

Advancing Child Trauma Screening Practices: An Evidence-Informed Framework for a Pictorial Child Trauma Screening Tool

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Abstract: *Child trauma screening practices have advanced considerably as child-serving systems have increasingly incorporated early identification and intervention into trauma-informed models of care. While research points to the necessity of screening practices that attend to a child's developmental capacities, cultural background, relational strengths, contextual details surrounding the traumatic experience, and complex trauma considerations, many of these features remain absent in common brief screening measures used in practice. Pictorial screening measures may offer an innovative opportunity to address attentional concerns and developmental capacities of young and complexly traumatized children, yet are understudied in this area. The purpose of this paper is threefold: 1) highlight areas for expansion within current brief trauma screening models, 2) propose an evidence-informed framework for a pictorial complex trauma screening tool for children, and 3) offer implementation considerations for piloting the proposed screening tool. Piloting and implementation considerations address the importance of cognitive interviewing, cultural sensitivity, development of a companion response and referral protocol, and embedding principles of trauma-informed care in the training and implementation process.*

Keywords: *Child trauma; trauma screening; complex trauma; child trauma measurement*

Child trauma exposure has been identified as a public health crisis, with lifetime victimization/exposure rates for children ages birth to 18 years ranging from 9% to over 50%, depending on the type of victimization (Finkelhor et al., 2013). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) defines individual trauma as an event or series of events that one perceives as harmful or life-threatening, and has persistent effects on one's physical, socio-emotional, and/or psychological well-being. Types of traumatic events experienced by children are wide-ranging and can occur across levels of the child's ecology, including interpersonal victimization (maltreatment, neglect, peer victimization), intimate partner violence (IPV) exposure, community violence exposure, terrorism, refugee trauma, natural disasters, medical trauma, and traumatic grief, among others (Greeson et al., 2014).

Childhood trauma has been linked with a variety of adverse outcomes across the lifespan, including cognitive, physical, behavioral, socio-emotional, and neurodevelopmental challenges, many of which can persist into adulthood if left untreated (Dye, 2018). Traumatic victimization also increases children's risk of subsequent traumatic exposures across different settings and perpetrators, a phenomenon referred to as polyvictimization (Turner et al., 2016). A dose-response relationship between exposure

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and outcomes indicates that the more traumatic exposures a child experiences, the higher their likelihood of experiencing maladaptive outcomes across the lifespan (Ballard et al., 2015; Copeland et al., 2018). For example, among child welfare populations, evidence has shown a 41% increase in trauma symptoms and a 34% increase in other mental health symptoms for each additional traumatic exposure a child reports (Griffin et al., 2011). The rapidly growing body of research on child trauma points to important areas for expansion to better identify and treat child traumatic exposure and sequelae. Accurate identification and treatment of child trauma symptoms requires screening and assessment tools that are not only developmentally- and culturally-sensitive, but also tap into a range of diverse reactions to child trauma. Failure to attend to both of these considerations places children at risk for misdiagnosis, poor treatment planning, and inadequate intervention.

The past two decades have brought substantial gains in the development of reliable and valid measures of child trauma exposure and symptomology. The National Child Traumatic Stress Network (NCTSN) maintains a robust database of trauma screening and assessment measures, providing an accessible repository for practitioners and clear information about target population, scoring, format, and administrative requirements (NCTSN, 2021). Distinctions are also made between screening and assessment tools, thus providing practitioners with a range of options depending on their practice setting, level of clinical training, and time limitations. While assessments typically require training in evaluation and scoring, trauma screening tools provide initial indicators as to whether an individual has been exposed to trauma and, if so, if he/she presents with trauma symptoms. (Conradi et al., 2011; Kerig et al., 2014; SAMHSA, 2009).

Systematic literature reviews have also sought to catalog and summarize instrument properties (e.g., Choi & Graham-Bermann, 2018; Eklund et al., 2018; Oh et al., 2018; Stover & Berkowitz, 2005; Whitt-Woosley, 2020), finding that child trauma measures are wide-ranging in their scope, depth, provider accessibility, and training requirements for administrators. While brief screening instruments like the Child Trauma Screen (Lang & Connell, 2017), Young Child Posttraumatic Stress Disorder Screen (YCP-Screen; Fraser et al., 2019), and the Trauma Symptom Checklist for Children—short form (TSCC; Briere, 1996) offer the benefits of time efficiency, swift identification, and broader accessibility to a range of providers, more extensive assessments like the Clinician Administered Posttraumatic Stress Disorder Scale for Children and Adolescents (CAPS-CA; Nader et al., 1996) and Child and Adolescent Needs and Strengths—Trauma (CANS-Trauma; Kisiel et al., 2018) can provide salient details about the child's context, clinical diagnoses, and resources/supports.

Despite the burgeoning body of literature on child trauma measurement, persistent gaps exist between the state of knowledge of children's developmental capacities, the complicated presentation of traumatic symptoms in young populations, and the translation of measures with strong research utility to practitioner-friendly tools that are well-suited for a range of practice contexts (Leigh et al., 2016; Strand et al., 2005). Thus, guided by contemporary research on child trauma exposure and measurement practices with children, this paper seeks to:

- 1) Highlight areas for expansion within current brief trauma screening models.

- 2) Propose an evidence-informed framework for a pictorial complex trauma screening tool for children ages 5 – 12 years.
- 3) Offer implementation considerations for piloting the proposed screening tool.

Screening for Child Trauma: Areas of Expansion

Considerations Around Complex Trauma

Trauma screening measures that account for the unique and variable symptom presentation associated with complex trauma in children—rather than those defined only by post-traumatic stress disorder (PTSD) diagnostic symptom clusters—may offer a more comprehensive understanding of children’s traumatic reactions. Complex trauma exposure is characterized by chronic, ongoing, or repetitive traumatic events that are often of an invasive, interpersonal nature, including experiences such as child neglect, exposure to intimate partner violence (IPV), and physical, sexual, and psychological abuse (D’Andrea et al., 2012). Complex traumatic reactions extend beyond criteria for PTSD, and manifest across symptom clusters including attachment, biology, affect regulation, dissociation, behavioral regulation, cognition, and self-concept (Cook et al., 2017; van der Kolk, 2017). Although the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., *DSM-5*, American Psychiatric Association, 2013) provides an updated and broadened definition of child PTSD, clinical concern has been raised that the expanded PTSD criteria still do not account for the disruptions to neurodevelopment—and subsequent regulatory challenges and developmental sequelae—that are linked to early and chronic traumatic stress (DeBellis & Zisk, 2014; DePierro et al., 2019; Ford, 2011).

Child trauma measures that screen for symptoms defined by *DSM-5* PTSD diagnostic criteria may fail to tap broader developmental indicators of complex trauma, including relational dysregulation, attachment difficulties, and physical and somatic complaints, and thus risk under-identification and missed opportunities for intervention (Ford, 2011). Recent systematic reviews of child trauma screening measures used with child welfare populations (Whitt-Woosley, 2020) and in school settings (Eklund et al., 2018) found that the majority of included measures use PTSD symptom clusters as evidence of traumatic stress. Examples included the University of California at Los Angeles PTSD Reaction Index (UCLA PTSD-RI; Steinberg et al., 2013), the Child Trauma Screen (CTS; Lang & Connell, 2017), the Child PTSD Symptom Scale (Foa et al., 2018), and the Child and Adolescent Trauma Screen (Sachser et al., 2017). Despite the important benefits these tools offer, their emphasis on PTSD criteria may present identification challenges when working with child welfare populations, which have high rates of complexly traumatized children. Greeson et al. (2011) found 70% of their sample of 2,251 foster children and teens had experienced two or more types of interpersonal trauma that constitute complex traumatic stress. If measurement tools lack the nuance necessary to detect the diversity of complex traumatic reactions, children can be inadequately diagnosed, subjected to faulty treatment decisions, or may not be identified for services at all (McMillen et al., 2007; Whitt-Woosley, 2020).

Relational Health and Resilience

Relational health, defined as one's connectedness to attuned, supportive, and caring adults, has demonstrated significant protective effects among trauma-exposed youth, promoting resilient functioning across cognitive, behavioral, and emotional domains (Hambrick et al., 2019). Clinical researchers have recently found that high levels of relational health can disrupt the dose-response relationship between exposures and outcomes and buffer children from the detrimental effects of increasingly high levels of trauma (Bartlett, 2020). In a study of children ages 6 – 13 years of age with histories of severe trauma and/or maltreatment, Hambrick and colleagues (2019) found that participants' current relational health was the strongest predictor of children's physiological, behavioral, and social-emotional functioning. Similar findings have been reported among child welfare-involved samples (Hambrick et al., 2018).

These studies assert that relational health holds a more powerful association to child outcomes than a cumulative traumatic exposure score, yet relational health remains absent among brief trauma screening tools. While some lengthier assessments include measures of relational support, such as the CANS Trauma (Kisiel et al., 2018), the time requirements (45 minutes) and clinician-report format preclude such measures from being used as a brief screening instrument across a variety of practice settings. Embedding relational health screening within brief child trauma screeners will offer a more balanced picture of the child's context, highlighting concern for children in relationally impoverished environments, and calling attention to interpersonal resources for those who are relationally healthy.

Culture and Trauma

Culture can influence how a child experiences trauma, their appraisal and perception of traumatic experiences, and their responses and reactions (Perry et al., 2019). A child's culture can shape their belief systems, familial relationships and attachment patterns, and coping skills, all of which can influence a child's interpretation of a traumatic event and their expression and communication about the experience (Nader, 2007). Cultural differences in the conceptualization of trauma symptoms have been identified, such as the Western method of dichotomizing physical and mental health symptoms, which differs from Eastern medical models that use a more integrated and holistic approach to mind-body connection when framing traumatic reactions (Zheng & Gray, 2015). Cross-cultural differences have also been noted in symptoms related to avoidance, hyperarousal, and cognitive structures related to self-blame (Perry et al., 2019). Moreover, belonging to a collectivist versus individualist culture has also been linked with differences in disclosure, perceptions, interpretations, and healing from trauma (Engelbrecht & Jobson, 2016).

Despite this evidence, cultural differences are rarely accounted for in many trauma screening tools (Bartlett, 2020), and little is known about their validity in diverse cultural contexts, particularly among children from non-Western cultures (Perry et al., 2019). Adding to concerns around the use of *DSM-V* PTSD criteria, Perry and colleagues (2019) note that when PTSD criteria are used as the gold standard by which to establish validity

in new screening tools, we may fail to capture cultural differences in trauma symptoms. Enhanced cultural sensitivity in screening tool design, piloting, and implementation is necessary for accurate identification of trauma exposure and reactions among children from diverse cultural backgrounds.

Sensitivity to Developmental Age and Stage

Practitioners and researchers working within child-serving systems have called significant attention to the importance of using developmentally-sensitive trauma screening practices (Bartlett, 2020; Fraser et al., 2019; Scheeringa, 2019; Scheeringa et al., 2011). It is well-established that children's information processing skills, verbal and communicative abilities, and presenting symptoms can vary by developmental age and stage, and age-appropriate screening tools must be developed with this in mind. Evidence of such developmental sensitivity is increasingly found in child screening practices, such as with the Massachusetts Child Trauma Project's use of the aforementioned brief YCP-Screen (Scheeringa, 2019) with its young child welfare population (Fraser et al., 2019). Similarly, New Hampshire's child welfare department developed a Mental Health Screening Tool (MHST; Butcher et al., 2020) that includes varying measures based on a child's age, including the Young Child PTSD Checklist (YCPC; Scheeringa, 2013) and the UCLA PTSD-RI (Steinberg et al., 2013), among other measures. As technology advances, options for measure formatting have also expanded to address children's developmental needs, such as the use of a tablet-based computer interface for trauma screening among youth with Autism Spectrum Disorders (Hoover & Romero, 2019).

Even with these advances, the majority of brief child-report trauma screeners still rely on verbal or written formats, which may present comprehension challenges for young and/or complexly traumatized children. Growing knowledge about the power of visual working memory (Constantinidou et al., 2011) and challenges with attentional capacity among complexly traumatized children (D'Andrea et al., 2012; Ford, 2011) offer a promising opportunity for the addition of pictures to enhance child comprehension of trauma screening questions. In current systematic reviews of child trauma screening measures, the Angie/Andy Cartoon Trauma Scale (Praver et al., 2000) is one of the only pictorial-based child trauma screening measures identified (Eklund et al., 2018), and some reviews do not identify any pictorial measures (Gadeberg et al., 2017; Whitt-Woosley, 2020). While the Angie/Andy Scale has demonstrated adequate reliability and validity among children ages 6 – 12 years, there has been a dearth of follow-up innovations in pictorial screeners since its development, and the scale's lengthy assessment format makes it inaccessible to a wide range of practitioners and for brief screening purposes. Such challenges highlight an opportunity for innovation in pictorial child trauma screening.

Closing the Gaps on Measurement of Complex Trauma in Children

Knowledge and measurement practices around child trauma have made significant gains in recent decades, much of which is evidenced by the database of screening and assessment measures available through the NCTSN (2021). Despite these advances, important gaps still exist in child trauma brief screening tools and practices. Building from

the contemporary body of research on complex trauma screening and identification, we propose a framework for the development of a pictorial child trauma screening tool. Seven key measurement priorities are highlighted to address the aforementioned gaps and enhance usability for a range of practitioners (see Table 1 for a summary).

Table 1. *Considerations for Development of a Brief Pictorial Child Trauma Screening Tool*

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| <ol style="list-style-type: none"> 1. A screening tool, rather than an assessment or formal interview, permits administration by a range of trained child-serving system professionals. 2. A self-report format ensures that data are obtained from the source closest to the traumatic incident(s): the child. 3. A child's relational health should be accounted for in brief child trauma screening tools. 4. Screening tools must attend to the developmental capacity of traumatized children under age 12, including language ability, attention and engagement, and memory. 5. A single self-report measure for children ideally screens for both exposure to traumatic events and traumatic reactions/symptoms. 6. Interpersonal proximity in the victim-perpetrator relationship is an important consideration when measuring child trauma exposure and symptoms. 7. Pictorial self-report measures offer potential for addressing measurement concerns related to children's developmental levels, including attention and engagement, expressive capabilities, and reading comprehension. |
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An Evidence-Informed Framework for the Pictorial Child Trauma Victimization Tool

1. A screening tool, rather than an assessment or formal interview, can be administered by a range of child-serving system professionals.

In addition to the mental health expertise and/or graduate-level training often required for assessment administration (Conradi et al., 2011; Kerig et al., 2014; SAMHSA, 2009), assessments also tend to be more comprehensive compared to screening tools. Assessments are designed to provide clinicians with detailed information about client functioning in multiple domains, and, in some cases, serve as diagnostic measures for clinical diagnoses (Lanktree et al., 2008). In contrast, trauma screening tools provide initial indicators of trauma exposure and symptoms. Results of the screener inform whether or not a child needs referral for a more comprehensive assessment (Conradi et al., 2011; Kerig et al., 2014).

A primary benefit of the screening tool format is its accessibility to a range of trained workers in child-serving systems. By not restricting screening tool administration to trained clinicians and mental health professionals, the spectrum of professionals who can screen and refer children for traumatic exposure expands significantly (SAMHSA, 2009), which has important implications for identifying children impacted by trauma, regardless of their entry point into the system or their involvement with child welfare.

2. A self-report format ensures that data are obtained from the source closest to the traumatic incident(s): the child.

Research has shown that children tend to report higher levels of traumatic exposure than caregiver reports on their behalf (Meiser-Stedman et al., 2007; Schreier et al., 2005; Stover et al., 2010; Tingskull et al., 2015). Discrepancies also exist with children's trauma symptomatology, with some studies showing parental under-report of child post-traumatic stress symptoms (Humphreys et al., 2017; Lanktree et al., 2008). Adult under-reporting of children's trauma exposure can have dire consequences for youth, including potential risk of ongoing exposure to traumatic incidents and failure to receive the treatment they need to heal. Furthermore, there are limitations to gathering trauma exposure and symptom information from a single source. Although the NCTSN has advised integration of symptom observations from caregivers, teachers, clinicians, and children (NCTSN, 2018), all of the brief trauma screening measures included in Whitt-Woosley's (2020) review use only a single reporting source. Triangulation of multiple perspectives in brief trauma screeners may offer an area for future expansion in screening tool development.

Perhaps most importantly, increasing attention has been directed toward child-centered measurement, whereby children's insight into their own experience is prioritized (Berliner et al., 2020; Deighton et al., 2014; Sidebotham, 2015; Valla et al., 2000). Evidence indicates that children are capable of providing accurate, reliable, and valid self-reports of their own mental and behavioral health symptoms (Berliner et al., 2020; Sturgess et al., 2002; Valla et al., 2000), thus illustrating the value of centering their voices in the screening process.

3. A child's relational health should be accounted for in brief child trauma screening tools.

As previously discussed, studies have increasingly pointed to the role of consistent, caring adults as a protective buffer against the negative outcomes associated with child trauma exposure, with evidence supporting these protective effects across the lifespan (Brown & Shillington, 2017; Hambrick et al., 2018, 2019; Southwick et al., 2007). Consequently, indicators of child victimization and traumatic reactions cannot be understood independent of a child's relational context. While a variety of well-validated measures exist to assess children's relational health and social connectedness, this construct is largely absent *within* commonly used brief trauma screening tools, such as the CTS (Lang & Connell, 2017), UCLA PTSD-RI (Steinberg et al., 2013), and the Child and Adolescent Trauma Screen (Sachser et al., 2017). Given current research on the powerful buffering effects of relational health, it would be prudent to embed relational connection screening within measures of trauma exposure.

4. Screening tools must attend to the developmental capacity of traumatized children under age 12, including language ability, attention and engagement, and memory.

Language ability. Empirical studies have documented a well-established link between child maltreatment and/or violence exposure, and poorer literacy and language skills in school-age children (Coohey et al., 2011; de Leeuw, 2011; Perkins & Graham-Bermann, 2012; Thompson & Whimper, 2010). The potential for child difficulties with reading and language-processing presents challenges for practitioners who must administer self-report measures for traumatic exposure and symptoms. This highlights the importance of administering measures that are simple for children to process and interpret, and are not reliant upon reading skills, when working with complexly traumatized children.

Attention and engagement. Children exposed to complex trauma often have difficulties with attention span, concentration, impulse control, and problem-solving (Cook et al., 2017; D'Andrea et al., 2012; van der Kolk, 2017). Questions pertaining to vague or abstract content can also present attention challenges as children under the age of 12 rely on concrete language to understand others and to express themselves (de Leeuw, 2011). Taken together, these factors can result in child disengagement and lower response rates (Denton et al., 2017).

Memory. Effective screening requires that children recall and report their experience with traumatic events. Activation of children's visual working memory has been suggested to promote accurate recall (Hitch et al., 1988), and studies have shown that children both with and without mental health symptoms perform significantly better on memory and processing tasks when information is presented pictorially, rather than verbally (Constantinidou et al., 2011).

5. A single self-report measure for children ideally screens for both exposure to traumatic events and traumatic reactions/symptoms.

The NCTSN recommends that child trauma evaluations screen for both exposure and symptoms in seven domains of functioning affected by complex trauma: attachment, biology, affect regulation, dissociation, behavioral regulation, cognition, and self-concept (Cook et al., 2017). Incorporating both exposure and symptom screening into a single tool reduces the administrative and scoring burden of multiple screeners. Furthermore, individual responses to trauma can vary widely based on a child's cultural background, previous victimizations, personal coping skills, and supportive connections. Screening for traumatic exposure only, without tapping into a child's traumatic reactions, provides an incomplete picture of their coping response and needs (Bartlett, 2020). Screening for a wide range of traumatic reactions in these seven domains also expands our identification of children affected by trauma who may not meet criteria for PTSD, and ensures that each child's unique constellation of symptoms is captured within a broader complex trauma framework.

6. Interpersonal proximity in the victim-perpetrator relationship is an important consideration when measuring child trauma exposure and symptoms.

A child's interpersonal proximity to their perpetrator can significantly impact the severity of their traumatic reactions. Research has shown that the closer a child's

relationship is to his/her perpetrator, the more likely the child is to experience feelings of betrayal and exhibit higher levels of traumatic symptoms (Kisiel et al., 2009; Price et al., 2013). Such close interpersonal proximity in the victim-perpetrator relationship is one of the defining features of complex trauma, as broken trust in these relationships may have lasting effects on attachment and biopsychosocial functioning (Cook et al., 2017; John et al., 2019; van der Kolk, 2017). When measuring child trauma exposure and reactions, attention to such nuance in the child-perpetrator relationship is necessary for the clinician to contextualize the child's experience, and garner a clearer understanding of the level of betrayal implicated by the trauma.

7. Pictorial self-report measures offer potential for addressing measurement concerns related to children's developmental levels, including attention and engagement, expressive capabilities, and reading comprehension.

Conveying survey content through pictures has been offered as one solution to address child attention span, engagement, and reliance on concrete stimuli (de Leeuw, 2011; Valla et al., 2000). Considering the broad spectrum of developmental levels represented by children ages 5–12, pictures have the capacity to engage a child's attention with visual stimuli and overcome reading comprehension challenges. Research on early childhood social-emotional skills highlights children's ability to recognize and relate to experiences depicted in pictorial images before they are capable of verbally articulating their feelings or experiences (Reid et al., 2013).

Consistent with such findings, pictorial screening tools for other childhood experiences have shown to be both reliable and valid, including mental health diagnoses (Valla et al., 2000), parent aggression (Cecil et al., 2016), and child fearfulness (Muris et al., 2003). There is also some evidence of success with pictorial assessment for child trauma, including a computer-based screener for children with autism (Hoover & Romero, 2019), and the Andy/Angie Cartoon Scale (Praver et al., 2000). The Cameron Complex Trauma Interview (CCTI) has also provided innovation in pictorial child trauma screening and preliminary evidence of internal consistency and convergent validity, though further piloting is needed in order to establish more robust psychometric properties (King et al., 2017). Given the limitations of these pictorial measures with regard to length and time requirements, psychometric properties, and the lack of information about cultural validity, there is room for expansion, innovation, and further research.

Conclusions and Implementation Considerations

This paper seeks to advance an innovative, pictorial approach to complex trauma screening, consistent with contemporary research on child development and the neurobiological impact of trauma. However, screening alone is an insufficient solution to the current challenges in child trauma screening. Several considerations around screening tool piloting, cultural sensitivity, and trauma-informed implementation must be embedded in the development process.

Piloting Process and Cognitive Interviewing

Cognitive interviewing has been identified as an important step in the design of questionnaires, particularly for children (LaPietra et al., 2020), yet the process is rarely mentioned in published studies describing the development of common child trauma screening tools. Cognitive interviewing reveals how question items are interpreted from the perspective of the respondent, and can enhance content and response validity by highlighting problematic questions, confusing wording, and areas that may contribute to response error (Drennan, 2003). Best practices suggest that piloting of the proposed pictorial screener should include at least one round of cognitive interviewing to gather data on items and pictures children found confusing or unclear, and items that had high rates of non-response in the initial pilot. Feedback from cognitive interviewing could be used to adjust item wording and illustrations before re-piloting the measure.

Cultural Sensitivity

As noted in the aforementioned framework, the traumatic symptom portion of a screener should address all seven domains of functioning for complex trauma (biology, self-concept, affect regulation, behavioral regulation, dissociation, cognition, and attachment; NCTSN, 2018; van der Kolk, 2017). This taps a broader range of symptoms than those defined by *DSM-V* diagnostic criteria and attends to one of the concerns that have been raised regarding cultural differences in the conceptualization and presenting symptoms of “posttraumatic stress” (Perry et al., 2019). For a pictorial screener, the images that accompany each question must be developed with input from a diverse, multicultural team of researchers, practitioners, and survivors. Each phase of piloting and cognitive interviewing must also include culturally and socioeconomically diverse child samples. Cultural background may influence children’s interpretation of images, language, and traumatic experiences; ensuring that items and images are consistently understood across groups will enhance the tool’s cultural and developmental validity.

Response and Referral Protocol

Screening for trauma is irresponsible in the absence of a clearly-delineated protocol for referral and resource linkage to proximal services that have demonstrated effectiveness with complexly traumatized children (Finkelhor, 2018). For this reason, the proposed pictorial child trauma screener must be developed in tandem with a culturally-sensitive response and referral protocol for practitioners. The response and referral protocol should include recommendations and guidelines for determining families’ cultural needs and preferences, collaborative engagement of youth and families in the referral process, logistical issues for the family (e.g., transportation, childcare, work schedule), steps for making a referral, and suggestions for post-referral follow-up. The Virginia HEALS (2019) project offers one such example of a trauma-informed protocol to accompany child trauma screening, including additional details about rapport-building, obtaining consent, and emphasizing the “warm handoff” referral process for trauma-informed systems. Alongside the response and referral protocol, service providers administering the screening tool must

have access to a local service and resource directory. While screening is a critical first step, equally as important is working with families to identify local agencies that are both accessible and the best-equipped to meet the unique needs of each child and their family circumstances.

Trauma-Informed Model of Care

The sensitive and personal nature of questions about traumatic exposure and reactions requires thoughtful implementation procedures that attend to all levels of the SAMHSA's (2014) key assumptions of a trauma-informed approach, with special attention to the need to resist retraumatization. The proposed screening tool must be developed with companion training materials on core principles of trauma-informed care (TIC) and concrete examples of how these principles are enacted in practice. Examples of system-wide implementation of TIC principles can be found for schools (Perry & Daniels, 2016; von der Embse et al., 2019), juvenile justice systems (Branson et al., 2017), and child welfare (Akin et al., 2017). Comprehensive training materials may include guidance for engaging children and families in collaborative relationships, establishing and maintaining trust, and practicing cultural humility and sensitivity throughout the screening and referral process.

Conclusion

Practitioners, clinicians, and social work educators are rapidly working to integrate contemporary findings on complex trauma and neurodevelopment, historical and systemic trauma, and relational health, into our direct practice work and student instruction. Paramount to this process is ensuring that complexly traumatized children are accurately screened and identified. Accurate identification of complex trauma permits a deeper understanding of child behavior, more focused treatment planning, and may prevent misdiagnosis, overmedication, and inadequate intervention with children improperly labelled with several social, emotional, and behavioral disorders. As we work to innovate and advance child trauma screening practices, this process must prioritize both clinical utility and embedding screening in a broader system of trauma-informed care.

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