Journ Child Adol Trauma (2017) 10:405–416
DOI 10.1007/s40653-017-0155-y

CASE STUDY

Trauma Screening in Child Welfare: Lessons Learned from Five States

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Published online: 13 June 2017

Abstract Children in the child welfare system experience high rates of exposure to potentially traumatic events, which are associated with significant impairments in safety, permanency, and well-being. However, child welfare systems have not routinely screened children for trauma, and little is known about such efforts. This paper describes five statewide and tribal projects to implement trauma screening for children in the child welfare system as part of broader, trauma informed care initiatives. Findings indicate that implementation strategies varied considerably but that screening generally resulted in identification of high rates of trauma exposure, trauma symptoms and service referrals. Further, screening was generally perceived favorably by child welfare workers and mental health professionals. However, wide variations were observed in the number of children screened, suggesting that more research is needed to identify optimal strategies. Lessons learned are described and recommendations made for implementing trauma screening in state or tribal child welfare systems.

Keywords Trauma · Screening · Child welfare · PTSD · Implementation

In 2014, there were 3.6 million referrals to child protective services alleging child maltreatment involving 6.6 million children in the United States (U.S. Department of Health and Human Services 2016). Children in the child welfare system (CWS) are frequently exposed to potentially traumatic events (PTEs), including physical abuse, sexual abuse, violence, and loss of or separation from caregivers (Miller et al. 2011). Many children are further exposed to the cumulative traumatic stress associated with child welfare investigations and potential removal from their home, separation from their caregiver(s) and siblings, and/or placement into multiple foster homes (Greeson et al. 2011). Subsequently, children in the CWS suffer from higher levels of posttraumatic stress disorder (PTSD) symptoms and other behavioral health concerns than the general population (Burns et al. 2004; Pecora et al. 2009).

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Children exposed to PTEs are also at greater risk for a number of chronic health and mental health problems through adulthood, including depression, suicide, heart disease, substance abuse, and premature death (Dube et al. 2003; Felitti et al. 1998). The costs to society associated with child maltreatment, including future healthcare costs, involvement with the child welfare and justice systems, and lost work productivity, have been estimated at $210,012 per child or $124 billion annually (Fang et al. 2012). Thus, there is a significant social and economic need to identify children in the CWS who are suffering from PTE exposure and provide them with effective trauma-focused services.

Recent research and increased recognition of the prevalence and consequences of exposure to trauma in childhood have fueled efforts to promote "trauma informed care" or creation of "trauma informed systems" in child welfare and other child-serving systems. While these "trauma informed" terms are not well-defined, nor the results of such efforts well-studied (Hanson and Lang 2016), the general notion is that a trauma-informed agency or system "provides a safe, supportive environment to staff and consumers that reflects available research about the prevalence and effects of trauma exposure and the best methods for supporting children and families exposed to trauma" (p. 2).

Practically, screening children for trauma is an important component of a trauma-informed system, together with workforce development and staff training, organizational strategies such as policy change, improving safety, reducing re-traumatization, and increasing inter-agency collaboration, and access to trauma-focused evidence-based treatments (EBTs). There are a growing number of trauma-focused EBTs that have demonstrated significant improvements in outcomes for children suffering from PTSD and other sequellae of trauma exposure; emerging research shows these EBTs are also cost-effective (Greer et al. 2013; Lee et al. 2015). However, few children in the CWS receive EBTs (Burns et al. 2004), and most children with significant emotional or behavioral problems do not even receive specialty mental health services (Burns et al. 2004). Recent calls have been made to provide more consultation to child welfare workers, social workers, and other "brokers" of behavioral health services to improve utilization of EBTs through screening to identify youth in need of treatment (Dorsey et al. 2012).

Several recent efforts have begun to promote trauma-informed care in the CWS. Many of these have been led by the National Child Traumatic Stress Network (NCTSN), a network of research and treatment centers across the United States funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). For example, the NCTSN has developed the Child Welfare Trauma Training Toolkit (CWTTT; Child Welfare Collaborative Group and National Child Traumatic Stress Network 2013), an evidence-informed curriculum for child welfare staff about child traumatic stress that has been adopted by a number of states, as well as a number of other products for developing trauma informed CWSs. Simultaneously, the Administration for Children and Families (ACF) has promoted an increased emphasis on and funding for well-being and trauma-informed care for children in the CWS to further these goals (Administration for Children and Families 2017).

Trauma screening is considered an essential component of efforts to promote trauma-informed care and to ameliorate the effects of childhood trauma for children in the CWS or other child-serving systems (Conradi et al. 2011; Hanson and Lang 2016). Screening for trauma may promote early identification and more rapid access to trauma-focused EBTs or other indicated services and may prevent misdiagnosis, which is especially common among children suffering PTE exposure (Grasso et al. 2009), and thus prevent referral for services that may be unhelpful or contraindicated. Trauma screening is especially important because of the high prevalence of PTEs experienced by children in the CWS, including PTEs experienced through system involvement (e.g. removal or separation from caregivers).

Despite the research on the effects of trauma exposure, limited utilization of trauma-focused EBTs among children in the CWS, and numerous calls for universal trauma screening, CWSs do not routinely screen children for trauma (Greeson et al. 2011), and very little research has been conducted about such efforts. Kerns et al. (2016) trained 71 newly hired child welfare staff who conducted assessments of children to screen for trauma. While feedback was generally positive and improvements in self-reported knowledge and skill were achieved, there were mixed responses six months later about commitment to continued screening. Fitzgerald et al. (2015) conducted a quasi-experimental study of 23 child welfare caseworkers who received training and consultation to screen and refer children for a range of behavioral health concerns, including trauma; promising results were observed in caseworker knowledge of screening and EBTs. While workers in the intervention group tripled their rate of trauma screening, this difference was not statistically significant, likely because of the small sample size.

One significant challenge to implementation of trauma screening has been the lack of brief, validated screening measures intended for use in the CWS (for a review of measures, see Conradi et al. 2011). Other potential barriers include the traditionally limited training on trauma among social workers and others in the CWS, limited time to administer measures, availability of trauma-focused services to which children may be referred, and the potential of secondary traumatic stress among workers discussing trauma with children (Conradi et al. 2011). And while many complementary efforts to disseminate trauma-focused EBTs have been successful (Ebert et al. 2012; Sigel et al. 2013), utilization of these treatments by child welfare staff for children in the CWS may be limited

without efforts to identify appropriate children through screening (Grasso et al. 2012).

This paper summarizes lessons learned from five statewide and tribal initiatives to implement trauma screening in the CWS as part of broader efforts to promote trauma-informed care. These initiatives were funded by ACF through five-year demonstration grants awarded in 2011. The broad goals were to develop and evaluate a range of strategies for improving care for children in the CWS suffering from exposure to PTEs, including workforce development, trauma screening and referral, dissemination of trauma-focused EBTs, and improved collaboration between child welfare and behavioral health. Each grant included a planning year for conducting a local readiness and capacity assessment to inform the four-year implementation plan. This paper describes the trauma screening approach of each of these initiatives, including local context and considerations, specific strategies used, and results. We conclude with a summary of common themes across these diverse initiatives, recommendations for implementing trauma screening in other CWSs, and highlight areas for further research.

Colorado

Context

This project is implemented through the Denver Department of Human Services (DDHS) in partnership with The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect (Kempe Center)/Department of Pediatrics/CU School of Medicine. DDHS and the Kempe Center planned, implemented, and evaluated the project in the city and county of Denver, Colorado. Close collaborators also include the Denver Juvenile Court, Denver Juvenile Probation, Colorado Access Behavioral Care (Denver Medicaid authority) and multiple providers of child/family mental health services. The City and County of Denver are urban areas and the second most populous county in the state.

Screening Approach

Measure Two measures were selected to pilot after a literature review and consideration of practical factors: the Child Trauma Assessment Center (CTAC) screen (Henry et al. 2010) and the Core Clinical Characteristics Trauma Detail Form developed by the NCTSN. These tools were considered for pilot testing because they: 1) represented different methodologies – caseworker report versus caregiver and child/youth report; 2) had been used previously with the population of interest; 3) were relatively brief; and 4) were available at no cost. A unit of 12 DDHS caseworkers conducted six weeks of pilot testing of the two screens with 32 individual children. The evaluation team conducted individual interviews with each caseworker to gather feedback about the two screens. Workers appreciated the Core Clinical Characteristics Trauma Detail Form as a means of establishing rapport with foster parents and as a means of "checking in" with biological parents. However, they questioned the validity of the data obtained and believed that biological parents were underreporting children's exposure to PTEs and/or symptoms based upon what workers already knew about the child. Workers reported that foster parents seemed to report symptoms accurately but had little knowledge about the child's PTE exposure. Caseworkers appreciated that the CTAC screen took an average of six minutes to complete. They reported that it was at least "somewhat helpful" in reviewing the child and considering how exposure to PTEs might be related to behavioral health concerns. Thus, the CTAC screen was selected for implementation.

Target Population The goal was to provide universal screening for all children aged birth to 18 involved in the CWS who had an open case for ongoing services, including voluntary and court-ordered child protective services (CPS) involvement (excluding children seen only in intake/investigations). Goals related to examining mental health referrals and receipt of mental health services and other Comprehensive Child Welfare Information System (CCWIS) data were only possible with families who received ongoing services.

Screening Process Caseworkers in the ongoing child protection and youth units are mandated to complete the screen for each child within 90 days of CPS involvement, coinciding with the initial treatment plan. Each worker received initial training in how to complete the screen and booster trainings and individual consultation have been provided. Workers complete the screen using their knowledge of the child and family through child welfare records; if desired, workers may also ask the client and/or family questions directly. The screen is completed online and submitted to the "Trauma Screen Review Team," comprised of a DDHS program administrator who consults with supervisors, Kempe clinical staff and other parties as needed (e.g. family preferences and court/GAL recommendations). The team reviews the screen, SACWIS data (e.g. placement type, availability of a caregiver to participate in treatment, current services in place), and contacts the caseworker within 48 h of the submission of the screen to discuss the child and family. A recommendation regarding need for trauma-focused or other mental health services is made when indicated, and referrals for EBTs are made when possible. Referrals to EBT providers and "other" referrals are tracked in the screening database. Challenges have occurred at various stages of the project including the inability to incorporate screening data into the CCWIS due to the number of requests for CCWIS changes and the length of time that it would take

to make changes. Thus, a separate screening database was created, but was built to interface with CCWIS in order to integrate screening and other CPS data.

Results In the initial 16 months of implementation, 1315 children/youth were part of an open CPS case. Of these, 697 (53%) were screened by 180 caseworkers and 39 supervisors. Screening occurred slightly more often for young children from birth to age 5 (56%) than children aged 6 to 18 (48%). Strategies to increase the screening rate have included training all workers in the CWTTT and providing booster trainings, making the screen mandatory, and providing monthly reports of screening rates by worker, supervisor, and unit. Moreover, another strategy used was employing a variety of incentives for caseworkers, such as water bottles and messenger bags with the project label, and recognition through "Champions" billboards in which the names and pictures of caseworkers are displayed in the hallways at DDHS.

Among children aged birth to 5 who were screened, the most common PTEs reported by workers were known physical abuse (21%) and exposure to domestic violence (35%). Among children aged 6 to 18, the most common PTEs reported by workers were also physical abuse (38%) and exposure to domestic violence (68%). Sexual abuse was also reported for 20% of older children. The most common symptoms for children aged birth to five were anger, problems with sleeping or appetite, and attachment difficulties; for older children, mood swings, anger, aggression, attention problems, and low grades were the most common symptoms. Referrals for trauma-focused EBTs were made for 22% of children/youth screened, while the remaining 78% did not receive a referral, typically because trauma-related symptoms were listed as not a concern by the worker completing the screen (40%) or the child/youth was already receiving treatment by the time the screen was completed (31%).

Connecticut

Context

Connecticut's Department of Children and Families (CT DCF) is a consolidated agency that has mandates for child protection, behavioral health, juvenile justice, education, and prevention. CT DCF has an average of 3400 staff who serve approximately 26,000 children who at any point in time are involved in the CWS. Despite a successful dissemination of Trauma Focused Cognitive Behavioral Therapy (TF-CBT) to 16 community-based agencies from 2007 to 2010 (Lang et al. 2015), there was limited awareness about TF-CBT among child welfare staff. In addition, CT DCF had been under a federal consent decree since 1991, in part for failing to meet the behavioral health needs of children in its care. In 2011, the new Commissioner of CT DCF identified trauma-informed care as one of the agency's seven cross-cutting themes; subsequently, CT DCF received an ACF grant to support development of a trauma-informed CWS. This initiative, called the Connecticut Collaborative on Effective Practices for Trauma (CONCEPT), included expansion of trauma-focused EBTs, workforce development for child welfare staff, and implementation of trauma screening (Lang et al. 2016). CT DCF partnered with the Child Health and Development Institute to lead implementation and The Consultation Center at Yale University to conduct the required evaluation. An original goal of CONCEPT was to implement universal trauma screening for every child age 5–17 who was involved with the CWS. A screening workgroup comprised of child welfare staff with diverse job functions (social workers, supervisors, clinical resource staff, academy of workforce development, behavioral health, Information Systems), community-based providers of TF-CBT, family members, and trauma experts developed the screening plan.

Screening Considerations

An assessment of trauma readiness and capacity was conducted in the planning year that included a web-based survey of CT DCF leadership and staff from all 14 area offices and facilities, as well as discussions and focus groups with key stakeholders to inform implementation plans. Feedback also provided through several pilots with CPS workers testing screening with children and caregivers directly. While most staff were enthusiastic about a trauma informed approach that included trauma screening, several concerns were raised. These included limited time for screening and data reporting given the requirements of existing risk assessments, the length of potential existing screens, the desire to integrate screening into existing child specific evaluations, concerns about talking about trauma with families, and whether screening would actually yield new information. Other concerns included the availability and capacity of services for children who screened positive for trauma-related needs. Finally, staff questioned how screening could be integrated into case planning and the CCWIS. Of note, a new CCWIS system was under development, limiting the ability to add trauma screening to the current system.

Screening Approach

Measure The Child Trauma Screen (CTS) is a 10-item, empirically-derived measure of PTE exposure and PTSD symptoms with strong psychometric properties (Lang and Connell 2017). The CTS was developed for this initiative due to the length of existing tools and the desire among CPS staff to customize items for the CWS.

Target Population The original intent to implement universal screening for all children aged 5 to 17 who were involved with the CWS was modified to focus on screening all children aged 6 to 17 who were entering the care of the CWS following removal from the family of origin. This change permitted the introduction of the screening process as part of CT DCF's Multidisciplinary Evaluation (MDE), where leadership determined it to be most feasible to embed it as part of a comprehensive assessment.

Screening Process Children were screened as part of the MDE, which is completed by CT DCF-contracted providers when a child enters state custody. Implementation was phased in between November 2014 and March 2015 at all 12 MDE providers. MDEs are required to be completed within 30 days of removal and include comprehensive health, dental, behavioral health, and psychosocial assessments; trauma screening was added as a contractual requirement. The CTS is administered as a face-to-face interview by clinicians who complete the behavioral health and psychosocial assessments and who received brief training on the CTS. The results of the MDE are included in a comprehensive report, which the child's CPS worker uses to make service referrals and develop case plans. Screening data are collected via paper, entered into a separate database, and reported in aggregate to determine compliance and rates of children's PTE exposure and PTSD symptoms. The long-term goal is to incorporate the CTS into the CCWIS.

Results

A total of 601 children were screened with the CTS between November 2014 and June 2016 by 11 clinicians as part of their MDE. Average age of children screened was 12.1 years old (sd = 3.3; range 7–18) and 52% were female. Children reported exposure to an average of 2.0 (sd = 1.2) out of the following 4 types of PTEs assessed by the CTS: witness violence (63.6%), victim of violence (46.8%), sexual abuse (20.1%), and other (68.1%). Most children (86.4%) reported exposure to at least one PTE and 10.9% to all four. Rates of PTSD symptoms on the CTS were also high (M = 5.0; sd = 4.4), with 39.8% of children scoring 6 or higher, the cutoff indicating a high likelihood of PTSD diagnosis. MDE evaluators' recommendations for children screened included a trauma assessment/treatment (50.8%), general mental health assessment/treatment (12.3%), no referral (28.9%), or other referral (8.0%).

A brief survey of the 11 clinicians responsible for completing the CTS across the 12 MDE providers was completed in June 2016 to assess utility and feasibility of the screen. MDE clinicians reported that the CTS usually enhanced their understanding of the child's needs (36.4% most or all of the time and 45.5% half the time). They reported learning new information about PTE exposure (46%) and PTSD symptoms (73%) at least half the time they administered the CTS. Finally, respondents indicated that the CTS took an average of 8.9 min (sd = 3.0 min) to administer and was relatively easy to implement. On a 5-point scale (1-strongly disagree to 5- strongly agree), ratings of ease of administration were very high (mean = 4.3, sd = 0.5), while fewer reported that it was challenging to ask youth about trauma (mean = 2.4, sd = 0.9). Most reported that the time spent on the CTS was worth the information learned (mean = 4.1, sd = 0.3), while most did not report an effect on engagement with either the youth (mean = 2.9, sd = 1.1) or the caregiver (mean = 2.8, sd = 1.0).

Massachusetts

Context

The Massachusetts Child Trauma Project (MCTP) initiated a statewide effort to enhance the capacity of child welfare workers and mental health providers to identify and intervene early and effectively with children exposed to PTEs. The goals were to: (1) train child welfare staff and resource parents to recognize and respond to child trauma; (2) disseminate three trauma-focused EBTs in community-based agencies via cohorts of Intensive Learning Communities; and (3) implement child welfare-led Trauma-Informed Leadership Teams (TILTs), including mental health providers, child welfare workers, consumers and other stakeholders to disseminate and sustain trauma-informed practices. MCTP is a collaborative project led by the Massachusetts Department of Children and Families (MA DCF) in partnership with LUK, inc., Justice Resource Institute, Boston Medical Center, and the University of Massachusetts Medical School. Representatives from all of these partner agencies participate on the MCTP Management Team, which is charged with the design, implementation and oversight of this initiative.

Considerations

Mental health providers utilized a range of trauma screening tools prior to MCTP implementation. Child welfare protective response workers assess for child safety and risk during the investigation phase, which includes an initial assessment of parental capacities. The assessment phase that follows includes a more in depth and comprehensive assessment of these capacities and includes questions about family history. Specific questions related to PTE exposure and symptoms were not included in child welfare screening; these questions are being incorporated into the new Family Assessment policy.

Screening Approach

Measure MCTP Management Team worked diligently to integrate a formal trauma screen into the CWS early in the project. The initial goal was to integrate the NCTSN-adapted Child Welfare Referral Tool as a universal screen for mental health and the CWS. This tool was integrated into a referral form by an NCTSN-funded trauma center in central Massachusetts and child welfare workers in the region were using it for several years. MCTP leaders requested feedback from mental health agency leaders prior to launching the screen in the MCTP design. Agency leader concerns included lack of training and education for front-line administrative staff, inability to add the screen into electronic health record platforms, and capacity limitations for providing rapid services for those positively screened. Therefore, a gradual implementation process in partnership with key stakeholders was essential for improvements in trauma screening for mental health. Through negotiations with the social work labor union about scaling the use of the trauma screen statewide, the decision was made to include questions about PTE exposure (including about the caregiver's early childhood experiences and significant life events) into the new CW Family Assessment and Action Plan, which will be implemented in FY17.

Target Population The proposed plan is that all children aged birth to 18 following a CPS report that has been flagged for further assessment will be screened for trauma.

Screening Process The Family Assessment and Action Plan is completed within 60 days after a substantiated maltreatment report or when a child protective case is opened for any other reason. It is updated at least every 6 months and more frequently if a significant change occurs in the family. The CWS also worked with MCTP to develop an addendum to the Family Assessment and Action plan on practice guidance with assessing for trauma. Questions include whether a trauma history is impacting parenting capacity, the child's history of PTE exposure, and if the child is displaying trauma-related symptoms.

To promote trauma screening until the rollout of formal screening in the Family Assessment and Action Plan, MCTP provided training on the impact of trauma within mental health and the CWS to enhance trauma screening capabilities. Strategies included (1) TILTs and Evidence-Based Learning Communities; (2) Trauma training of more than 2000 child welfare staff and 300 resource parents; (3) Leadership Support for EBT implementation teams; and (4) Development of the MCTP one question trauma screen ("Has anything worrisome or scary happened in your lifetime?"). A limited number of TILTs had child welfare workers who volunteered to pilot the use of the MCTP trauma screen. Many EBT teams installed the one question trauma screen into their agency's referral process with five agencies implementing the full MCTP screener. Although trauma screening was commonly conducted during the mental health intake process, agencies were encouraged to integrate the MCTP screen and/or the one-question pre-screener into their first contact with families or the referral source, critical to early identification and linkage to the appropriate service(s). Most mental health referral systems were open to all consumers as agencies accessed public and private insurance for payment.

Results

As the Family Assessment and Action Plan implementation is pending, results from initial strategies to implement trauma screening are provided. MCTP gathered information on screening capacity in mental health agencies from EBT agency leaders at baseline and at six-month follow-up interviews. Two cohorts were surveyed about whether their agency screened for trauma at the point of referral. Of 42 agencies, the average rate of screening increased from baseline (40.3%) to follow-up (75.0%). Children with positive screens were assigned to EBT trained clinical staff for further assessment and treatment. In a screening sample of 841 children with child welfare involvement presenting for mental health treatment, the average number of PTEs that children were exposed to was 5.19 (*SD* = 2.52, *Range* = 0–20). The five most common PTEs were: emotional abuse (66.8%), impaired caregiver (66.5%), domestic violence (64.3%), traumatic loss/bereavement (62.9%), and neglect (56.2%). These children were 53.6% female and 45.3% male with a mean age of 9.1 (SD = 4.7; Range = 0–18 years). Custody status for children was 43.5% parent, 38.0% state, and 11.8% relative. Notably, 38.2% of children used psychotropic medications. Of children screened, 38.3% of children 7 and under and 32.5% of youth ages 8–18 exceeded the clinical cutoff for PTSD symptoms.

Including questions related to PTE exposure and symptoms into mental health assessment yielded minimal concerns from trained clinical staff. Generally, the screens integrated well into standard intake procedures. Concerns that emerged were more related to the number of MCTP assessment tools and the burden of entering the tools into the MCTP electronic system. Many staff reported screening as helpful to their clinical formulation of the case and usefulness in developing treatment plans.

Montana

Context

The Transforming Tribal Child Protective Services Project is an initiative that is part of the Phyllis J. Washington College of Education and Human Sciences, University of Montana. The

community partner responsible for Tribal child protection is the Bureau of Indian Affairs Social Services Division. The Indian Health Service and two private mental health agencies provide mental services to children and families in care. Project goals include increasing collaboration and trauma informed screening, assessment, and referrals, and implementation of trauma informed evidence based or evidence informed practices. It is important to note that this has been a challenging initiative due to the complexities of the impact of trauma in Indian Country, the vast rural geography of Montana (making travel difficult), and lack of resources in partner communities.

The Tribal CPS partners were trained in the CWTTT and the NCTSN's Secondary Traumatic Stress Curriculum. In addition, the three mental health partners have developed a trauma informed approach to their work that was informed by elements of Attachment, Self-Regulation and Competency (Blaustein and Kinniburgh 2010). Mental health partners have also received training on secondary traumatic stress and in some elements of the CWTTT.

Considerations

The setting has been a major factor in implementation. Montana is a vast state in terms of landmass but has a population of only one million. Travel much of the year is time consuming and difficult in the rural areas served through this initiative, limiting the frequency of in-person meetings and trainings. There are also tremendous challenges in terms of economics, unemployment, and resources in all three partner communities, which are small, isolated, and rural. The largest of the communities has less than 8000 people. American Indian communities provide a special opportunity and multiple challenges. Native Americans officially comprise 6.3% of Montana's population, although estimates suggest it may actually be as high as 9% because of reservation census discrepancies. Extreme poverty on reservations is a distinctive factor that influences child welfare, and Native children are consistently over-represented in the CWS. For example, 40% of youth in Montana's juvenile detention facilities are American Indian (Montana Board of Crime Control, Youth Justice Advisory Council 2007). Despite the difficulties, it is important to note that each community also has incredible strengths. Culture, family, and core values of the communities promote resilience throughout each of the three partner communities.

The project utilizes a "steering committee" that was tasked with developing a trauma screening implementation plan. From the initial conversations, it was apparent that buy-in would take time but was essential from workers to top-level leaders. For example, BIA has a complex system of leadership in which there is both a centralized BIA leadership and also a Tribal Superintendent who is in charge at the community level. Capacity building within the BIA CWS is challenged by frequent turnover.

Screening Approach

Measure Project leaders discussed trauma screening tools with the steering committee. As the BIA Child Protection is based on the "Code of Federal Regulations" which is very different than state-based child welfare, time was taken to carefully review several tools for utility and cultural appropriateness. The steering committee selected the CTAC screen as the best initial fit (Henry et al. 2010). The free CTAC screen was considered comprehensive yet easy to administer, which was important to workers who were overburdened and concerned about adding an additional measure, and was deemed compatible with the culture of the communities. The CTAC screen was piloted and selected for use in all three Tribal CWSs.

Target Population Due to the high incidence of trauma in Native children in the CWS, the implementation plan was to screen all children that were in contact with the BIA CWS (U.S. Department of Health and Human Services 1999). The main objective was to screen as many children as possible to further the project goal of improving referral to trauma-informed mental health treatment for children suffering from exposure to trauma.

Screening Process Initially, BIA workers were instructed to use the CTAC as part of their standard CPS procedures. This approach was problematic due to issues of turnover and retention at BIA. An alternate approach where private mental health provider partners complete the CTAC for BIA has shown promise. When a screen is positive and further assessment is indicated, the child is referred to either IHS or one of the private, non-profit local mental health agencies. Due to the rural nature of the area, access to EBTs varies considerably and when not available, children are referred to standard mental health services. The sustainability plan includes further dissemination of trauma-focused EBTs.

Results

The initial numbers of children screened has been low, with only ten or fewer children screened at each site. However, the impact of the screening pilot is potentially high. Informal feedback from IHS staff who have completed screens indicates that the CTAC is well-received and provides helpful information. As the project has concentrated on creating a true collaborative partnership, the process has been slow. However, there is now a strong foundation for the ongoing process of making the Tribal CWS trauma informed. An implementation and sustainability plan is underway, including the development of a partnership between private mental health partners and BIA to further expand trauma screening.

North Carolina

Context

In 2011, the North Carolina Department of Health and Human Services, Division of Social Services (NC DSS), in partnership with the Center for Child and Family Health (CCFH) and the University of North Carolina at Chapel-Hill School of Social Work Jordan Institute, launched *Project Broadcast*, a five-year initiative to develop a trauma-informed CWS through funding from ACF. One of the main catalysts to this vision of a trauma-informed system occurred in 2009 when NC DSS and CCFH participated in the NCTSN's Using Trauma-Informed Child Welfare Practice to Improve Foster Care Placement Stability Breakthrough Series Collaborative (BSC). The BSC offered training by leading child welfare and mental health experts, the opportunity to collaborate with other state CWSs, and the use of small tests of change in one North Carolina (NC) pilot county.

Screening Considerations

During the planning year, Project Broadcast staff worked over 720 h on the development of a Learning Collaborative (Ebert et al. 2012) for trauma-informed child welfare practice based on NCTSN's Child Welfare Trauma Training Toolkit (CWTTT), including the development of a new child welfare trauma screen (Sullivan et al. 2013). NC DSS and CCFH had previously learned, through implementing small tests of change during the BSC, that when child welfare workers asked direct questions about exposure to PTEs, children often reported previously unknown exposures. NC DSS leadership determined that existing screening tools were too long or complex, so a new, one-page screening tool was developed. Given that NC is a state guided, county administered CWS, NC DSS formed a state level team to participate in the training to glean implementation lessons learned before spreading to all 100 counties.

Screening Approach

Measure Child welfare and project leaders decided to combine features from several screens to create the 6- and 11-question (with 16 options of PTEs, including an "other" category) versions of the Project Broadcast Screening Tool (Sullivan et al. 2013). Separate versions were created for children under 6 and those between 6 and 18 years old. CCFH and NC DSS selected the format of the CTAC screen (Henry et al. 2010), requiring completion by the caseworker based upon knowledge of the child, and four questions about PTEs to be asked directly of children aged 6–18 years. A more comprehensive list of trauma-related symptoms was developed from a number of other measures, primarily the NCTSN Core Clinical Characteristics Trauma Detail Form, and the clinical knowledge of the CCFH/NC DSS team.

Target Population Children from birth to age 18 entering foster care were the intended population. Screening children in other units (e.g. intake/investigations) was optional.

Screening Process A key component of Project Broadcast was the implementation approach. In January 2013, nine county teams were trained on the screen at the first CWTTT Learning Collaborative Session; training and subsequent consultation utilized active learning principles and behavioral rehearsal to practice screening. Teams consisted of one senior staff person (deputy director or program administrator), supervisors, and front line workers. All attendees were informed that, by the end of the collaborative in October 2013, their county agency would be required to screen all children entering foster care. Teams were permitted to choose their own protocol to achieve this goal, to extend screening to other units, and to rescreen children if desired. If the information on the screen indicated PTE exposure *and* impairment, the child was referred for a trauma-informed assessment. If the results of the screen indicated either PTE exposure *or* impairment, the case was staffed (i.e., discussed by a team of professionals). If neither was endorsed, no referral was made.

After CPS workers completed the screen, completed forms were faxed with a unique identifier assigned by NC DSS to project evaluators. Screening data was matched to the NC DSS administrative data, which included child demographics and child welfare history.

Results

Over the course of 36 months (January 2013 to December 2015), child welfare workers in the twelve Project Broadcast counties[1] completed a total of 9714 trauma screens (66% Assessment/Investigation, 26% Foster Care/Out-of-Home Placement, 6% In-Home, 1% Other) representing 6651 unique children (some children were re-screened). Children were an average age of 8.39 years; 51% male; and 39% white, 39% black, and 13% Hispanic. These 6651 children reported experiencing an average of 1.35 (SD = 1.78) PTEs, with the most common being exposure to domestic violence (48%). Workers reported that 3% of the screens resulted in the report of a previously unknown PTE. Workers indicated that 30% of screens showed that trauma-related concerns were likely; of these, 44% resulted in no referral (e.g., the child was already in treatment), 38% resulted in a trauma-informed assessment referral (of which 31% were rostered with the NC Child Treatment Program), and 18% in a general mental health

[1] Counties included nine original counties and three expansion counties (Alamance, Chatham, and Rowan) for the trauma screen.

assessment referral. As a part of assessing the feasibility of implementing the screen for front-line workers, interviews assessing challenges, benefits, and general feedback regarding trauma screener training and implementation were conducted. Data from these qualitative studies are currently being analyzed.

Summary & Recommendations

The five demonstration projects have implemented trauma screening for children in the CWS using a range of measures and strategies. However, there were wide variations in the length of time (or ability) to implement routine screening as well as the number of children screened across initiatives. States that required screening generally screened more children than those where screening was optional, though compliance appeared modest even when screening was required. Initial results suggest that trauma screening was generally perceived as important, helpful, and feasible, notwithstanding significant concerns about workload. Results also suggest that rates of PTE exposure and traumatic stress/PTSD symptoms were high, consistent with prior research (Miller et al. 2011). Importantly, screening resulted in thousands of children being identified and referred for trauma-focused assessment or treatment, usually EBTs.

Overall, implementation of trauma screening in each of the five CWSs has been a somewhat lengthy and challenging process, including the use of pilots and/or substantial modifications to the original implementation plans. This is noteworthy considering the comparatively less difficult process for other implementation activities that comprised these five-year demonstration grants (e.g. EBT dissemination, training staff in childhood trauma). While challenges associated with trauma screening included common systemic issues related to child welfare (e.g. the size and scope of the CWS, the number of staff to be trained, competing demands and priorities in a CWS, staff turnover, secondary traumatic stress), some of the biggest barriers tended to be due to unique local issues (e.g. lawsuits, union requirements, CCWIS system constraints, tribal culture, limited buy-in, local availability of EBTs). Despite these challenges and delays, several successful strategies were identified. Further, the consensus among key stakeholders was that trauma screening should be conducted with children in the CWS, but that the details about who, what, when, where, with what, and how to screen required careful consideration and flexibility based on local context. The following considerations and recommendations are made based on lessons learned from these initiatives:

Assemble an Implementation Team

An important first step has been to assemble a consistent, multidisciplinary trauma screening (or broader trauma-informed care) planning and implementation team. This team should include staff from leadership and individuals with a range of job functions in child welfare and behavioral health, particularly those with the authority to make decisions about implementation. Including academic, evaluation, trauma, and implementation experts, as well as consumers, is also recommended. A planning team can identify local factors relevant to trauma screening, conduct a readiness and capacity assessment, design and evaluate pilots, and develop, modify, and oversee implementation plans. The team should develop a timeline and multi-year work-plan for implementation. Local implementation teams, such as the interdisciplinary TILT teams in Massachusetts, may also be helpful.

Select a Measure or Measures

While the paucity of brief, free, validated trauma screens for children in the CWS is a challenge, a number of measures are under development or have initial validation data, including those described above (CTAC screen, the Project Broadcast Screening Tool, the MCTP screen, and the CTS). Considerations for selecting a screen include cost, length, complexity, overlap with existing assessments, reliability, validity, available cut points (including sensitivity and specificity), acceptability, and especially the overall goals for trauma screening. For example, screening might include exposure to PTEs, traumatic stress or PTSD symptoms, or both. If a goal is to identify children who may benefit from trauma-focused treatment due to clinical levels of distress, screening for symptoms should be considered.

Identify the Population

While it is a laudable goal to screen all children who have contact with the CWS, achieving this quickly may be overly ambitious due to the range of diverse programs and settings serving children in the CWS and complexity of implementing a system-wide change. A phased approach may be helpful, for example beginning screening with a specific population (e.g. children in foster care) or in a specific geographical area (e.g. one office or county). If a goal of screening is to link to EBTs, then consideration should be given to what EBTs are available (e.g. geographically, by age). Successful demonstrations may facilitate further expansion of screening.

Define the Screening Process

Selection of a measure(s) and population of children to be screened will inform the screening process. The primary considerations are to determine by whom and when the screening will be conducted, what happens with the screening results and data, and how screening is integrated with CPS case plans. Screening may be completed by the child welfare worker (or mental health worker) based upon existing records and knowledge of the child and family, or may be conducted directly with the child and/or caregiver via interview or self-report. Worker-completed screens may require less time than direct screening, but direct screening may provide new information about PTE exposure or symptoms and may allow the worker to more easily provide psychoeducation and discuss the impact of trauma with the family. When screening takes place is another consideration; for example, it is recommended that screening occur on the same schedule as other assessments and prior to service referrals. Finally, decisions about how screening results and data are used include how feedback is provided to families, how service referral decisions are made, whether and how screening data are shared with providers, and how screening informs case planning and ongoing work with children and families.

Develop the Implementation Plan

Trauma screening touches many areas of the CWS, so implementation plans must consider a number of factors to address initial implementation and sustainability. First, support from leadership to front-line workers is important for ensuring that necessary changes to accommodate screening can be implemented and that staff perceive that screening is valued by leadership. Related, relevant policies should be updated to reflect implementation of trauma screening as an integral part of CPS practice. Second, the training/workforce development strategy must be developed, including content and format for training staff in childhood trauma and the screening measure, as well as institutionalizing training given the high rates of staff turnover (23–60% annually) in the CWS (Strand et al. 2010). Experience from the initiatives described and EBT implementation research (Beidas and Kendall 2010) suggests that one-time trainings are insufficient for sustained change, and use of learning collaboratives and/or ongoing consultation and supervision opportunities including behavioral rehearsal and feedback are recommended. However, such approaches are also more time consuming and costly, making scale-up challenging. Finally, decisions must be made about data systems/IT for collecting and reporting screening data, including potential integration with CPS or behavioral health data to examine the impact of screening on outcomes. While integration with the CCWIS may be the gold standard for screening data and integration with case planning, this goal has proven challenging and interim solutions may be required.

Other Considerations

Two other considerations are suggested. First, efforts to improve coordination and collaboration between child welfare and mental health services were considered an important component of all initiatives. Various strategies were used, including cross training, cross-system learning collaboratives, and TILT teams. Improving collaboration can help address the traditionally siloed nature of each system, can improve child welfare and mental health workers' knowledge of each system, and may facilitate successful referrals and engagement in treatment. Additionally, concerns were noted in most initiatives about the impact of secondary traumatic stress on child welfare staff. An increased focus on trauma and direct screening of children and families (and associated discussions) may increase the likelihood of secondary traumatic stress. Thus, it is recommended that CWSs work to promote wellness and offer support to staff.

Conclusions

The high prevalence of exposure to PTEs and associated traumatic stress symptoms among children in the CWS, together with the lifelong health, social, and economic consequences of trauma exposure, necessitate that CWSs adapt to include a trauma informed approach. Screening children in the CWS for trauma is an important component for identifying children suffering from trauma as early as possible, understanding the impact of trauma on their current functioning, and connecting children with trauma-focused EBTs when indicated. However, the interest in trauma screening has outpaced the research, and there is currently a lack of brief, validated screening measures for use in the CWS, limited research on implementation approaches and evidence about the effects of screening on service referrals, access to treatment, or child welfare outcomes. Despite a number of promising examples of screening strategies, implementation approaches, and pilots in the current paper, universal trauma screening in the CWS has proven an elusive goal. Thus, further research is needed to develop screening measures, strategies, and implementation approaches, as well as to evaluate whether the time and costs associated with screening result in improved outcomes. Finally, in addition to (or in the absence of) systemic efforts, social workers in the CWS and other settings may benefit from improving their knowledge and understanding of childhood trauma and their ability to administer and interpret trauma screening measures in order to improve their practice with children and families.

Acknowledgements The authors wish to acknowledge the Administration for Children and Families, the Connecticut Department of Children and Families, the Massachusetts Department of Children and Families, North Carolina Department of Health and Human Services, North Carolina Department of Social Services, Jessica Bartlett, Kim Campbell, Marilyn Cloud, Dean Duncan, Dina Gerber, Jessica Griffin, Jenifer Goldman Fraser, David Hamolsky, Sandra J. Hoy-Maruschak, Tim Marshall, Robert A. Murphy, Jeanne Preisler, Paul Shanley, Joseph Spinazzola, Carla Stover, Ricka Wolman, and Bethany Zorba. This work was funded by the following grants from the Administration for Children and Families: #90C01055 (CT), #90CO1056 (MT). #90CO1059 (CO), #90C01057 (MA), and #90CO1058 (NC).

Compliance with Ethical Standards

Conflict of Interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

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