Implementation of Trauma Screening in Three Tribal Communities

Ashley Trautman, MSW, JD
Maegan Rides At The Door, MA, LCPC, NCC
Gaynell Realbird, MSW
Marilyn Zimmerman, MSW, PhD

The Transforming Tribal Child Protective Services (TTCPS) project was funded by the Administration for Children and Families and designed to respond to the important issues of abuse and neglect in tribal communities. Though not specific to the tribal communities involved on this project, 2016 statistics on rates of maltreatment published by the U.S. Department of Health and Human Services (USDHHS) show that American Indian/Alaska Native youth served by state Child Protective Services had the highest rate of victimization at 14.2 per 1,000 children of the same race/ethnicity (USDHHS, 2018). American Indian children are more likely to be identified as victims of neglect (65.5%) and less likely to be identified as victims of physical abuse (7.3%) than children of any other race or ethnicity (The Pew Charitable Trusts & National Indian Child Welfare Association [NICWA], 2007). The high rate of neglect speaks to the important contextual factors such as poverty and substance use that must be considered when evaluating statistics such as these and when working toward the development of trauma-informed systems of care.

The TTCPS project was the result of a collaboration between the National Native Children's Trauma Center (NNCTC) at the University of Montana and the Rocky Mountain Region Bureau of Indian Affairs (BIA), Social Services Department. Project activities were implemented with three tribal communities in the Rocky Mountain West (NNCTC, 2011). These tribal communities are rurally located and span large geographic areas. Each tribe has its own unique culture, traditions, strengths, and challenges. In addition, though each partnering tribal community has social service programs operated by the Bureau of Indian Affairs, other important ancillary services such as behavioral health are provided by a mix of federal, state, and tribal agencies. Given this framework of service delivery, key partners on the project, in addition to NNCTC and BIA, included Indian Health Service (IHS) behavioral health clinicians and two nonprofit statewide mental health agencies.

The overarching goal of the TTCPS project was to create trauma-informed tribal child welfare systems. The two main goals of the project were to implement (1) trauma screening, referral procedures, and trauma-specific treatment for American Indian children involved in the BIA social service system and (2) trauma treatment by Indian Health Service Behavioral Health clinicians (NNCTC, 2011). Each goal had corresponding objectives that were designed as benchmarks and a guide to implementation activities. Although the project resulted in various successes, the piloting of a trauma screening instrument in a tribal community was a particularly innovative strategy. Therefore, this article details the challenges, lessons learned, and next steps for implementing trauma screening in tribal communities.

Strengths and Challenges of Trauma Screening Implementation

Strengths and barriers to implementation of trauma screening resulted in important lessons learned for the project. One strength of this process was a consequence of the selection and adaptation of the screening instrument, which was guided by the project's Steering Committee. The Steering Committee, comprising project partners from BIA, NNCTC, and IHS, completed a literature review of trauma screening instruments, contrasted and compared these instruments, engaged in an iterative process of adapting the chosen screening instrument, and employed mechanisms, such as regular check-ins with workers, to collect feedback on implementation of the screening instrument in order to best fit the policies, practices, and needs of each partnering site.

Although none of the reviewed instruments was designed for use in Indian Country, the following were considered for implementation: Trauma Symptom Checklist for Children (Briere & Lanktree, 1995), Trauma Symptom Checklist for Young Children (Briere et al., 2001), Connecticut Trauma Screen (Lang, Cloud, Stover, & Connell, 2014); Child and Adolescent Needs and Strengths (Lyons, 1999), Child Welfare Trauma Referral Tool (Taylor, Steinberg, & Wilson, 2006), and Southwest Michigan Children's Trauma Center Assessment Screening Checklist (Henry, Black-Pond & Richardson, 2010). The Southwest Michigan checklist was piloted by project partners and selected for implementation. This particular screen was chosen because it captured all necessary information and workers were able to complete the document in a relatively short amount of time.

Adaptations were made to the screen to support its efficient use by workers, ensure its relevancy to the organization, and facilitate referral mechanisms between agencies. These adaptations included adding information for traumatic stress reactions common in youth ages 6–18 to expand the applicability of the screen to a greater population of children, the bolding of certain text in the traumatic experiences section (e.g., physical and sexual abuse, exposure to domestic violence, and suicidal ideation) that would trigger an automatic referral to behavioral health, a decision tree for easy calculation of scores and efficient decision making by workers, and a brief referral form to accompany the screen and provide basic information (e.g., reason for child welfare involvement, medication, and allergies) helpful to the behavioral health clinician.

One of the most consequential factors influencing implementation of the screen was the existence of competing demands BIA social service workers must balance. Namely, BIA social service workers, unlike some state child welfare workers, are responsible for coordinating all human service activities in addition to their role as investigators and case managers in cases of child maltreatment (U.S. Department of the Interior [USDI], n.d.-b). It is not uncommon for BIA social service workers to carry responsibilities in the areas of child protection, adult protection, welfare assistance, and Individual Indian Money accounts management. In addition to this broad set of responsibilities, BIA social service workers are tasked with responding to incidents located on reservations with exterior boundaries that encompass up to one million acres of land (USDI, n.d.-a). Responding to the needs of individuals located within such a large land mass, combined with high caseloads and chronic shortage of staff, means that BIA social service workers have become, as one worker described, "emergency responders" (Realbird, personal communication, 2017). Within the context of this work load, feedback during implementation included that some workers felt the trauma screen added another task and piece of documentation to an already heavy workload and paperwork burden.

Additionally, uptake of trauma screening practices was influenced by perceptions held by some social service workers. For example, feedback during implementation from a select number of local social service workers included a concern that labeling a child with a mental health diagnosis may be more likely as a result of screening. Workers remained concerned that certain mental health diagnoses attached to youth was problematic due to potential stigmatization. Furthermore, due to high rates of turnover and staff shortages at IHS behavioral health

units, some social service workers questioned the utility of screening given the limited number of licensed mental health professionals available to conduct trauma assessments and receive referrals.

These findings, which were noted in the TTCPS project evaluation, are consistent with national dialogue regarding the potential limitations of screening for Adverse Childhood Experiences (ACEs). For example, Finkelhor noted the need to understand potential negative outcomes of ACE screening without first understanding important factors, such as whether current treatments are effective at treating high ACE scores in children (2017).

In addition, findings from the TTCPS evaluation revealed commonalities with other similar projects. Barriers around trauma screening in other child welfare systems and those experienced during the TTCPS project included common systemic challenges, such as the size of staff within any given office, the number of responsibilities each worker was required to balance, high caseloads, staff and supervisor turnover, and the number of clinicians who can provide evidence-based trauma treatments (Lang et al., 2017). As a result, maintaining the consistency of implementation was a challenge.

Lessons Learned and Solutions

The lessons learned through the TTCPS project have provided a framework for moving forward with solutions. An important success of the project, and perhaps the reason why trauma screening activities progressed as they did, was due to the strength of collaboration among project partners and their voice and choice in the decision-making process. In addition to providing selection, adaptation, and planning for implementation of the trauma screening instrument, Steering Committee meetings offered an opportunity for dialogue regarding challenges and finding solutions to these challenges.

After the project concluded, some members of the Steering Committee continued collaborative efforts toward building trauma-informed BIA child welfare systems, broadly, and implementation of the trauma screen, specifically. To respond to worker concerns regarding potential labeling of children who are screened and to reinforce the purpose of trauma screening, BIA Regional-level supervisors and local champions continue to work toward regular and consistent trauma trainings as a component of professional development for all new staff. These trainings, when they occur, provide a context for workers around the importance of screening for trauma. As a result, BIA leadership has noted a change in the language used by workers and their corresponding referral practices. Specifically, one member of BIA leadership commented that when discussing a case, consideration is given to the impact of trauma on a child. As she noted, "We're using the word *trauma*. We wouldn't have used that word before."

Though a lack of behavioral health providers to accept referrals continues to be a challenge, BIA social service workers are circumventing this barrier by reaching out to non-tribal mental health agencies who provide services to tribal communities. Additionally, one site found it helpful to have an IHS 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. A similar process could be replicated at other sites.

Finally, refinement and adaptation of the trauma screening tool continues to occur in order to best fit the needs of each site. For example, workers are finding the screening tool to be useful in an expanded capacity to support care for the newborns on their caseloads. In these cases, the screening tool has been a foundation for gathering a more comprehensive picture of each family, building safety plans, and assessing the support system for caregivers. Based on the results, the worker is able to determine appropriate services for the child and family.

Though no concrete plans have been made to formally evaluate the adapted screen for validity, informal conversations and efforts to understand the impact of screening implementation continue. Emerging themes from these conversations illustrate that workers, seeing its usefulness, help maintain movement toward consistent use of the screen in practice.

Next Steps for Trauma Screening Implementation

Moving forward, BIA social services will continue to lean on the strength of collaborative relationships and local champions to support the implementation of trauma screening. Modeling the use of trauma screening has resulted in a growing shared understanding of the impact of trauma on children. Workers have learned to be curious about what treatments mental health providers are using and that it is best for treatment to be trauma specific when possible. Screening activities have also led to cross pollination into other systems such as shelter care and are beginning to achieve goals toward systemwide trauma-informed service delivery. This cross-agency collaboration, in addition to institutionalized and regular professional development training, is the focus of work to come. Replicating components of the TTCPS project such as trauma training and trauma screening with other BIA regions has also occurred and continued efforts in this area are ongoing. Currently there are no special projects to report, however. Ultimately, though the TTCPS project experienced both unique and common challenges compared with other systems implementing trauma-informed practices, the successes and considerable strength of each community yielded a strong framework on which to build.

About the Authors

***Ashley Trautman, MSW, JD**, serves as Assistant Professor in the School of Social Work at the University of Montana and as Juvenile Justice Technical Assistance Specialist at the National Native Children's Trauma Center. Ashley's area of professional experience includes collaborating with tribal communities to develop trauma-informed systems of care.*

***Maegan Rides At The Door, LCPC, NCC**, is Director and Principal Investigator at the National Native Children's Trauma Center at the University of Montana. Maegan is responsible for implementing a range of training and technical assistance initiatives in tribal communities to develop trauma-informed systems of care.*

***Gaynell Realbird, MSW,** is Rocky Mountain Region Meth Initiative Coordinator/Child and Family Specialist. She is also the Awarding Official Technical Representative for her region and works directly with tribal programs to improve outcomes for families impacted by the opiate/methamphetamine epidemic. Gaynell's area of expertise is child and family services in the area of child protection.*

***Marilyn Bruguier Zimmerman, MSW, PhD**, serves as Co-Principal Investigator and Sr. Director of Policy and Programs at the National Native Children's Trauma Center (NNCTC). She served as former Tribal Senior Policy Advisor at OJJDP and was the founding Director of the NNCTC. She has expertise in trauma-informed systems-change, cultural adaptation of evidence-based practices, relationship- and community-based development of trauma-informed best practices, and project and grant management.*

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