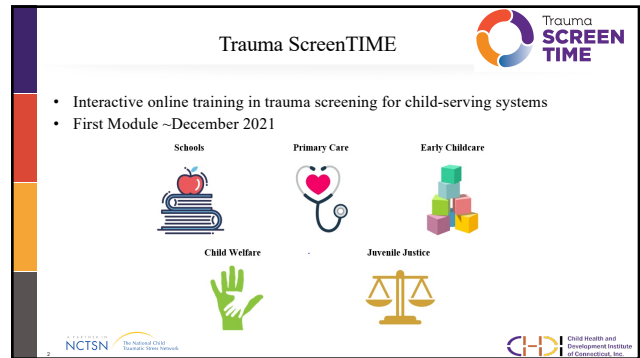
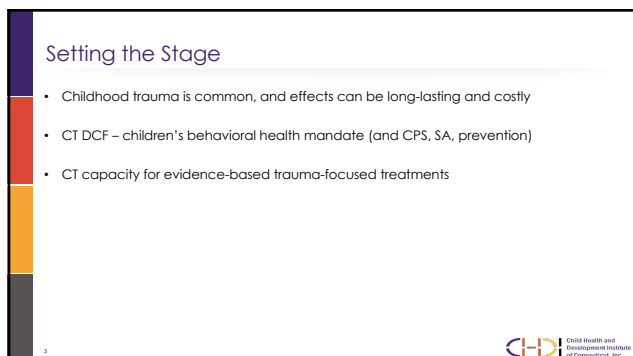


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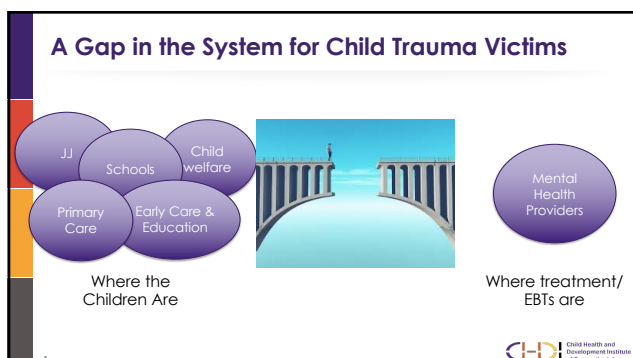
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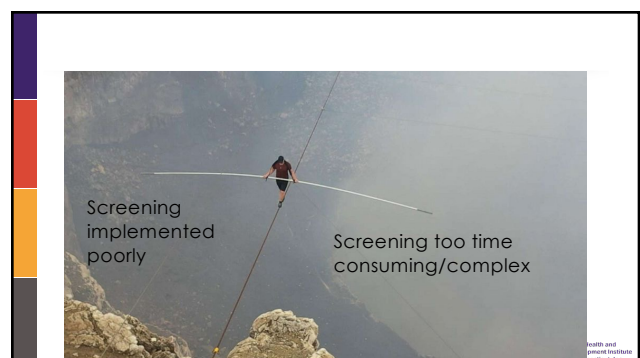
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4



5



6

What is your goal with screening?

Function > Form



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Potential benefits for you/your role

Early identification

Enhance child/family resiliency

Can offer insight into problems a child is experiencing

Allows you to support the child/family through a discussion about trauma

Can inform your service planning for the child/family

Can identify need for trauma assessment/treatment

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Potential benefits for child/family

Supports recovery and safety and reduces effects of trauma exposure

Destigmatizes conversations about trauma

Can help the child and family feel heard/listened to

Learn about trauma

Can provide the child and family with strategies to support the child and improve communication

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Trauma Screening & Equity



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Screening Process – Remember to UPLIFT

- U**nderstand
- P**repare
- L**isten and reflect
- I**nstill hope
- F**ind a path forward
- T**ake the next step

NCTSN

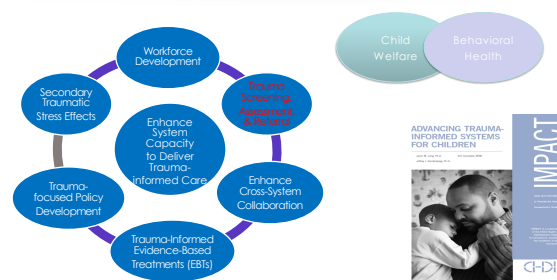
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CT Collaborative on Effective Practices for Trauma (CONCEPT) 2011-2018



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Developing a Screening Process for your Program/Organization

Who, What, When, Where, How

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Who?

- Who will be screened?
 - Targeted vs. selective universal vs. universal
 - Pilot
- Who will complete the screening measure?
 - Child, caregiver(s), both
- Who will introduce, conduct, and discuss results of the screening?

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What?

- What screening measure?
- SAMHSA's 3Es of trauma
 - Events** (exposure): PTEs, ACEs, adversities, etc.
 - Experience** of the event (subjective)
 - Effects** (reactions)
- Screening vs. assessment
- What will the results/data be used for?

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Cautions about screening for ACEs (or events) only

American Journal of Preventive Medicine

Inside the Adverse Childhood Experience Score: Strengths, Limitations, and Misapplications

Robert F. Anda, MD, MS,¹ Laura E. Porter, BA,² David W. Brown, DSc, MSPH, MSc³

JAMA Pediatrics | Original Investigation
Population vs Individual Prediction of Poor Health From Results of Adverse Childhood Experiences Screening


Joseph E. Ruffolo, PhD, Andrew Cogg, PhD, Amy L. Mearns, PhD, Anthony Andrie, MSc, Louise Annand, PhD, Helen L. Fisher, PhD, Victoria Livingston, BA, Timothy Matheson, PhD, Candace S. O'Leary, PhD, Robert P. Taylor, PhD, David R. Williams, PhD, David C. Reardon, PhD, Andrew Chan, MD, PhD

CONCLUSIONS AND RELEVANCE This study suggests that, although ACE scores can forecast mean group differences in health, they have poor accuracy in predicting an individual's risk of later health problems. Therefore, targeting interventions based on ACE screening is likely to be ineffective in preventing poor health outcomes.

ence scaffolds it. The ACE questionnaire was designed to research—not screen—the relationship between childhood adversities and health and social outcomes. There risk; thus, the ACE score is not suitable for screening individuals and assigning risk for use in decision making about need for services or treatment. Researchers are actively working to modify measures and expand the set. Inferences about an individual's risk for health or social problems should not be made based upon an ACE score, and no arbitrary ACE score, or range of scores, should be designated as a cut point for decision making or used to infer knowledge about individual risk for health outcomes.

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When?

- When will screening occur?
- Child welfare
 - Earlier vs. later
 - Investigation
 - Ongoing services

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Where?

- Home, office, other
- Virtual or in-person

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How?

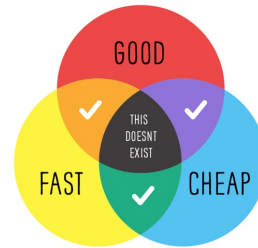


- How are staff trained/receive consultation?
- How are results used?
 - Integrated into case plan?
 - Inform care/future visits
 - Service referrals – what is available?!
- How do you support staff wellness/STS?



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Goals for CTS Development



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Initial CTS Development

- Screening Workgroup (CW staff, trauma experts, family members)
- Measure review
- Empirical item analysis
- Small pilots
- Started with Trauma + Behavioral Health measure
- Staff feedback form



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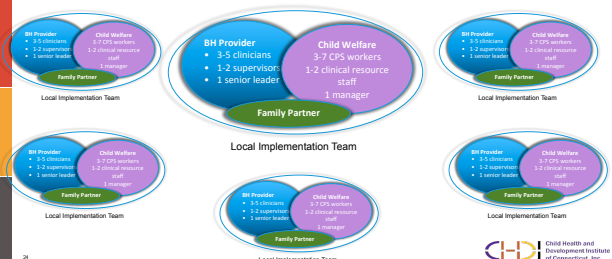
EBT Cross-System Learning Collaboratives:
Reframing the Mission

	Mission	Who	How
Original:	Increase access to EBTs	BH staff	EBT model
Cross-System:	Increase access to EBTs for children in the CWS	BH and child welfare staff	EBT model, screening & referral, collaboration



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Learning Collaborative Pilots



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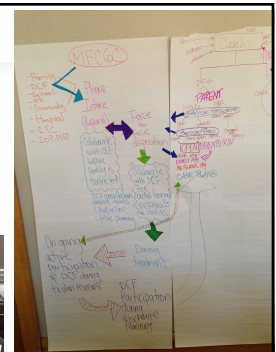
LC Activities

Process mapping

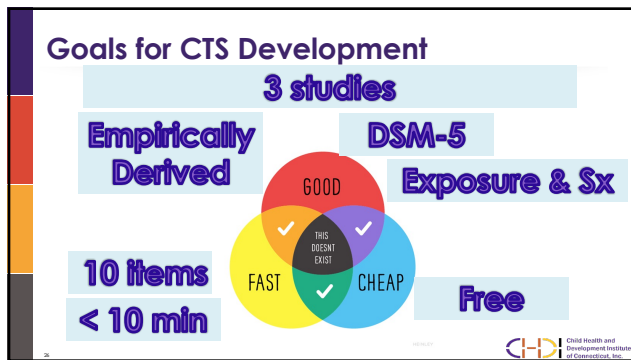
Sharing information/communication/
coordination

Aligning treatment & case plans

Team building



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CTS Caregiver Report (Age 6-17)

1 Child Name: ID: Age: Gender: ☐ Male ☐ Female ☐ Other

Administered By: Date Completed:

2 EVENTS: Sometimes, scary or very upsetting things happen to people. These things can sometimes affect what we think, how we feel, and what we do.

1. Has your child ever seen people pushing, hitting, throwing things at each other, or making threats or trying to hurt each other? Yes ☐ No ☐

2. Has someone ever really hurt your child? (e.g., punched, or kicked them really hard with hands, belt, or other objects, or tried to choke or stab them?) Yes ☐ No ☐

3. Has someone ever touched your child on the parts of their body that is usually not covered, in a way that made you or your child uncomfortable? Or has someone had your child touch them in this way? Yes ☐ No ☐

4. Has anything else very upsetting or scary happened to your child (besides one that, happened to him/her once, like with a dog or a long time not being enough friends, or, serious accident or illness, fire, dog bite, kidnapping)? What was it? Yes ☐ No ☐

3 REACTIONS: Sometimes scary or upsetting events affect how people think, feel, and act. The next questions ask how your child has been feeling and thinking recently.

How often did each of these happen in the last 30 days?

	Never	1-2 times per month	1-2 times per week	3+ times per week
5. Your child has strong feelings in their body when they remember something that happened (swimming, heart beats fast, feel sick).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Your child tries to get away from people, places, or things that remind them about something that happened.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Your child has trouble feeling happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Your child has trouble sleeping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. It's hard for your child to concentrate or pay attention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Your child feels alone and not close to people around them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

www.chdi.org/cts

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Feasibility/Utility – Screening Youth in JJ System (prelim.)

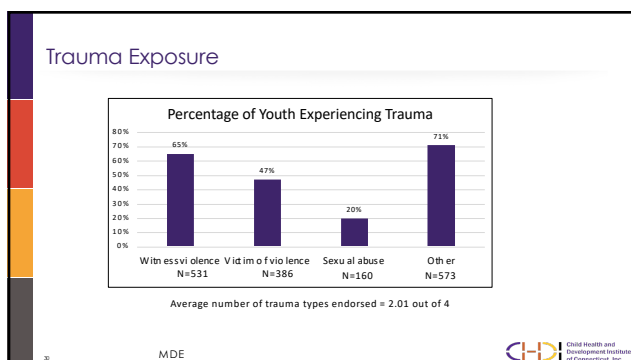
	Child Report N=975	Caregiver Report N=1007
Identify new trauma exposure ?	44%	44%
Identify new trauma symptoms ?	42%	40%
Screening impact on engagement ?		
Helped	36%	33%
No effect	61%	66%
Hindered	2%	2%
Was time spent worth info learned?	68%	68%
"A lot" or "Extremely" distressed	1.7%	2.1%

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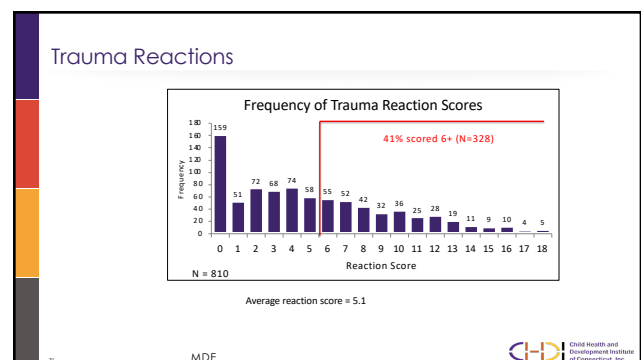
Trauma Screening in Child Welfare

- Used in Multidisciplinary Evaluation (30 days from removal)
- CTS (age 6-17)
 - Caregiver & child reports
- CTS-Young Child for age 3-6 (caregiver report)
- Full MDE report → worker for services
- Ongoing use of data for QI

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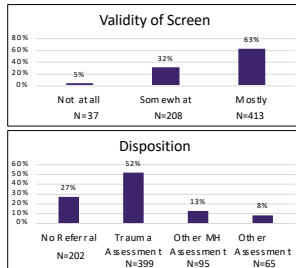


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Validity & Disposition



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Staff Feedback Form– MDE Providers

- Ratings of the CTS were favorable:
 - enhanced understanding of child's needs (82% at least half the time)
 - Identified new traumatic exposures (46%) or symptoms (73%)
 - Information led to changes in case service plans (36%)
 - Relatively low levels of discomfort for youth or caregiver
- Feasibility/Utility:
 - average of 8.9 minutes (sd=3.0 minutes) to administer
 - Ease of administration was very high (4.3 out of 5)
 - Worth time spent rated favorably (4.1 out of 5)
 - Didn't impact engagement positively or negatively



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Trauma Screening Evaluation

CPS Case Review

Compare children screened with matched sample

Examine differences in case plans, referrals, services, etc.

Those screened for trauma were:

- More likely to have documentation about trauma reactions in case plan
- More likely to be recommended and referred for trauma-focused MH services
- More likely to be referred for other MH services
- Trend towards more receipt of trauma-focused MH services



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Sustainability

NCTSN Trauma Training Toolkit – now part of preservice training

EBTs – supported through state-funded EBT Center

- Challenge: cross system collaboration

Trauma screening – embedded in MDE service

* Data analysis/reporting

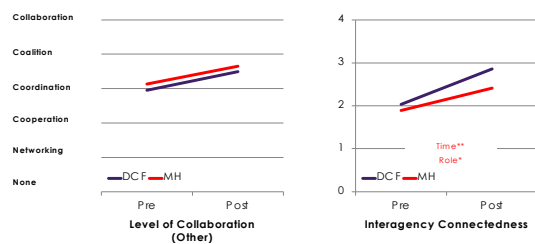
Policy & Practice Guides



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Changes in Levels of Collaboration



** p < .01; * p < .05

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Beyond Child Welfare

- Juvenile Justice system – all youth at intake
- Care coordination – all youth
- Mobile crisis – all youth
- Schools - limited mostly to those offering CBITS/BB
- Pediatric primary care - limited



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Final Thoughts

- Diverse planning/implementation team
- Who needs to support it and how can you get support?
- Focus more on process (and less about the measure)!
 - Referral sources/connections
- Identify and utilize early adopters/champions
- Pilot a lot
- Use data, but don't ask for too much



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Thank you!

Please complete a VERY quick evaluation:

<https://survey.alchemer.com/s3/6517485/Child-Trauma-Screen-Training-Evaluation-Survey-CTTF>

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Child Health and Development Institute (CHDI)

jalana@uchc.edu



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