Developed by the Missouri Trauma Roundtable through the Department of Mental Health

Arthur Center

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Bootheel Counseling Services

Catholic Family Services

Child Advocacy Services of Greater St. Louis

Comtrea Community Treatment

Crittenton Children's Center

Disaster and Community Crisis Center at UMC

Fulton State Hospital

KVC Hospitals

Lafayette House

MO Children's Division

MO Coalition Against Domestic and Sexual Violence

MO Dept. of Mental Health

MO Division of Youth Services

Ozark Center

Pathways Community Behavioral Healthcare

Piney Ridge

Places for People

St. Louis Center of Family Development

Truman Behavioral Health

POLICY GUIDANCE ON SCREENING FOR TRAUMA

2015

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"The way questions were asked was impersonal, cold and intimidating. I needed understanding and empathy."**

Screening

As organizations begin to travel along the path of becoming trauma informed, a common first step is to explore implementation of screening for trauma. This would seem to make natural sense from a global perspective. However in actuality this raises many issues that should be examined through the "trauma lens" prior to taking action. There is an inherent tension around screening within the context of trauma. On one hand identification of a trauma history is critical to be able to effectively support and respond to an individual and we want to promote open discussion of trauma We must balance this with the risks related to triggering and re-traumatizing the individual if we ask intrusive questions without consideration of the potential negative impact and our capacities and willingness to respond to the individual's reaction. Under the *Missouri Model: A Developmental Framework for Trauma Informed* an organization begins to explore issues pertinent to screening early in the process, but implements screening only after the organization is working at the trauma responsive level.

In considering issues related to screening for trauma, an organization needs to be well grounded in principles of trauma-informed care. The MO Model was developed on the basis of the five values identified through the work of Fallot and Harris[1]. There are other versions of trauma informed values that an organization can consider using such as those provided by SAMHSA and others.[2] . The following is a brief description of the five principles on which the MO Model is based:

- **Safety:** Ensuring physical and emotional safety for individuals as well as staff
- **Trustworthiness:** Making tasks clear, ensuring consistency within practice and maintaining appropriate boundaries
- **Choice:** Maximizing the experience of developmentally appropriate choice and control
- **Collaboration:** Maximizing collaboration and sharing of power
- **Empowerment:** Focus on building capacities and encourage having a voice and mastery of the life and prioritizing the individual's power and growth

The following is meant to provoke consideration of some of these issues. There is no one single answer that is best for all organizations.

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[1] https://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf

[2] http://www.samhsa.gov/nctic/trauma-interventions; http://www.mhsinc.org/files/file/Online%20Training%20Handouts/Principles%20of%20trauma%20informed%20services%20for%20women.pdf; http://www.familyhomelessness.org/media/90.pdf; http://www.thenationalcouncil.org/wp-content/uploads/2012/11/Is-Your-Organization-Trauma-Informed.pdf

* The artwork on the front cover was done by Anna Caroline Jennings (1960-1992). She suffered from abuse as a child and through her short life and was institutionalized for more than 12 years. She took her own life while on a back ward of a state mental hospital. Her artwork, through which she expressed her history of abuse, can be found at www.TheAnnaInstitute.org.

** The quotes provided throughout this document are taken from **IN THEIR OWN WORDS:** Trauma Survivors and Professionals They Trust Tell What Hurts, What Helps and What Is Needed for Trauma Services, Maine Trauma Advisory Group, Ed. by Ann Jennings, Ph.D. and Ruth Ralph, Ph.D, 1997. A link to the document can be found at www.TheAnnaInstitute.org

"**It is fearful to disclose the abuse.** You risk being judged, being penalized, being discredited, invalidated, and having your feelings minimized."

Population Served

To be trauma aware, we must know the prevalence of trauma histories in the population served by an organization. In child welfare, where the population by definition has been exposed to physical, emotional or sexual abuse or neglect, the prevalence of exposure is theoretically 100%. However each child brings a level of resiliency based on their internal and external coping strategies so the experience and effects of exposure to potentially traumatizing events may vary. The same could be said for domestic violence. Other populations, including individuals with serious mental illness and veterans, also have extremely high rates of exposure to potentially traumatic events as a child and/or adult. Organizations that serve the general population such as schools or medical providers may have prevalence rates that are much lower in regards to chronic exposure to potentially traumatic events. However, in communities that have experienced a natural disaster such as a tornado or flooding or have high rates of poverty or violence, even agencies that serve the general population might need to consider trauma screening.

Considering the prevalence of trauma in a specific population may determine whether screening is needed and may shape the organization's decisions about the screening process. Organizations need to conduct due diligence in researching and determining the level of trauma exposure in the population they serve.

Not being asked about a history of trauma is also hurtful and can be harmful. "Her sister took her own life. She was in hospitals, including AMHI for years, and no one ever asked her about her abuse history or pursued it." Not being asked can also contribute to isolation. "Until 10 years ago, when a priest was exposed for molesting children, I thought I was the only one." Without information about trauma history, behavior and responses to questions are misinterpreted, and treatment planned is inappropriate.

For What Are You Screening?

After determining whether it is actually necessary to screen for exposure to trauma, the next question to consider may be For What Are We Screening? If we know exposure is 100% we may wish to screen for the impact of exposure. Is a person experiencing nightmares, sleeplessness, irritability, substance use, etc.? Some of this information is gathered through assessments completed when an individual first has contact with an organization whether it is the juvenile/criminal justice system or a primary care physician and may not be unique to exposure to trauma. Ultimately we are assessing for specific behavioral, educational or health needs, each of which can have a variety of etiologies. So we may need to question to what end we would conduct a screening for symptoms of trauma rather than assessing for the individual's current functioning. In a trauma aware organization our knowledge of the impact of trauma would allow us to view these descriptors of functioning through a lens of trauma, recognizing the role that past trauma may continue to play in our abilities to learn, build and maintain relationships and fill our role requirements.

When considering if, when and how to screen, an organization must also think about their responsibility to respond to the information they receive, particularly when the trauma is current and ongoing. Such factors as reporting child, domestic or senior abuse and the impact on the individual, as well as developing a safety plan with the individual may need to be addressed.

Organizations may also elect to screen for protective factors that create resilience. This is critical not only in future interventions but also in helping the individual process and manage questions related to trauma exposure which can open up wounds. We must always strive to leave an individual with the sense of hope for healing and recognition of their strengths that have helped them find the means to survive that can also be tools for recovery.

"Establish some relationship and trust before asking questions." "Be sensitive to the person's readiness to answer questions and don't bombard with lots of questions, especially at a time when the person is in distress." "Allow time for the person to think about the questions asked and to respond."

Readiness of Organization

As we begin screening, assessing and gathering information, we need to consider whether we are doing this in an environment that feels safe and promotes trauma-sensitive practices. This is a fundamental consideration. If these activities are not conducted within a trauma responsive environment, the information obtained may be limited or inaccurate. Of even greater concern, individuals may be at risk for being triggered or re-traumatized.
The basic premise is that if you are screening for trauma, you must have the capacity to address any subsequent reaction or need, either directly or through an effective referral.

Screening should occur in an emotionally and physically safe environment. The organization will need to assess their organization's capacity to do so and consider their staff's comfort level with asking for and receiving intimate and perhaps provocative information. Staff will need to be knowledgeable in responding to and supporting individuals with trauma histories with flexibility built in to allow the staff and organization to respond to and support an individual who has been triggered. For example can the time of a therapy session or meeting be extended to allow the individual time to de-escalate and/or recover? The organization will also need a plan on how the information will be used including where the information will be housed and what resources, internal or external, can be offered.

The organization may wish to consider how they will prepare their clientele for the screening process. Trust is a core principle of trauma-informed organizations and may be foundational for an accurate screening to occur Questions or issues to explore include:

- How do we build trust prior to screening?
- Have we prepared all staff to respond to whatever may arise from the screening process?
- Can we inform the individual ahead of time that questions may be asked about past experiences and give them an option to participate or not?
- What are we missing if we don't screen?
- Are we conducting the screening in an emotionally and physically safe environment?
- If we cannot ensure safety in the environment do we have the flexibility to delay until we can?
- How will screening information be used?
- Are there other ways of obtaining the information rather than use of specific screening tool or process?
- How do we respond if screening triggers an emotional or behavioral response?
- What is our obligation as an organization if a screening is positive for trauma?

"The person doing intake should understand the fear (of disclosing abuse)." "Threats from the past are still present. If you tell, you will die, your sister will die." This can be true even if there is no abuse occurring in the present. Threats made to children can remain psychologically real in adulthood even if there is no present danger.

Process and Tools

Finally an organization will need to develop policies that guide the implementation of a screening process/tool. The following questions can guide the development of discussion and subsequent policy statements.

- When do we screen?
    - If upon intake, when the client is new to the organization, how have we made this a safe process?

- If later, how do we know when we have the relationships and environment that promotes safety for the client during the screening process?
- Does it occur only once, or should the process be repeated and if so at what times and frequency?

- For what are we screening?
  - What is the likely prevalence of trauma in the population served?
  - Events – Do we need to know the events to which they have been exposed that could be potentially traumatizing? Do we need to know when they occurred? …the chronicity of the exposure?...the age of exposure?
  - Effects – Do we need to know the symptoms the person is experiencing? How do we relate trauma to these effects?...could there be other precipitants to the symptoms besides or in addition to trauma?

- Selection of a Tool – As noted above an organization would need to determine the focus of the screening to select a tool or process. Consideration of allowing the person's "story" to unfold naturally through a developing, trusting relationship may need to be considered as an alternative to using a specific tool at a specific time. This allows time for trust to develop, gives the individual choice in when and how to reveal their history, and empowers them to maintain control over sharing personal information. If using a specific tool, it is important to use a validated tool to know that we are screening accurately and efficiently, weighing the pros and cons of obtaining false negatives and/or false positives. Consideration of whether it is best to have a self-administered or staff administered tool or even a web-based tool may play into selection. The organization may consider whether to have a stand-alone screening process or is it part of a more comprehensive assessment. Resources on trauma screening tools are listed below[3]. Inclusion or exclusion from this list does not reflect an endorsement of any specific tool.

- Process – An organization will need to explore how they will implement regulatory requirements in regards to schedule and use of screening while still maintaining a trauma informed view. Trust and choice are critical values to be applied. Documentation of the consumer's choice and response to screening can assist in addressing the requirements.

> "**It is important that providers give as much control as is safe to the client. Decisions should be made together**. There are healthy ways for providers to influence clients in decision making. This may sound basic but needs to be a focus in training, as it is often forgotten."

The information provided in this document is meant to prompt organizational discussion and exploration. There are no specific right or wrong answers as each organization is unique in the population served, mission and goals. However it is critical for this examination to occur through the lens of trauma. It is recommended that individuals with lived experiences of trauma participate and assist an organization in its review of policies and practices. The main premise is that to be trauma informed an organization must be committed to a review of its culture and be open to procedural and policy changes. Trauma screening, as often cited as a core function of a trauma informed organization, must be implemented with full consideration of the values of safety, trust, choice, collaboration and empowerment.

[3] http://www.nctsn.org/resources/online-research/measures-review
http://www.nctsn.org/resources/online-research/measures-review
http://www.integration.samhsa.gov/clinical-practice/screening-tools#TRAUMA
http://www.bhevolution.org/public/trauma_screening.page
http://www.childsworld.ca.gov/res/pdf/KatieA/ChildAdolescentTraumaScreenTools.pdf
https://www.healthcaretoolbox.org/tools-and-resources.html
http://www.healthcaresaboutipv.org/tools/