   - "Trauma Screening Overview" for staff at all levels
   - Sector-specific training for staff directly involved in screening
   - Technical assistance for organizations to develop a system to collect and analyze data

2. Resources on trauma screening and referral
   - Guidance on how to choose a screening tool
   - Sample language in multiple languages with info on "who, what, when, where, and how" for organizations to use

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

[work on this recommendation is ongoing and dependent on CTTF discussions]

- Expanding availability of services
- Increasing access to services
- Building the mental health workforce capacity

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TRAUMA SCREENING IN CHILD WELFARE

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Overview of Presentation

1. Why screen?

2. When should children be screened?
   - Timing and target population are dependent on agency's goals

3. Who should screen?

4. What is needed to implement trauma screening in child welfare?

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Trauma-Informed Child Welfare Systems In the United States

- Beginning in the early 2010s, the federal gov't has supported the use of screening as part of trauma-informed and responsive care in child welfare systems across the U.S.

- This presentation is based on studies and reports of a dozen jurisdictions that have received federal grants (NCTSN, SAMHSA, Children's Bureau) to implement trauma screening

- To date, at least 4 states have implemented trauma screening state-wide (CT, LA, MI, KY) and six in some counties (OH, KS, CO, NC, CA)

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Why Have Some CW Systems Chosen to Screen Children for Trauma?

- We already know children involved with child welfare (CW) have been exposed to traumatic events
  - Abuse and/or neglect (before CW contact) as well as removal from home and multiple placements (after CW contact)
  - One study found that 70% of children in foster care meet the criteria for complex trauma

- But a "presumption of trauma" does not always give the necessary information on type, chronicity, or impact of trauma
  - Connecticut: 46% of surveyed staff identified new traumatic exposures in a child they were not aware of and 73% identified new symptoms
  - Project Atlas (NYC): "even among children who had been in a given program for months or years at the point of assessment, staff often reported learning new things about the child's experiences and current sources of stress."

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Goals of Screening for Trauma

- Help caseworkers operationalize trauma-informed care
- Inform service needs of all children involved with CW
- Improve family functioning & avoid out-of-home placements
- Inform placement decision and service need
- Improve placement stability
- Inform case management

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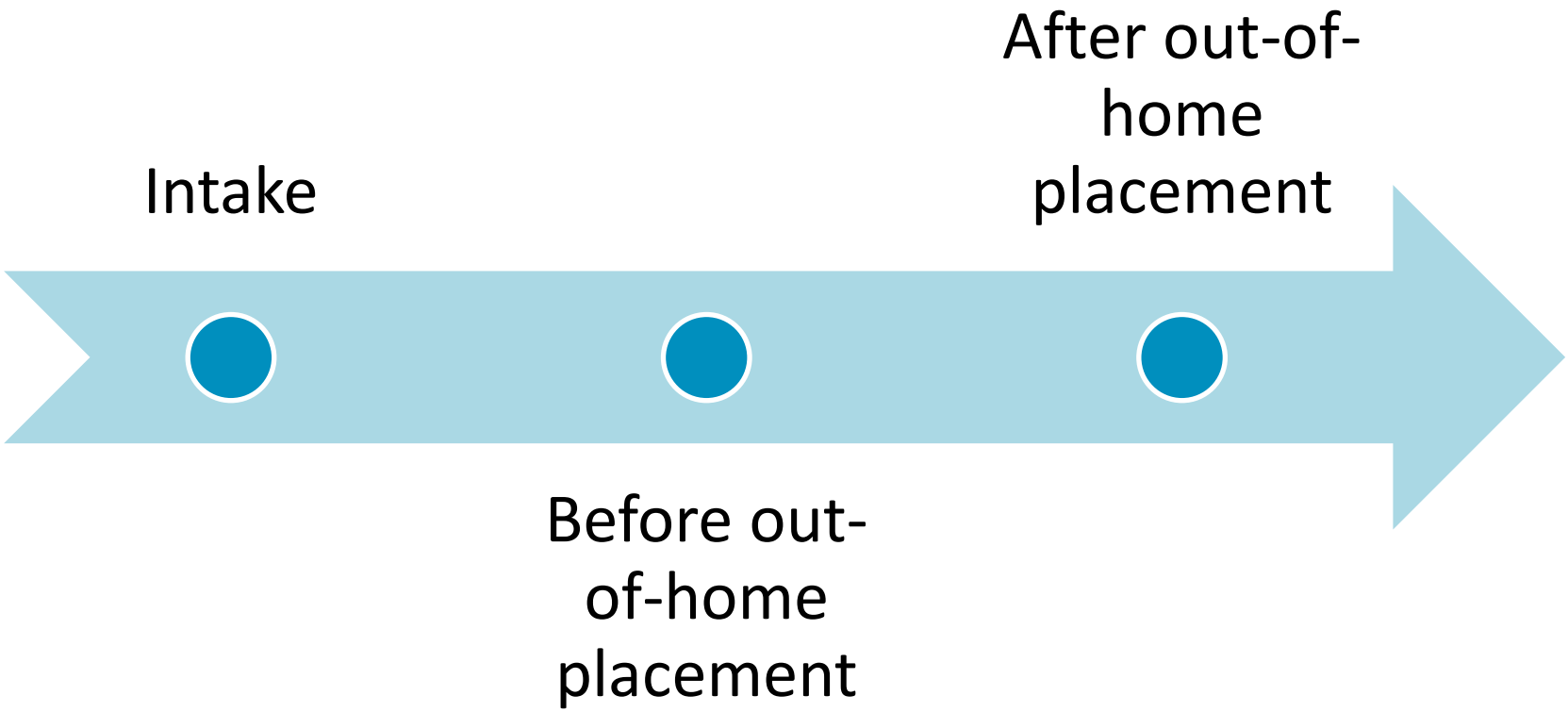
When Should Screening Take Place?



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Screening at Intake

Goal: Improve family functioning and avoid out-of-home placements

- Louisiana chose universal screening at intake to help strengthen biological families
  - Screening provides a structure to discuss trauma with family
  - Screening is the first step towards improving the functioning of children who have trauma-related psychiatric problems

- Some North Carolina counties screen when child/family is receiving in-home services

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Screening at Intake

Goal: Inform service needs of all children involved with CW

- Montana's Bureau of Indian Affairs CW system screened all children at intake; some selections trigger an automatic referral to behavioral health (i.e. physical and sexual abuse, exposure to domestic violence, and suicidal ideation)

- North Carolina's participating counties initially screened children before placement in foster care, but some counties later opted to use it earlier, as part of intake and assessment process

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Screening at Intake

Goal: Help caseworkers operationalize TIC

- Michigan's caseworkers use the trauma screening tool to implement trauma-responsive strategies, shifting away from a behavior-centered protocol to trauma-informed care. Additionally, it is used to monitor progress/document changes

- North Carolina collaborated with CW caseworkers to develop a trauma screening *Companion Guide* covering the purposes of the tool, the different ways it can be used, and FAQs. The language used is clear and concise.

Screening Before Out-of-Home Placement

Goal: Inform placement decision and service need

Caseworkers in some North Carolina counties use it to make better informed out-of-home placement decisions when applicable. Results from the screen help:

- Match specific trauma exposures with foster parent's skills/experience
- Match caregivers & providers to child's individualized needs
- Identify potential triggers and avoid inadvertent re-traumatization (in foster home or relating to foster parents themselves)

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Screening After Out-of-Home Placement

Goal: Improve placement stability

- In 2018, participating Colorado counties screened youth who met one of the following criteria:
  - Current or recent placement in congregate care
  - Considered at-risk for congregate care based on traumatic exposure, symptoms, and/or behaviors
  - Involvement in the juvenile justice system, and/or "beyond control of parent"

- Connecticut administers a trauma screen to children (3+ yo) shortly after home removal during Multidisciplinary Evaluation, which results in a comprehensive report including recommendations re: the child's trauma-related needs

Screening After Out-of-Home Placement

Goal: Improve placement stability

Atlas Project in New York City served children with acute behavioral health needs at Treatment Family Foster Care (TFFC) programs

- Screening for trauma took place within 30 days of admission to the foster care program to inform need for assessment and subsequent services, such as Trauma Systems Therapy (which has been demonstrated to increase placement stability)

Repeated Screening

Goal: Inform case management

Systematic

- Michigan: every 3 months & prior to case closure
- Louisiana: Screening repeated every 6 months
  - In practice, a repeat screen was only administered for 29% of newly opened cases
- NYC: Initially repeated every 3 months but changed to every 6 months in response to workload challenges

Recommended

- North Carolina: as needed every 1, 3, 6 months, annually OR when there is a placement disruption, a move to a higher level of care, and/or major change in the child's circumstances.
- Colorado: if additional relevant information becomes available

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Who Should Conduct a Screening?

- Most jurisdictions opted for case workers to administer the screen
  - Interview
  - Self-administered, reviewed by caseworker (Louisiana)

- A few sites chose to have the screen administered by behavioral health clinicians or specialized workers
  - In Montana, *"one site found it helpful to have an [Indian Health Service] behavioral health clinician ask the screening questions with the worker over the phone. This allowed the clinician to obtain helpful information about the client to be referred and shifted the burden of completing the screen so that it was shared between the worker and the clinician."*

Challenges and Solutions

- Concern about staff workload
  - Connecticut's screen takes <9 min and staff surveyed overwhelmingly believed it was easy to administer & worth the time spent
  - Louisiana developed a screening tool that could be completed in 5-10 min and was self-administered (as opposed to interview-style)
  - States overwhelmingly reported that the use of screening within a TIR system was useful to caseworkers and professionals working with the child/family

- Fear that use of screen will stigmatize or re-traumatize children/families
  - Jurisdictions repeatedly found that training/coaching of CW staff alleviated staff's fears by giving them tools to address this (e.g. effective administration of tool; handling challenging situations)
  - Research suggests that trauma screening does not cause high levels of upset

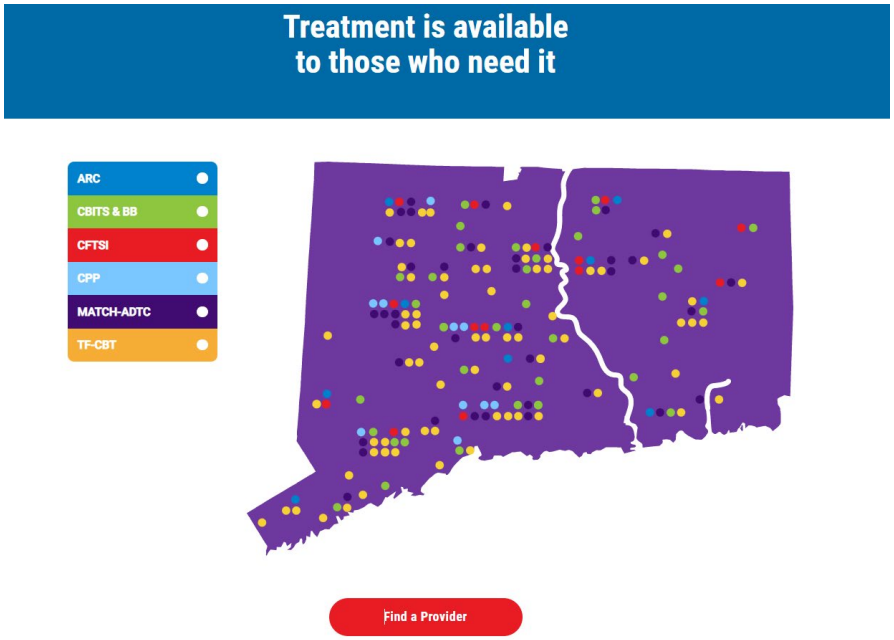
Challenges and Solutions

- What works in theory might not work in practice
  - Participating counties in North Carolina and Colorado revised who should be screened and when after a few years (respectively expanded and narrowed target population)
  - Highlights importance of studying implementation and revising plan as necessary

- Insufficient buy-in
  - States found that their project was successful when key supporters in each sector were identified early and involved throughout the project
  - Implementation literature shows that use of internal change champion is crucial to successful program implementation

Challenges and Solutions

- Difficulty implementing effective referral process
  - Connecticut trained providers on EBTs and then created and continues to update a map with EBT providers



  - Louisiana embarked in a “mystery shopper project” to see if these services actually exist

Lessons Learned: Key Factors for Continued Implementation

- Leadership
- Identified champions

- Embedding trauma screening and TIR practices in agency policy

- Ongoing collection and use of data
- Training & technical assistance
- Services (i.e. referral or provision)

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Implementing a Trauma Screen in Child Welfare in Massachusetts: Strengths to Build On

MA Child Trauma Project (2011-2017) efforts continue today:

1. Policy & Training

- Information on symptoms of traumatic stress included in DCF's *Family Assessment & Action Planning*, which is used by caseworkers to determine if DCF should remain involved and, if so, to inform development of a plan to support the child/family.

- Information on trauma embedded in DCF staff training:
  - *New Social Worker Pre-service Training Program* now includes information on the impact of trauma
  - Mandatory in-service trainings includes many modules on trauma and trauma-informed practice
  - Ongoing professional development opportunities includes the Trauma Practice Certificate program (Simmons Univ.)
  - DCF caregiver training (MAAP) includes information about the impact of trauma on child's functioning and behavior

Implementing a Trauma Screen in Child Welfare in Massachusetts: Strengths to Build On

2. Buy-In: Created Trauma-Informed Leadership Teams (TILTs) in each Area Office, which brought together DCF staff, mental health providers, and other community partners

- Some, though not all, TILT teams are still active
- Most area offices also formed Wellness groups to address STSS in workforce

3. External Support

- Training
  - Child Trauma Training Center (UMass) trains clinicians in EBTs + DCF staff in TIC
  - Center on Child Wellbeing and Trauma provides TIR training & coaching to child-serving organizations

- Referral: LINK KID operates a centralized assessment/referral line + database of clinicians trained in trauma treatments

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Questions?

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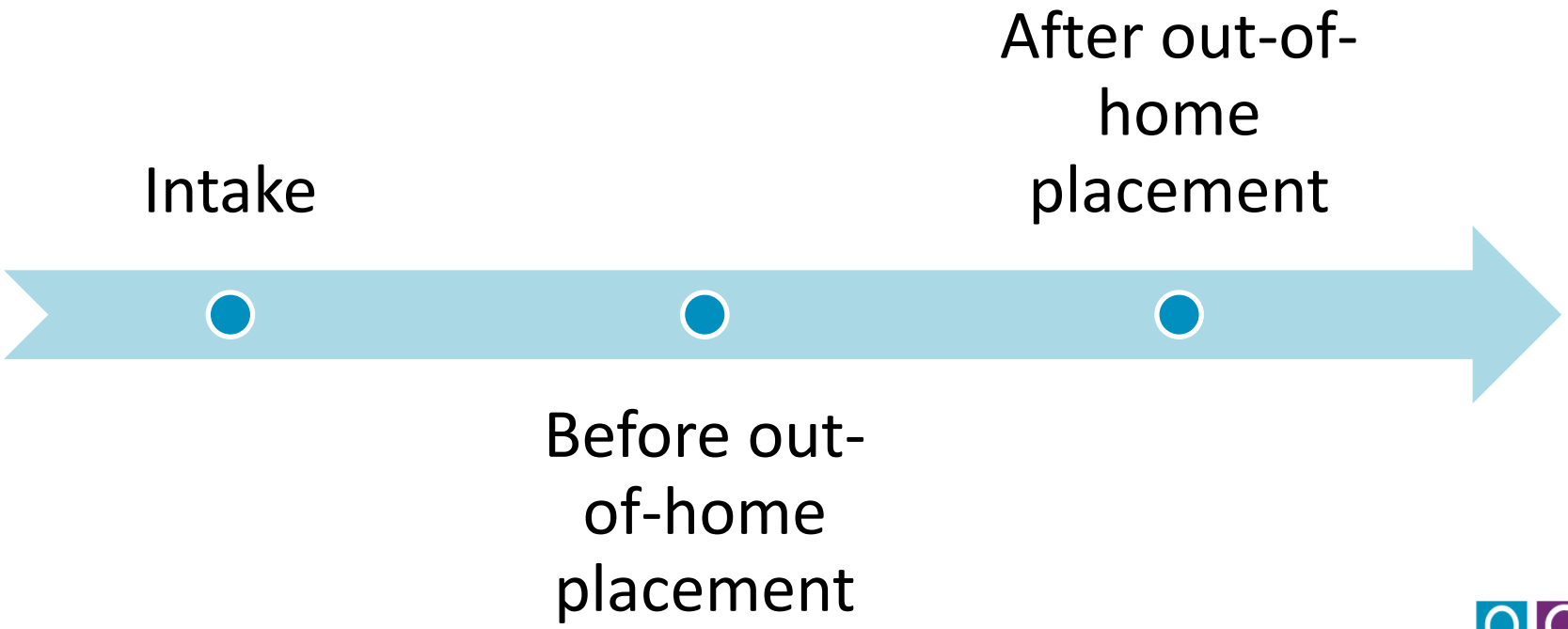
Questions for Discussion

1. Should we recommend the use of a formal trauma screening tool by DCF caseworkers?
2. If so, at what part(s) of the process?



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For More Information

- Murphy, J., & Ingoldsby, E. (2020). *Trauma-informed innovative practices: Insights from Children's Bureau discretionary grantees on addressing trauma in child welfare*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.
- CHDI presentation to CTTF (9/14/2021)
- Bartlett et al. (2015). Trauma-Informed Care in the Massachusetts Child Trauma Project. *Child Maltreatment*, 1-12.
- Scheeringa, M. & Mai, T. A. (2018). Louisiana Child Welfare Trauma Project (LCTP): Background, Implementation, and Results. Tulane University, New Orleans, LA.
- Bunting, L. et al. (2019). Trauma Informed Child Welfare Systems-A Rapid Evidence Review. *International Journal of Environmental Research and Public Health*, 16(13).

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Next Meeting

May 2, 2022

1:00pm-3:00pm

Virtual Meeting

For virtual meeting information, email Morgan Byrnes at Morgan.Byrnes@mass.gov

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