Revised Child Welfare Trauma Referral Tool

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Screening for trauma and behavioral health needs is a critical element within a trauma-informed child welfare system. Screening early for trauma and behavioral health needs can identify children who are experiencing difficulties and would benefit from a comprehensive trauma-informed mental health assessment.

The Revised Child Welfare Trauma Referral Tool (CWT) is a provider-completed tool designed to help child welfare workers make more trauma-informed decisions about the need for referral to trauma-specific and general mental health services. It is designed to be completed by the child welfare worker following a thorough record review and interview with key informants in the child's life (i.e., natural parent, foster parent, child therapist, school-aged children or adolescents if appropriate, and other significant individuals in the child's life). It is recommended that the CWT be completed within 30 days of the child's entry into the child welfare system. For children who do not need a mental health referral at this time, it is recommended that the child be re-screened during key decision points (i.e., when a new trauma is reported, change in placement, etc.). The CWT was originally developed in 2006 and revised in 2013.

Directions for Completing the CWT

The CWT is designed to be completed in steps whereby the child welfare worker (CW worker) walks through each section of the CWT in order. In answering the questions on the CWT, use the following guidelines:

Yes	No	Suspected
Indicate "Yes" if there is substantiated knowledge that this child is exhibiting this behavior or experienced this event.	Indicate "No" if there is no indication that the child is exhibiting this behavior or experienced this event.	Indicate "Suspected" if a key informant has indicated concern that a behavior *might* be occurring or if the child *may* have experienced a specific event. This does not need to be substantiated, only a concern.

Section 1: Behaviors Requiring Immediate Stabilization

The first step is to identify if the child is exhibiting any of the following high-risk behaviors (see definitions below). Indicate answers in Section 1 of the CWT.

- If the child exhibits or is suspected of exhibiting any of the following high-risk behaviors, immediate action is required and the CW worker skips to Section 5.
- If the child does not exhibit any of the following, the CW worker continues onto Section 2.

Suicidal Ideation:	Thinking about, considering, or planning for suicide.
Active Substance Abuse:	An unhealthy pattern of substance (alcohol or drug) use that results in significant problems in one of the following ways: (1) An inability to adequately take care of your responsibilities or fill your role at work, school, or home; (2) The frequent use of substances in situations where it might be dangerous to do so (for example, driving while under the influence); (3) Repeated legal problems due to substance use (for example, public intoxication or disorderly conduct); and (4) The continued use of substances even though the substance use is causing considerable problems in your life.
Eating Disorder:	Any of several psychological disorders (as anorexia nervosa or bulimia) characterized by serious disturbances of eating behavior.
Serious Sleep Disorder:	Disturbance in the patient's amount of sleep, quality or timing of sleep, or in behaviors or physiological conditions associated with sleep.

Section 2: Trauma/Loss Exposure History

The next step is to determine if the child has been exposed to a traumatic event (see definitions below). Indicate answers in Section 2 of the CWT.

- If the child has experienced or is suspected of experiencing a traumatic event including a penetrated injury or sexual assault, a referral to a trauma-specific mental health provider is recommended and the CW worker should skip to Section 5 and indicate so.
- If the child has experienced or is suspected of experiencing any of the following traumatic events aside from the type listed above, the CW worker should continue to section 3 to see if the client is experiencing traumatic stress reactions.
- If the child has not experienced any of the following traumatic events, the CW worker should skip to Section 4.

Community Violence Exposure:	Extreme violence in the community (i.e., neighborhood and gang violence).
Domestic violence exposure:	Exposure to emotional abuse, actual/attempted physical or sexual assault, or aggressive control perpetrated between a parent/caretaker and another adult in the child victim's home environment.
Emotional Abuse:	Acts of commission against a minor child, including: Verbal abuse (e.g., insults; debasement; threats of violence), emotional abuse (e.g., bullying; terrorizing; coercive control), excessive demands on a child's performance (e.g., scholastic; athletic; musical; pageantry) that may lead to negative self-image and disturbed behavior.
Extreme Personal/ Interpersonal Violence:	Includes extreme violence by or between individuals that has not been reported elsewhere, including exposure to homicide, suicide and other similar extreme events.
Forced Displacement:	Forced relocation to a new home due to political reasons.
Natural/Manmade Disasters:	Major accident or disaster that is an unintentional result of a manmade or natural event.
Neglect:	Failure by the child victim's caretaker(s) to provide needed, age-appropriate care although financially able to do so, or offered financial or other means to do so. Includes: ***Physical neglect*** (e.g., deprivation of food, clothing, shelter), ***Medical neglect*** (e.g., failure to provide child victim with access to needed medical or mental health treatments and services; failure to consistently disperse or administer prescribed medications or treatments (e.g., insulin shots)), and ***Educational neglect*** (e.g., withholding child victim from school; failure to attend to special educational needs; truancy).
Physical Abuse or Assault:	Actual or attempted infliction of physical pain (e.g., stabbings; bruising; burns; suffocation.) by an adult, another child, or group of children to a minor child including use of severe corporal punishment.
School Violence Exposure:	Violence that occurs in a school setting (i.e., school shootings, bullying, classmate suicide).
Serious Accident/ Illness/Medical Procedure:	UNINTENTIONAL injury or accident such as car accident, house fire, or accidental fall down stairs. Having a physical illness or experiencing medical procedures that are painful and/or life threatening.
Sexual Abuse or Assault/Rape:	Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-inappropriate sexual material or environments by an adult to a minor child.
Systems-Induced Trauma:	Traumatic removal from the home, traumatic foster placement, sibling separation, or multiple placements in a short amount of time.
Traumatic Grief/ Separation:	Includes: Death of a parent, primary caretaker or sibling; Abrupt, unexpected, accidental, or premature death or homicide of a close friend, family member, or other close relative; Abrupt, unexplained and/or indefinite separation from a parent, primary caretaker, or sibling due to circumstances beyond the child victim's control.
War/Terrorism/Political Violence:	Exposure to acts of war/terrorism/political violence. Includes incidents both within the U.S. (e.g., Oklahoma bombing, 9-11) and outside of the U.S. (e.g., bombing, shooting, or accidents) that are a result of terrorist activity.

Section 3: Current Traumatic Stress Reactions

The next step is to identify if the child is currently experiencing traumatic stress reactions (see definitions below). Indicate answers in Section 3 of the CWT.

- If the child is, or is suspected of, experiencing any of the following reactions, a referral to a trauma-specific mental health provider is recommended and the CW worker should continue to Section 5 and indicate so.
- If the child is not experiencing any of the following reactions, then no mental health referral is needed and the CW worker should continue to Section 5 and indicate so.

Re-Experiencing

These symptoms consist of difficulties with intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences. Also included is pronounced reactivity to trauma or loss reminders. These symptoms are part of the DSM-IV criteria for PTSD.

Avoidance

These symptoms include efforts to avoid stimuli associated with traumatic experiences. The child may avoid certain places or people, or avoid discussing the specifics of the trauma. These symptoms are part of the DSM-IV criteria for PTSD.

Numbing

These symptoms include numbing responses that are part of the DSM-IV criteria for PTSD. These responses were not present before the trauma. Numbing symptoms include feelings of detachment or estrangement from others, restricted range of emotion (e.g., unable to have loving feelings), feeling out of sync with others, or having a sense of a foreshortened future.

Arousal

These symptoms consist of difficulties with hypervigilance (an exaggerated awareness of potential dangers), difficulty concentrating, exaggerated startle reactions, difficulties falling or staying asleep, and irritability or outbursts of anger. Children with these symptoms often seem distractible, impulsive and inattentive, leading to a common misdiagnosis of ADHD.

Section 4: Current Reactions/Behaviors/Functioning

The next step is to identify the child's current reactions/behaviors/functioning if no trauma history.

- If the child is having attachment difficulties and his/her trauma history between birth and 3 years old is unknown, a referral to a trauma-specific mental health provider is recommended and the CW worker should continue to Section 5 and indicate so.
- If the child has any of the following reactions/behaviors/functioning, a referral to a general mental health provider is recommended and the CW worker should continue to Section 5 and indicate so.
- If the child does not have any of the following reactions/behaviors/functioning, no mental health referral is recommended and the CW worker should continue to Section 5 and indicate so.

Affect Dysregulation:	Children with affect dysregulation may have difficulty expressing specific feelings, whether positive or negative, and may have trouble fully engaging in activities. They may have problems modulating or expressing emotions, experience intense fear or helplessness, or have difficulties regulating sleep/ wake cycle.
Anxiety:	Anxious children often appear tense or uptight. Worries may interfere with activities and they may seek reassurance from others or be clingy. These children may be quiet, compliant and eager to please, so they may be overlooked. Anxious children may report phobias, panic symptoms, and report physical complaints, startle easily, or have repetitive unwanted thoughts or actions.
Attachment Difficulties:	This category refers to a child's difficulty forming or maintaining relationships with significant parental or caregiver figures. It relates to the child's sense of security and trust in interacting with others. Often children with attachment difficulties interact with new acquaintances in unusual ways. They may bond too quickly (e.g., hugging strangers and climbing on their laps), or fail to engage in appropriate ways (e.g., avoid eye contact and fail to engage in appropriate conversations/ interactions).
Attention/ Concentration:	Children with problems with attention, concentration and task completion often have difficulty completing schoolwork or may have difficulty forming strong peer relationships.

Conduct Problems:	Defined by a variety of different conduct problems. Child may be physically or verbally aggressive to other people or animals. Children with conduct problems may destroy property, steal, break the law, or start fires. They may run away from home or act in a sexually promiscuous or aggressive fashion.
Depression:	Depressed children may appear tearful/sad, show decreased interest in previous activities, have difficulty concentrating, or display irritability. They may present with depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, loss of motivation, verbal aggression, sullenness, hopelessness, or negativity and have frequent complaints of physical problems.
Dissociation:	Children experiencing dissociation may daydream frequently. They may seem to be spacing out and be emotionally detached or numb. They are often forgetful and sometimes they experience rapid changes in personality.
Impulsivity:	Acting or speaking without first thinking of the consequences.
Oppositional Behaviors:	Defined by negativistic, hostile and defiant behaviors. Child may lose temper frequently, argue with adults, and refuse to comply with adult rules. Child may deliberately annoy people and blame others for mistakes or misbehaviors.
Regression:	Child ceases using previously adaptive behaviors. Child may begin wetting or soiling themselves after they had been potty trained, and may begin using baby talk or refusing to sleep alone when these skills were previously mastered.
Somatization:	Somatization is characterized by recurrent physical complaints without apparent physical cause. Children may report stomachaches or headaches, or on the more serious end of the spectrum, they may report blindness, pseudoseizures, or paralysis.
Suicidal Behavior:	Includes both superficial and more serious actions with potentially life-threatening consequences. Examples include overdosing, deliberately crashing a car, or slashing wrists.
Self-Harm:	When someone deliberately harms him or herself. Includes cutting behaviors, punching oneself, pulling out hair or eyelashes, picking skin causing sores, burning, inhaling or overdosing on medications.

Section 5: Identify Appropriate Next Step Using Referral Flowchart

In scoring the *Child Welfare Trauma Referral Tool*, the following guidelines are recommended (as outlined in the referral flowchart):

Immediate Stabilization Mental Health Referral:

- Hospital: If the child presents with suicidal intent, a referral to the hospital for stabilization is recommended. The child should be re-assessed once they are stabilized.
- Substance-Abuse Program: If the child presents with a significant substance abuse problem, a referral to a substance-abuse specific program is recommended. The child should be re-assessed once substance-abuse problem is stabilized.
- Eating Disorder Program: If the child presents with a significant eating disorder, a referral to an eating disorder program for stabilization is recommended. The child should be re-assessed once they are stabilized.
- Specialized Mental Health Professional: if the child presents with a serious sleep disturbance.

Trauma-Specific Mental Health Referral:

- The child has a trauma exposure history with a penetrating injury or sexual assault.
- The child has a trauma exposure history and is currently experiencing traumatic stress reactions.
- The child had a trauma history before the age of three, or the caregiver is unaware of the child's history before the age of three, and they are experiencing attachment difficulties.

General Mental Health Referral:

- If the child exhibits current reactions/behaviors/ functioning problems (other than traumatic stress reactions) in the absence of a trauma history.

No Mental Health Referral:

- If the child has a trauma exposure history but there are no traumatic stress reactions.
- If there is no trauma exposure history and the child is functioning well.

Child Welfare Trauma Referral Tool

Instructions for the flow of the referral tool are in the shaded areas below, please refer to the flow chart on next page or manual for more details.

Child Name: ___________________________DOB: ________
Completed by: _________________________Date: ________
Reason for Screening: _______________________________

1. Behaviors Requiring Immediate Stabilization

Suicidal Ideation:	Yes	No	Suspected	**Active Substance Abuse:**	Yes	No	Suspected
Eating Disorder:	Yes	No	Suspected	**Serious Sleep Disorder:**	Yes	No	Suspected

If "Yes" or "Suspected" to any of the above, skip sections 2 through 4 and please check option 1 in Section 5 and refer to flow chart for specific referrals for each type of problem.

2. Trauma/Loss Exposure History

Community Violence Exposure:	Yes	No	Suspected	**Physical Abuse or Assault:**	Yes	No	Suspected
Domestic Violence Exposure:	Yes	No	Suspected	**School Violence Exposure:**	Yes	No	Suspected
Emotional Abuse:	Yes	No	Suspected	**Serious Accident/Illness/ Medical Procedure:**	Yes	No	Suspected
Extreme Personal/ Interpersonal Violence:	Yes	No	Suspected	**Sexual Abuse or Assault/Rape:**	Yes	No	Suspected
Forced Displacement:	Yes	No	Suspected	**Systems-Induced Trauma:**	Yes	No	Suspected
Natural/Manmade Disasters:	Yes	No	Suspected	**Traumatic Grief/Separation:**	Yes	No	Suspected
Neglect:	Yes	No	Suspected	**War/Terrorism/Political Violence:**	Yes	No	Suspected

If any of the experienced or suspected trauma included penetrated injury or sexual assault, please skip sections 3 and 4 and check option 2 in Section 5. If "Yes" or "Suspected" to any of the above, please continue on to section 3. If "No" to all of the above, please skip section 3 and answer the items in section 4.

3. Current Traumatic Stress Reactions

Re-Experiencing (*nightmares, flashbacks, or intrusive thoughts*):	Yes	No	Suspected
Avoidance *(not wanting to talk about the trauma, avoiding trauma reminders):*	Yes	No	Suspected
Numbing *(lack of emotion, social withdrawal):*	Yes	No	Suspected
Arousal *(exaggerated startle response, hypervigilance, being "on edge"):*	Yes	No	Suspected

Please skip section 4. If "Yes" or "Suspected" to any of the above, check option 2 in section 5. If "No" for all items, check option 4 in section 5.

4. Current Reactions/Behaviors/Functioning (*Does this interfere with child's daily functioning at home, school, or in the community?)*

Affect Dysregulation:	Yes	No	Suspected	**Impulsivity**:	Yes	No	Suspected
Anxiety:	Yes	No	Suspected	**Oppositional Behaviors:**	Yes	No	Suspected
Attachment Difficulties:*	Yes	No	Suspected	**Regression:**	Yes	No	Suspected
Attention/Concentration:	Yes	No	Suspected	**Somatization:**	Yes	No	Suspected
Conduct Problems:	Yes	No	Suspected	**Suicidal Behavior:**	Yes	No	Suspected
Depression:	Yes	No	Suspected	**Self-Harm:**	Yes	No	Suspected
Dissociation:	Yes	No	Suspected				

- *If "Yes" for Attachment Difficulties and trauma history for ages Birth to 3 years is unknown, please check option 2 in section 5.*
- *If "Yes" or "Suspected" for any of the others (including Attachment Difficulties in all other circumstances), please check option 3 in section 5.*
- *If "No" for all items, please check option 4 in section 5.*

5. Appropriate Next Step

- ❑ 1. Immediate stabilization mental health referral (any behaviors requiring immediate stabilization)
- ❑ 2. Trauma-specific mental health referral (trauma exposure/history and current traumatic stress reactions)
- ❑ 3. General mental health referral (current problems in behavior or functioning but no current traumatic stress reactions)
- ❑ 4. No mental health referral (no current problems in behavior or functioning/no current traumatic stress reactions). We recommend rescreening at periodic intervals.

Child Welfare Trauma Referral Tool: Referral Flowchart – Linking Experiences to Reactions