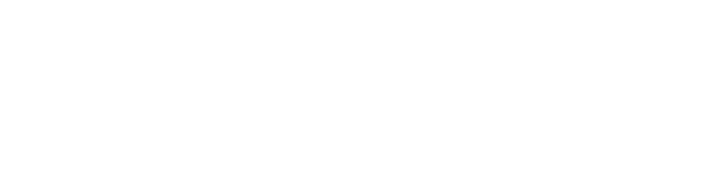
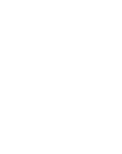
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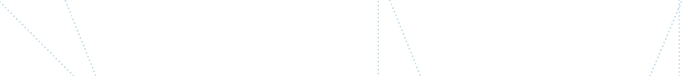
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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment

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Trauma-Informed Care in Behavioral Health Services

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###### Disclaimer

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X

## What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at [http://store.samhsa.gov.](http://store.samhsa.gov/)

Although each consensus-based TIP strives to include an evidence base for the practices it rec­ ommends, SAMHSA recognizes that behavioral health is continually evolving, and research fre­ quently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, cita­ tions are provided.

XI

## Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of sub­ stance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to improve pre­ vention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and imple­ mentation requirements. A panel of non-Federal clinical researchers, clinicians, program admin­ istrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly par­ ticipatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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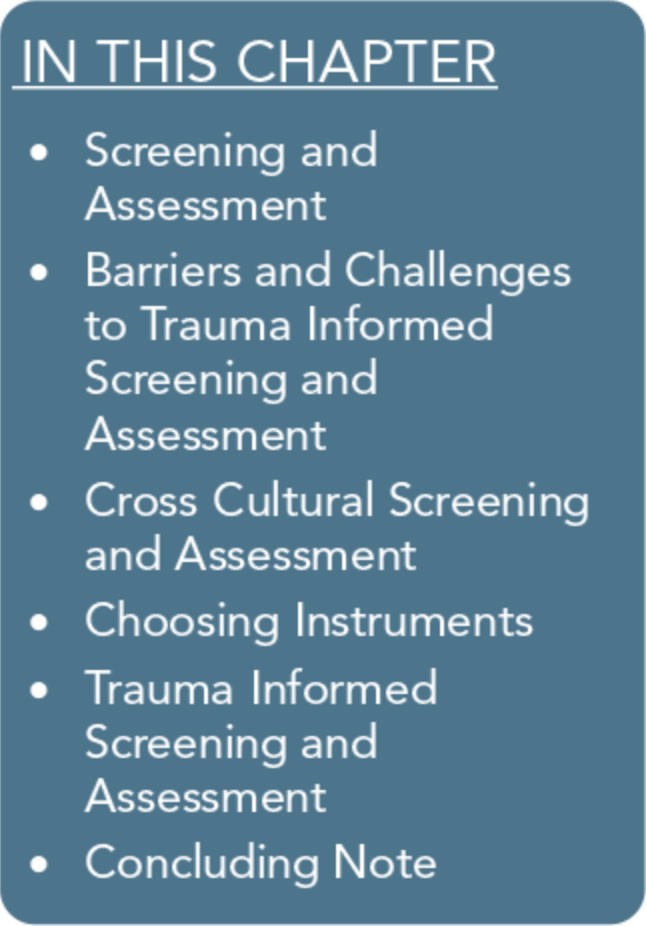
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Substance Abuse and Mental Health Services Administration

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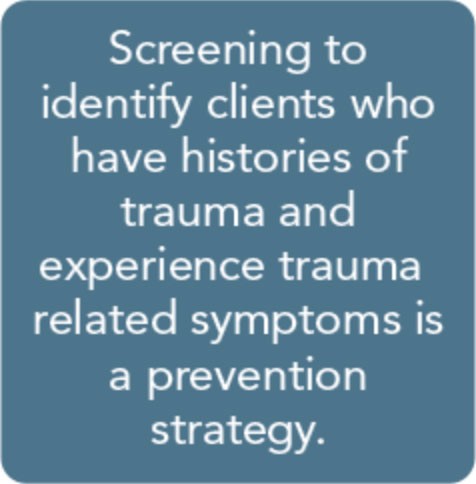
### Screening and Assessment

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Why screen universally for trauma in behavioral health services? Ex­ posure to trauma is common; in many surveys, more than half of re­ spondents report a history of trauma, and the rates are even higher among clients with mental or substance use disorders. Furthermore, behavioral health problems, including substance use and mental dis­ orders, are more difficult to treat if trauma-related symptoms and disorders aren't detected early and treated effectively (Part 3, Section 1, of this Treatment Improvement Protocol **[TIP],** available online, summarizes research on the prevalence of trauma and its relation­ ship with other behavioral health problems).

Not addressing traumatic stress symptoms, trauma-specific disor­ ders, and other symptoms/disorders related to trauma can impede successful mental health and substance abuse treatment. Unrecog­ nized, unaddressed trauma symptoms can lead to poor engagement in treatment, premature termination, greater risk for relapse of psy­ chological symptoms or substance use, and worse outcomes.

Screening can also prevent misdiagnosis and inappropriate treat­ ment planning. People with histories of trauma often display symptoms that meet criteria for other disorders.

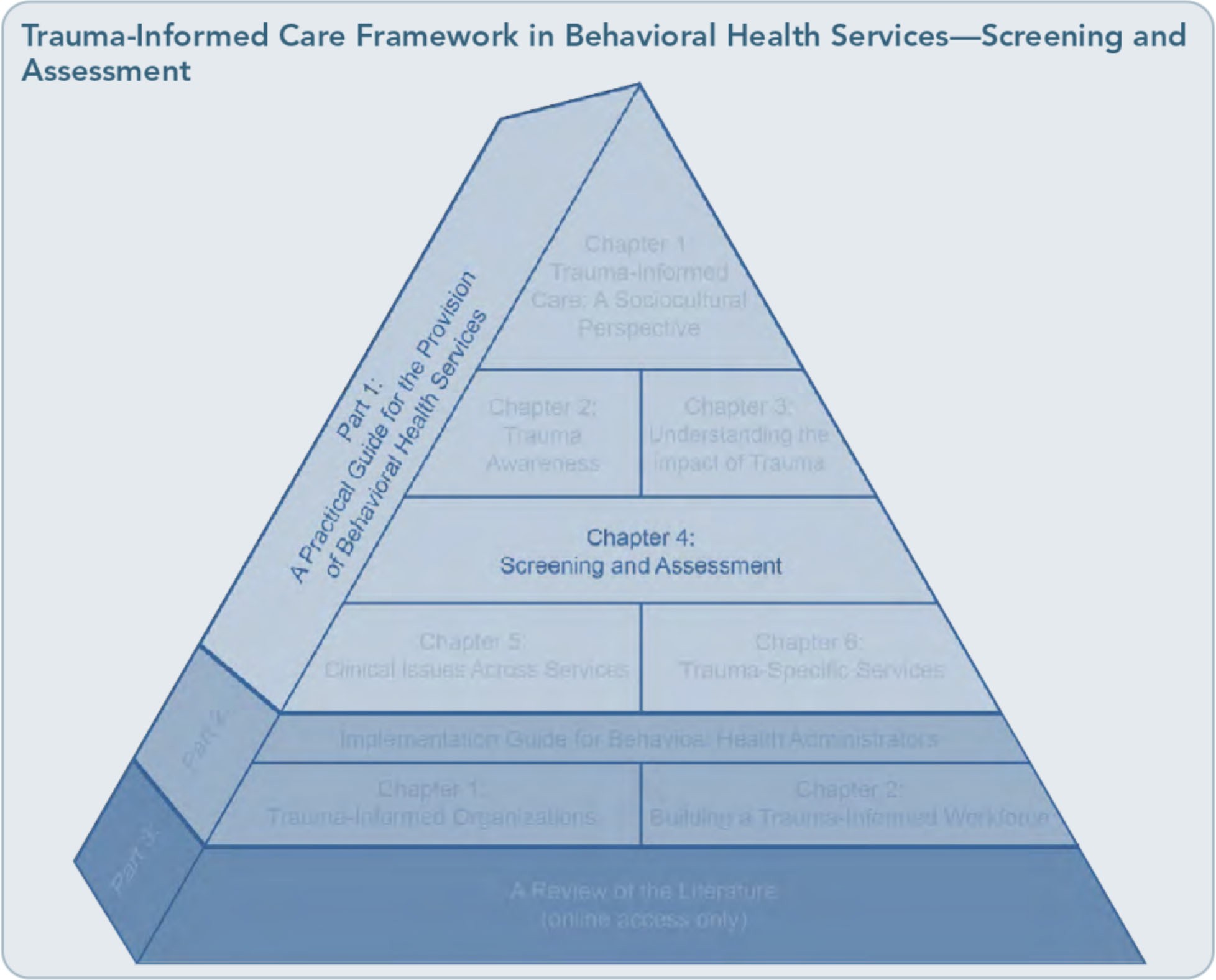
Without screening, clients' trauma histories and related symptoms often go undetected, leading providers to direct services toward symptoms and disorders that may only partially explain client presentations and distress. Universal

screening for trauma history and trauma- related symptoms can help behavioral health practitioners identify individuals at risk of developing more pervasive and se- vere symptoms of traumatic stress.

Screening, early identification, and inter- vention serves as a prevention strategy.

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Trauma-Informed Care in Behavioral Health Services



The chapter begins with a discussion of screening and assessment concepts, with a particular focus on trauma-informed screen­ ing. It then highlights specific factors that influence screening and assessment, including timing and environment. Barriers and chal­ lenges in providing trauma-informed screen­ ing are discussed, along with culturally specific screening and assessment considerations and guidelines. Instrument selection, trauma­ informed screening and assessment tools, and trauma-informed screening and assessment processes are reviewed as well. For a more research-oriented perspective on screening and assessment for traumatic stress disorders, please refer to the literature review provided in Part 3 of this TIP, which is available online.

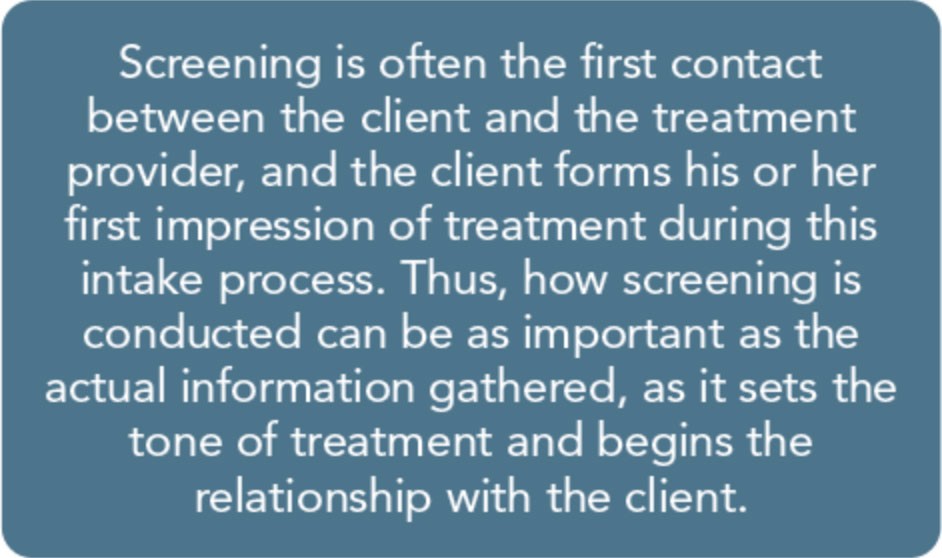
##### Screening and Assessment

Screening

The first two steps in screening are to deter­ mine whether the person has a history of trauma and whether he or she has trauma­ related symptoms. Screening mainly obtains answers to "yes" or "no" questions: "Has this client experienced a trauma in the past?" and "Does this client at this time warrant further assessment regarding trauma-related symp­ toms?" If someone acknowledges a trauma history, then further screening is necessary to determine whether trauma-related symptoms are present. However, the presence of such symptoms does not necessarily say anything about their severity, nor does a positive screen indicate that a disorder actually exists. Positive

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Part 1, Chapter 4-Screening and Assessment



screens only indicate that assessment or fur­ ther evaluation is warranted, and negative screens do not necessarily mean that an indi­ vidual doesn't have symptoms that warrant intervention.

Screening procedures should always define the steps to take after a positive or negative screening. That is, the screening process es­ tablishes precisely how to score responses to screening tools or questions and clearly defines what constitutes a positive score (called a "cut­ off score") for a particular potential problem. The screening procedures detail the actions to take after a client scores in the positive range. Clinical supervision is helpful-and some­ times necessary-in judging how to proceed.

Trauma-informed screening is an essential part of the intake evaluation and the treatment planning process, but it is not an end in itself. Screening processes can be developed that allow staff without advanced degrees or gradu­ ate-level training to conduct them, whereas assessments for trauma-related disorders re­ quire a mental health professional trained in assessment and evaluation processes. The

most important domains to screen among individuals with trauma histories include:

* Trauma-related symptoms.
* Depressive or dissociative symptoms, sleep disturbances, and intrusive experiences.
* Past and present mental disorders, includ­ ing typically trauma-related disorders (e.g., mood disorders).
* Severity or characteristics of a specific trauma type (e.g., forms ofinterpersonal vi­ olence, adverse childhood events, combat experiences).
* Substance abuse.
* Social support and coping styles.
* Availability of resources.
* Risks for self-harm, suicide, and violence.
* Health screenings.

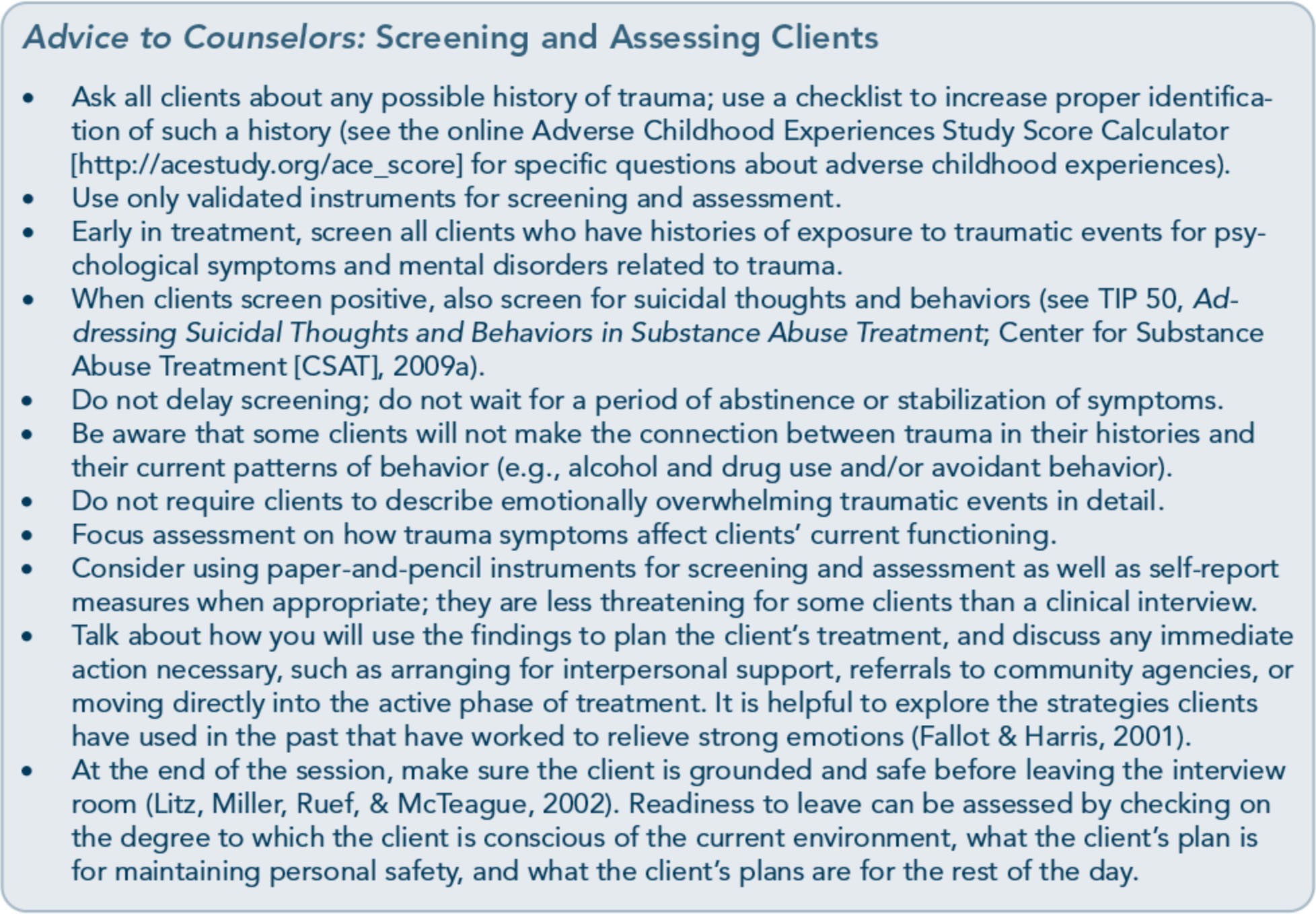
**Assessment**

When a client screens positive for substance abuse, trauma-related symptoms, or mental disorders, the agency or counselor should fol­ low up with an assessment. A positive screen­ ing calls for more action-an assessment that determines and defines presenting struggles to develop an appropriate treatment plan and to make an informed and collaborative decision about treatment placement. Assessment de­ termines the nature and extent of the client's problems; it might require the client to re­ spond to written questions, or it could involve a clinical interview by a mental health or sub­ stance abuse professional qualified to assess the client and arrive at a diagnosis. A clinical assessment delves into a client's past and cur­ rent experiences, psychosocial and cultural history, and assets and resources.

Assessment protocols can require more than a single session to complete and should also use multiple avenues to obtain the necessary clini­ cal information, including self-assessment tools, past and present clinical and medical records, structured clinical interviews, assess­ ment measures, and collateral information from significant others, other behavioral health professionals, and agencies. Qialifica­ tions for conducting assessments and clinical interviews are more rigorous than for screen­ ing. Advanced degrees, licensing or certifica­ tion, and special training in administration, scoring, and interpretation of specific assess­ ment instruments and interviews are often

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Trauma-Informed Care in Behavioral Health Services



required. Counselors must be familiar with (and obtain) the level of training required for any instruments they consider using.

For people with histories of traumatic life events who screen positive for possible trauma­ related symptoms and disorders, thorough assessment gathers all relevant information necessary to understand the role of the trauma in their lives; appropriate treatment objectives, goals, planning, and placement; and any ongo­ ing diagnostic and treatment considerations, including reevaluation or follow-up.

Overall, assessment may indicate symptoms that meet diagnostic criteria for a substance use or mental disorder or a milder form of symptomatology that doesn't reach a diagnos­ tic level-or it may reveal that the positive screen was false and that there is no significant cause for concern. Information from an as­ sessment is used to plan the client's treatment.

The plan can include such domains as level of care, acute safety needs, diagnosis, disability, strengths and skills, support network, and cultural context. Assessments should reoccur throughout treatment. Ongoing assessment during treatment can provide valuable infor­ mation by revealing further details of trauma history as clients' trust in staff members grows and by gauging clients' progress.

Timing of Screening and Assessment

As a trauma-informed counselor, you need to offer psychoeducation and support from the outset of service provision; this begins with explaining screening and assessment and with proper pacing of the initial intake and evalua­ tion process. The client should understand the screening process, why the specific questions are important, and that he or she may choose to delay a response or to not answer a question

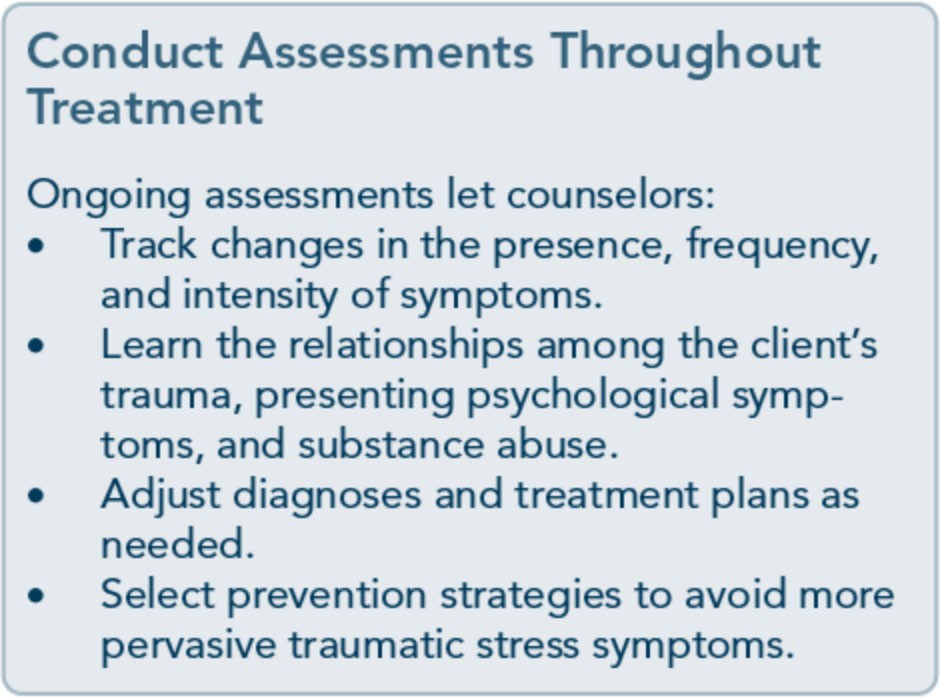
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Part 1, Chapter 4-Screening and Assessment

at all. Discussing the occurrence or conse­ quences of traumatic events can feel as unsafe and dangerous to the client as if the event were reoccurring. It is important not to en­ courage avoidance of the topic or reinforce the belief that discussing trauma-related material is dangerous, but be sensitive when gathering information in the initial screening. Initial questions about trauma should be general and gradual. Taking the time to prepare and ex­ plain the screening and assessment process to the client gives him or her a greater sense of control and safety over the assessment process.

***Clients with substance* use *disorders*** No screening or assessment of trauma should occur when the client is under the influence of alcohol or drugs. Clients under the influence are more likely to give inaccurate information. Although it's likely that clients in an active phase of use (albeit not at the assessment it­ self) or undergoing substance withdrawal can provide consistent information to obtain a valid screening and assessment, there is insuf­ ficient data to know for sure. Some theorists state that no final assessment of trauma or posttraumatic stress disorder (PTSD) should occur during these early phases (Read, Bollinger, & Sharkansky, 2003), asserting that

symptoms of withdrawal can mimic PTSD and thus result in overdiagnosis of **PTSD** and other trauma-related disorders. Alcohol or drugs can also cause memory impairment that clouds the client's history of trauma symp­ toms. However, Najavits (2004) and others note that underdiagnosis, not overdiagnosis, of trauma and **PTSD** has been a significant issue in the substance abuse field and thus claim that it is essential to obtain an initial assess­ ment early, which can later be modified if needed (e.g., if the client's symptom pattern changes). Indeed, clinical observations suggest that assessments for both trauma and **PTSD­** even during active use or withdrawal-appear



robust (Coffey, Schumacher, Brady, & Dansky, 2003). Although some PTSD symptoms and trauma memories can be dampened or in­ creased to a degree, their overall presence or absence, as assessed early in treatment, appears accurate (Najavits, 2004).

The Setting for Trauma Screening and Assessment

Advances in the development of simple, brief, and public-domain screening tools mean that at least a basic screening for trauma can be done in almost any setting. Not only can cli­ ents be screened and assessed in behavioral health treatment settings; they can also be evaluated in the criminal justice system, edu­ cational settings, occupational settings, physi­ cians' offices, hospital medical and trauma units, and emergency rooms. Wherever they occur, trauma-related screenings and subse­ quent assessments can reduce or eliminate wasted resources, relapses, and, ultimately, treatment failures among clients who have histories of trauma, mental illness, and/or sub­ stance use disorders.

***Creating* an *effective screening and***

**assessment *environment***

You can greatly enhance the success of treat­ ment by paying careful attention to how you approach the screening and assessment pro­ cess. Take into account the following points:

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Trauma-Informed Care in Behavioral Health Services

* + ***Clarify for the client what to expect in the screening and assessment process.*** For exam­ ple, tell the client that the screening and as­ sessment phase focuses on identifying issues that might benefit from treatment. Inform him or her that during the trauma screening and assessment process, uncom­ fortable thoughts and feelings can arise. Provide reassurance that, if they do, you'll assist in dealing with this distress-but also let them know that, even with your assis­ tance, some psychological and physical re­ actions to the interview may last for a few hours or perhaps as long as a few days after the interview, and be sure to highlight the fact that such reactions are normal (Read et al., 2003).
  + ***Approach the client in a matter-of-fad, yet supportive, manner.*** Such an approach helps create an atmosphere of trust, respect, acceptance, and thoughtfulness (Melnick & Bassuk, 2000). Doing so helps to normalize symptoms and experiences generated by the trauma; consider informing clients that such events are common but can cause con­ tinued emotional distress if they are not treated. Clients may also find it helpful for you to explain the purpose of certain diffi­ cult questions. For example, you could say, "Many people have experienced troubling events as children, so some of my questions are about whether you experienced any such events while growing up." Demon­ strate kindness and directness in equal measure when screening/assessing clients (Najavits, 2004).
  + ***Resped the client's personal space.*** Cultural

and ethnic factors vary greatly regarding the appropriate physical distance to maintain during the interview. You should respect the client's personal space, sitting neither too far from nor too close to the client; let your observations of the client's comfort level during the screening and assessment pro­ cess guide the amount of distance. Clients

with trauma may have particular sensitivity about their bodies, personal space, and boundaries.

* ***Atijust tone and volume of speech to suit the client's level of engagement and degree of comfort in the interview process.*** Strive to maintain a soothing, quiet demeanor. Be sensitive to how the client might hear what you have to say in response to personal dis­ closures. Clients who have been trauma­ tized may be more reactive even to benign or well-intended questions.
* ***Provide culturally appropriate symbols of safety in the physical environment.*** These include paintings, posters, pottery, and other room decorations that symbolize the safety of the surroundings to the cli­ ent population. Avoid culturally inappro­ priate or insensitive items in the physical environment.
* ***Be aware of one's own emotional responses to hearing clients' trauma histories.*** Hearing about clients' traumas may be very painful and can elicit strong emotions. The client may interpret your reaction to his or her revelations as disinterest, disgust for the cli­ ent's behavior, or some other inaccurate in­ terpretation. It is important for you to monitor your interactions and to check in with the client as necessary. You may also feel emotionally drained to the point that it interferes with your ability to accurately lis­ ten to or assess clients. This effect of expo­ sure to traumatic stories, known as secondary traumatization, can result in symptoms similar to those experienced by the client (e.g., nightmares, emotional numbing); if necessary, refer to a colleague for assessment (Valent, 2002). Secondary traumatization is addressed in greater detail in Part 2, Chapter 2, of this TIP.
* ***Overcome linguistic barriers*** *via* ***an inter­ preter.*** Deciding when to add an interpreter requires careful judgment. The interpreter should be knowledgeable of behavioral

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health terminology, be familiar with the concepts and purposes of the interview and treatment programming, be unknown to the client, and be part of the treatment team. Avoid asking family members or friends of the client to serve as interpreters.

* + ***Elicit only the information necessary for determining a history of trauma and the possible existence and extent of traumatic***

***stress symptoms and related disorders.*** There is no need to probe deeply into the details of a client's traumatic experiences at this stage in the treatment process. Given the lack of a therapeutic relationship in which to process the information safely, pursuing details of trauma can cause re­ traumatization or produce a level of re­ sponse that neither you nor your client is prepared to handle. Even if a client wants to tell his or her trauma story, it's your job to serve as "gatekeeper" and preserve the client's safety. Your tone of voice when sug­ gesting postponement of a discussion of trauma is very important. Avoid conveying the message, "I really don't want to hear about it." Examples of appropriate state­ ments are:

"Your life experiences are very im­ portant, but at this early point in our work together, we should start with what's going on in your life currently rather than discussing past experiences in detail. If you feel that certain past experiences are having a big effect on your life now, it would be helpful for us to discuss them as long as we focus on your safety and recovery right now." "Talking about your past at this point could arouse intense feelings-even more than you might be aware of right now. Later, if you choose to, you can talk with your counselor about how to work on exploring your past."

"Often, people who have a history of trauma want to move quickly into the

details of the trauma to gain relief. I understand this desire, but my concern for you at this moment is to help you establish a sense of safety and support before moving into the traumatic expe­ riences. We want to avoid retraumati­ zation-meaning,we want to establish resources that weren't available to you at the time of the trauma before delv­ ing into more content."

* ***Give the client as much personal control as***

***possible during the assessment by:*** Presenting a rationale for the interview and its stress-inducing potential, mak­ ing clear that the client has the right to refuse to answer any and all questions. Giving the client (where staffing per­ mits) the option of being interviewed

by someone of the gender with which he or she is most comfortable.

Postponing the interview if necessary (Fallot & Harris, 2001).

* ***Use self-administered, written checklists rather than interviews when possible to as­ sess trauma.*** Traumas can evoke shame, guilt, anger, or other intense feelings that can make it difficult for the client to report them aloud to an interviewer. Clients are more likely to report trauma when they use self-administered screening tools; however, these types of screening instruments only guide the next step. Interviews should coin­ cide with self-administered tools to create a sense of safety for the client (someone is present as he or she completes the screen­ ing) and to follow up with more indepth data gathering after a self-administered screening is complete. The Trauma History

Qyestionnaire (THQ2 is a self­ administered tool (Green, 1996). It has been used successfully with clinical and nonclinical populations, including medi­

cal patients, women who have experi­ enced domestic violence, and people with serious mental illness (Hooper, Stockton,

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Krupnick, & Green, 2011). Screening in­ struments (including the THQ2 are includ­ ed in Appendix D of this TIP.

* + ***Interview the client*** *if* ***he or she has trouble***

***reading or writing or*** *is* ***otherwise unable to complete a checklist.*** Clients who are likely to minimize their trauma when using a checklist (e.g., those who exhibit significant symptoms of dissociation or repression) benefit from a clinical interview. A trained interviewer can elicit information that a self-administered checklist does not cap­

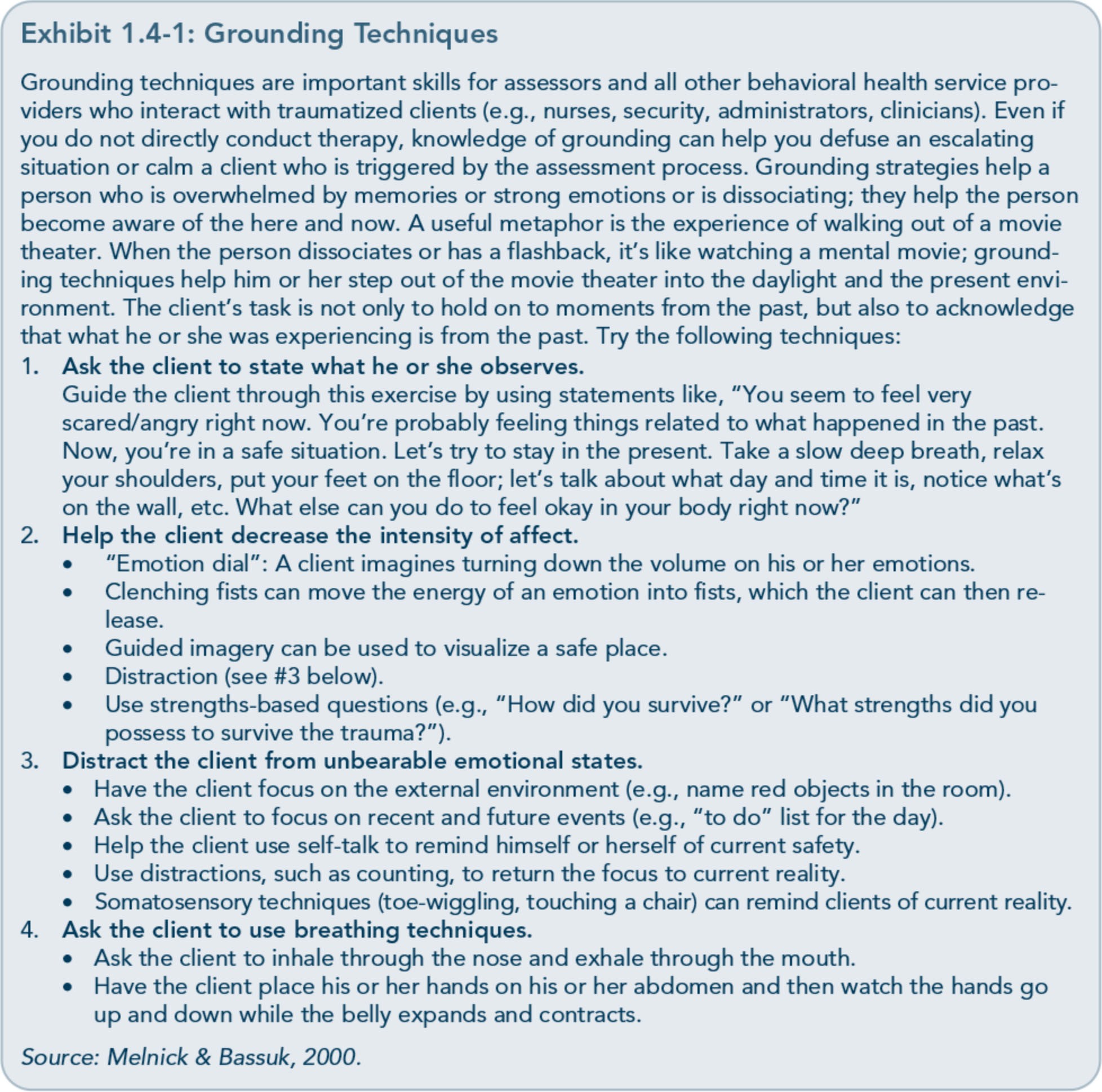
ture. Overall, using both a self-administered

questionnaire and an interview can help achieve greater clarity and context.

* ***Allow time for the client to become calm and***

***oriented to the present*** *if* ***he or she has very intense emotional responses when recalling***

***or acknowledging a trauma.*** At such times, avoid responding with such exclamations as "I don't know how you survived that!" (Bernstein, 2000). If the client has difficul­ ty self-soothing, guide him or her through grounding techniques (Exhibit 1.4-1), which are particularly useful-perhaps even critical-to achieving a successful



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interview when a client has dissociated or is experiencing intense feelings in response to screening and/or interview questions.

* + ***Avoid phrases that imply judgment about the trauma.*** For example, don't say to a cli­ ent who survived Hurricane Katrina and lost family members, "It was God's will," or "It was her time to pass," or "It was meant to be." Do not make assumptions about what a person has experienced. Ra­ ther, listen supportively without imposing personal views on the client's experience.
  + ***Provide feedback about the results of the***

***screening.*** Keep in mind the client's vulner­ ability, ability to access resources, strengths, and coping strategies. Present results in a synthesized manner, avoiding complicated, overly scientific jargon or explanations. Al­ low time to process client reactions during the feedback session. Answer client ques­ tions and concerns in a direct, honest, and compassionate manner. Failure to deliver feedback in this way can negatively affect clients' psychological status and severely weaken the potential for developing a ther­ apeutic alliance with the client.

* + ***Be aware of the possible legal implications of assessment.*** Information you gather dur­ ing the screening and assessment process can necessitate mandatory reporting to au­ thorities, even when the client does not

want such information disclosed (Najavits, 2004). For example, you can be required to report a client's experience of child abuse even if it happened many years ago or the client doesn't want the information report­ ed. Other legal issues can be quite com­ plex, such as confidentiality of records, pursuing a case against a trauma perpetra­ tor and divulging information to third par­ ties while still protecting the legal status of information used in prosecution, and child custody issues (Najavits, 2004). It's essen­ tial that you know the laws in your State,

have an expert legal consultant available, and access clinical supervision.

#### Barriers and Challenges to Trauma-Informed Screening and Assessment

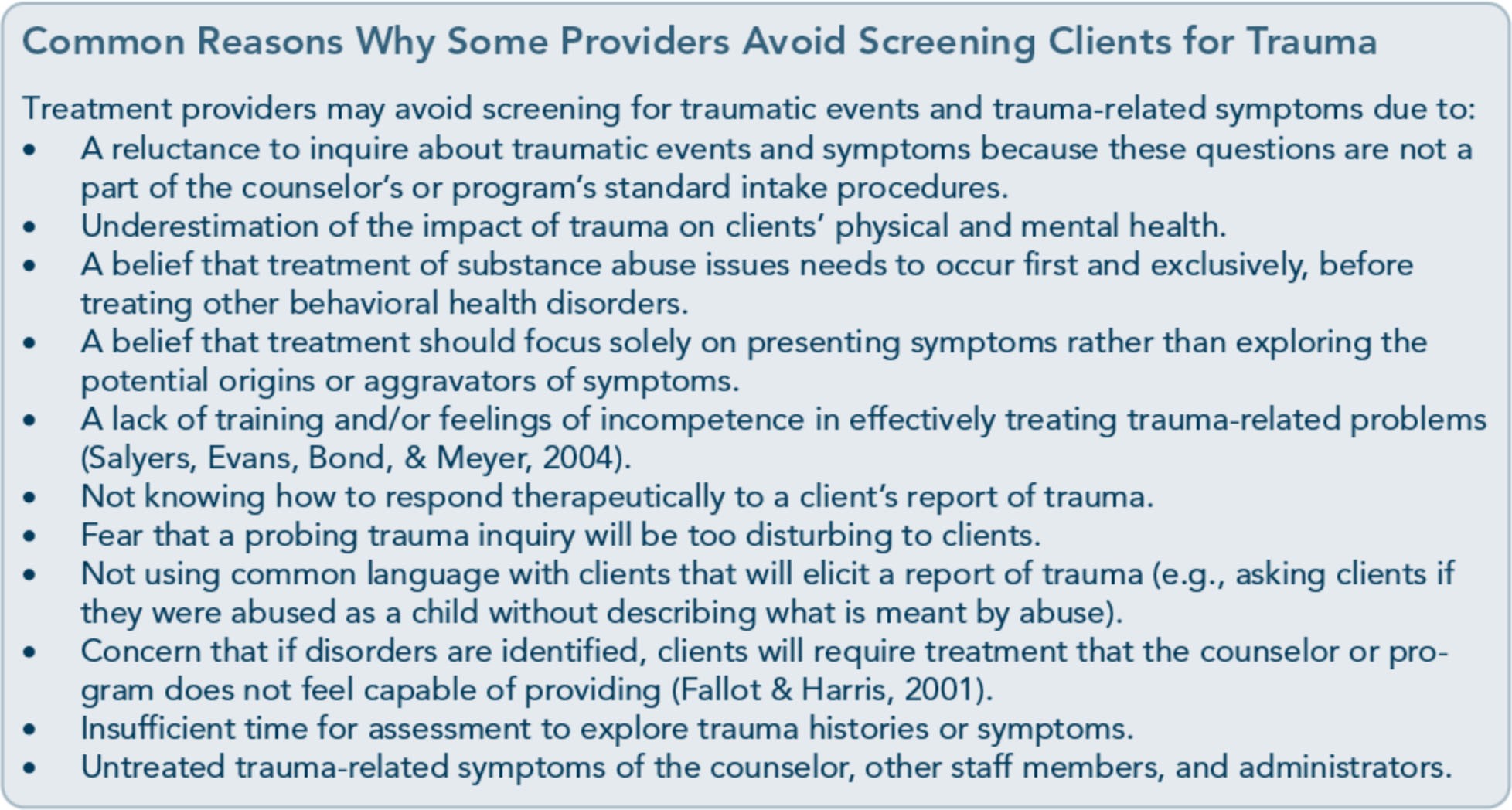
Barriers

It is not necessarily easy or obvious to identify an individual who has survived trauma with­ out screening. Moreover, some clients may deny that they have encountered trauma and its effects even after being screened or asked direct questions aimed at identifying the oc­ currence of traumatic events. The two main barriers to the evaluation of trauma and its related disorders in behavioral health settings are clients not reporting trauma and providers overlooking trauma and its effects.

Concerning the first main barrier, some events will be experienced as traumatic by one person but considered nontraumatic by another. A history of trauma encompasses not only the experience of a potentially traumatic event, but also the person's responses to it and the mean­ ings he or she attaches to the event. Certain situations make it more likely that the client will not be forthcoming about traumatic events or his or her responses to those events. Some clients might not have ever thought of a particular event or their response to it as trau­ matic and thus might not report or even recall the event. Some clients might feel a reluctance to discuss something that they sense might bring up uncomfortable feelings (especially with a counselor whom they've only recently met). Clients may avoid openly discussing traumatic events or have difficulty recognizing or articulating their experience of trauma for other reasons, such as feelings of shame, guilt, or fear of retribution by others associated with the event (e.g., in cases ofinterpersonal or

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domestic violence). Still others may deny their history because they are tired of being inter­ viewed or asked to fill out forms and may be­ lieve it doesn't matter anyway.

A client may not report past trauma for many reasons, including:

* + Concern for safety (e.g., fearing more abuse by a perpetrator for revealing the trauma).
  + Fear of being judged by service providers.
  + Shame about victimization.
  + Reticence about talking with others in re­ sponse to trauma.
  + Not recalling past trauma through dissocia­ tion, denial, or repression (although genuine blockage of all trauma memory is rare among trauma survivors; McNally, 2003).
  + Lack of trust in others, including behavior- al health service providers.
  + Not seeing a significant event as traumatic.

Regarding the second major barrier, counselors and other behavioral health service providers may lack awareness that trauma can signifi­ cantly affect clients' presentations in treatment and functioning across major life areas, such as relationships and work. In addition, some counselors may believe that their role is to

treat only the presenting psychological and/or substance abuse symptoms, and thus they may not be as sensitive to histories and effects of trauma. Other providers may believe that a client should abstain from alcohol and drugs for an extended period before exploring trau­ ma symptoms. Perhaps you fear that address­ ing a clients' trauma history will only exacerbate symptoms and complicate treat­ ment. Behavioral health service providers who hold biases may assume that a client doesn't have a history of trauma and thus fail to ask the "right" questions, or they may be uncom­ fortable with emotions that arise from listen­ ing to client experiences and, as a result, redirect the screening or counseling focus.

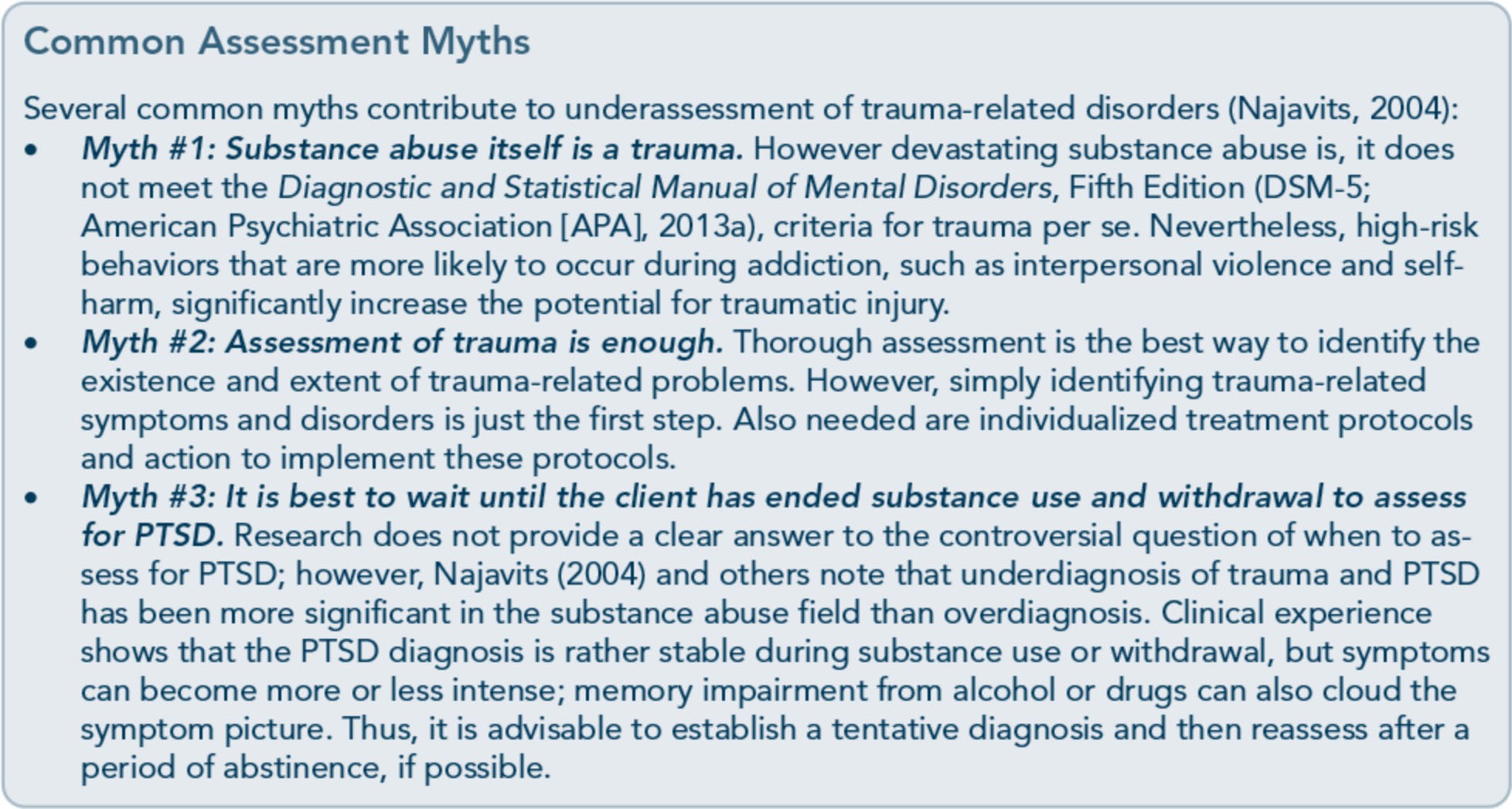
**Challenges**

***Awareness* of *acculturation and language***

Acculturation levels can affect screening and assessment results. Therefore, indepth discus­ sions may be a more appropriate way to gain an understanding of trauma from the client's point of view. During the intake, prior to trauma screening, determine the client's history of

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migration, if applicable, and primary language. Qyestions about the client's country of birth, length of time in this country, events or reasons for migration, and ethnic self-identification are also appropriate at intake. Also be aware that even individuals who speak English well might have trouble understanding the subtleties of questions on standard screening and assessment tools. It is not adequate to translate items simp­ ly from English into another language; words, idioms, and examples often don't translate di­ rectly into other languages and therefore need to be adapted. Screening and assessment should be conducted in the client's preferred language by trained staff members who speak the lan­

guage or by professional translators familiar with treatment jargon.

***Awareness of co-occurring diagnoses*** A trauma-informed assessor looks for psycho­ logical symptoms that are associated with trauma or simply occur alongside it. Symptom screening involves questions about past or present mental disorder symptoms that may indicate the need for a full mental health as­

sessment. A variety of screening tools are available, including symptom checklists.

However, you should only use symptom checklists when you need information about how your client is currently feeling; don't use them to screen for specific disorders. Responses will likely change from one administration of the checklist to the next.

Basic mental health screening tools are availa­ ble. For example, the Mental Health Screening Form-III screens for present or past symptoms of most mental disorders (Carroll &McGinley, 2001); it is available at no charge from Project Return Foundation, Inc. and is also reproduced in TIP 42, *Substance Abuse Treatment far Per­ sons With Co-Occurring Disorders* **(CSAT,** 2005c). Other screening tools, such as the Beck Depression Inventory II and the Beck Anxiety Inventory (Beck, Wright, Newman, &Liese, 1993), also screen broadly for mental and sub­ stance use disorders, as well as for specific dis­ orders often associated with trauma. For further screening information and resources on depression and suicide, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* **(CSAT,** 2008), and **TIP** 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (**CSAT,** 2009a).

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For screening substance use disorders, see TIP 11, *Simple Screening Instruments far Outreach far Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT, 1994); TIP *24,A Guide to Substance Abuse Services far Primary Care Cli­ nicians* (CSAT, 1997a); TIP 31, *Screening and Assessing Adolescents far Substance Use Disorders* (CSAT, 1999c); TIP 42, *Substance Abuse Treatment far Persons With Co-Occurring Dis­ orders* (CSAT, 2005c); and TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d).

A common dilemma in the assessment of trauma-related disorders is that certain trauma symptoms are also symptoms of other disor­ ders. Clients with histories of trauma typically present a variety of symptoms; thus, it is im­ portant to determine the full scope of symp­ toms and/or disorders present to help improve treatment planning. Clients with trauma­ related and substance use symptoms and dis­ orders are at increased risk for additional Axis I and/or Axis II mental disorders (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Cottler, Nishith, & Compton, 2001). These symptoms need to be distinguished so that other presenting subclinical features or disor­ ders do not go unidentified and untreated. To accomplish this, a comprehensive assessment of the client's mental health is recommended.

***Misdiagnosis and underdiagnosis*** Many trauma survivors are either misdiagnosed (i.e., given diagnoses that are not accurate) or underdiagnosed (i.e., have one or more diagno­ ses that have not been identified at all). Such diagnostic errors could result, in part, from the fact that many general instruments to evaluate mental disorders are not sufficiently sensitive to identify posttraumatic symptoms and can mis­ classify them as other disorders, including per­ sonality disorders or psychoses. Intrusive posttraumatic symptoms, for example, can show up on general measures as indicative of

hallucinations or obsessions. Dissociative symptoms can be interpreted as indicative of schiwphrenia. Trauma-based cognitive symp­ toms can be scored as evidence for paranoia or other delusional processes (Briere, 1997). Some of the most common misdiagnoses in clients with PTSD and substance abuse are:

* ***Mood and anxiety disorders.*** Overlapping symptoms with such disorders as major de­ pression, generalized anxiety disorder, and bipolar disorder can lead to misdiagnosis.
* ***Borderline personality disorder.*** Historically, this has been more frequently diagnosed than **PTSD.** Many of the symptoms, in­ cluding a pattern of intense interpersonal relationships, impulsivity, rapid and unpre­ dictable mood swings, power struggles in the treatment environment, underlying anxiety and depressive symptoms, and tran­ sient, stress-related paranoid ideation or se­ vere dissociative symptoms overlap. The effect of this misdiagnosis on treatment can be particularly negative; counselors often view clients with a borderline personality diagnosis as difficult to treat and unrespon­ sive to treatment.
* ***Antisocial personality disorder.*** For men and women who have been traumatized in childhood, "acting out" behaviors, a lack of empathy and conscience, impulsivity, and self-centeredness can be functions of trau­ ma and survival skills rather than true anti­ social characteristics.
* ***Attention deficit hyperactivity disorder***

***{ADHD).*** For children and adolescents, impulsive behaviors and concentration problems can be diagnosed as ADHD ra­ ther than PTSD.

It is possible, however, for clients to legiti­ mately have any of these disorders in addition to trauma-related disorders. Given the overlap of posttraumatic symptoms with those of oth­ er disorders, a wide variety of diagnoses often needs to be considered to avoid misidentifying

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other disorders as **PTSD** and vice versa. **A** trained and experienced mental health profes­ sional will be required to weigh differential diagnoses. TIP 42 **(CSAT,** 2005c) explores issues related to differential diagnosis.

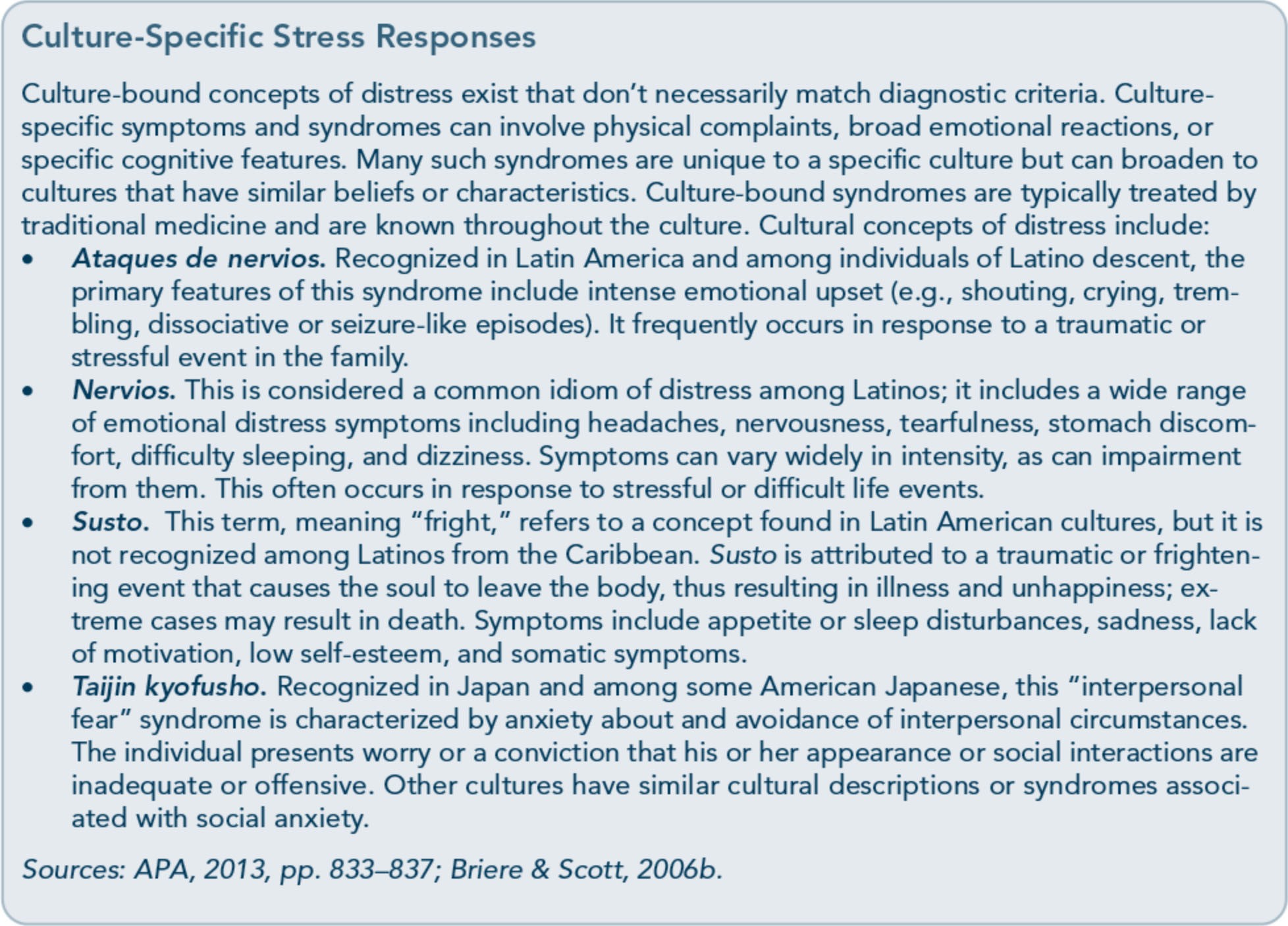
#### Cross-Cultural Screening and Assessment

Many trauma-related symptoms and disorders are culture specific, and a client's cultural background must be considered in screening and assessment (for review of assessment and cultural considerations when working with trauma, see Wilson & Tang, 2007). Behavioral health service providers must approach screen­ ing and assessment processes with the influ­ ences of culture, ethnicity, and race firmly in mind. Cultural factors, such as norms for ex­ pressing psychological distress, defining trau-

ma, and seeking help in dealing with trauma, can affect:

* How traumas are experienced.
* The meaning assigned to the event(s).
* How trauma-related symptoms are ex­ pressed (e.g., as somatic expressions of dis­ tress, level of emotionality, types of avoidant behavior).
* Willingness to express distress or identify trauma with a behavioral health service provider and sense of safety in doing so.
* Whether a specific pattern of behavior, emotional expression, or cognitive process is considered abnormal.
* Willingness to seek treatment inside and outside of one's own culture.
* Response to treatment.
* Treatment outcome.

When selecting assessment instruments, coun­ selors and administrators need to choose,



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whenever possible, instruments that are cul­ turally appropriate for the client. Instruments that have been normed for, adapted to, and tested on specific cultural and linguistic groups should be used. Instruments that are not normed for the population are likely to con­ tain cultural biases and produce misleading results. Subsequently, this can lead to misdiag­ nosis, overdiagnosis, inappropriate treatment plans, and ineffective interventions.Thus, it is important to interpret all test results cautious­ ly and to discuss the limitations of instruments with clients from diverse ethnic populations and cultures. For a review of cross-cultural screening and assessment considerations, refer to the planned TIP, *Improving Cultural Com­ petence* (Substance Abuse and Mental Health Services Administration, planned c).

##### Choosing Instruments

Numerous instruments screen for trauma his­ tory, indicate symptoms, assess trauma-related and other mental disorders, and identify relat­ ed clinical phenomena, such as dissociation.

One instrument is unlikely to meet all screen­ ing or assessment needs or to determine the existence and full extent of trauma symptoms and traumatic experiences. The following sec­ tions present general considerations in select­ ing standardized instruments.

Purpose

Define your assessment needs. Do you need a standardized screening or assessment instru­ ment for clinical purposes? Do you need in-

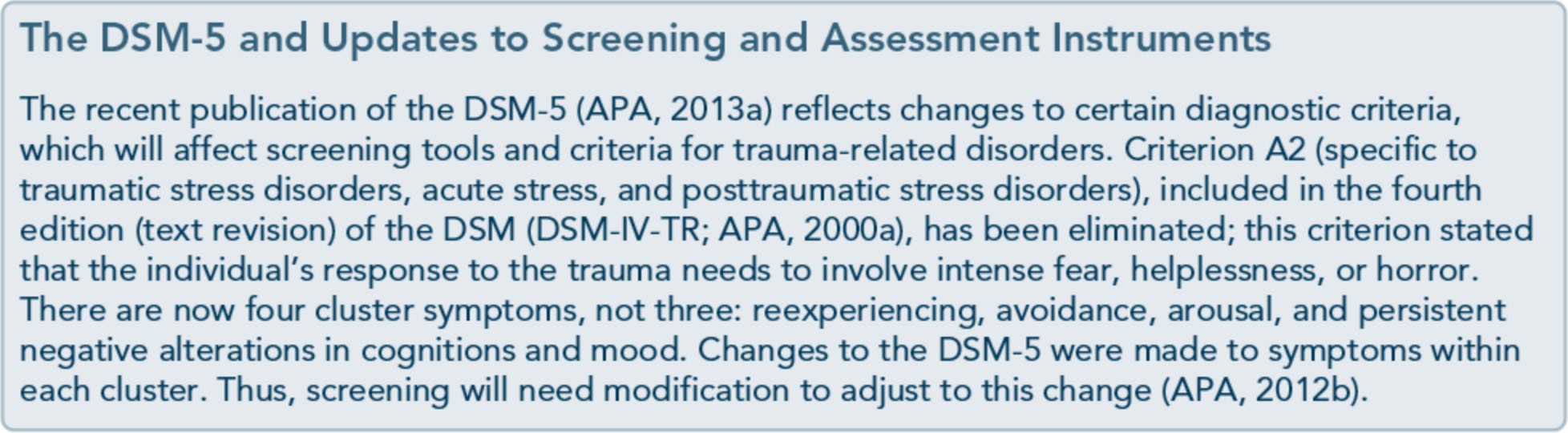
formation on a specific aspect of trauma, such as history, PTSD, or dissociation? Do you wish to make a formal diagnosis, such as PTSD? Do you need to determine quickly whether a client has experienced a trauma? Do you want an assessment that requires a clini­ cian to administer it, or can the client com­ plete the instrument himself or herself? Does the instrument match the current and specific diagnostic criteria established in the **DSM-5?**

Population

Consider the population to be assessed (e.g., women, children, adolescents, refugees, disaster survivors, survivors of physical or sexual vio­ lence, survivors of combat-related trauma, peo­ ple whose native language is not English); some tools are appropriate only for certain populations. Is the assessment process devel­ opmentally and culturally appropriate for your client? Exhibit 1.4-2 lists considerations in choosing a screening or assessment instrument for trauma and/or **PTSD.**

Instrument Quality

An instrument should be psychometrically adequate in terms of sensitivity and specificity or reliability and validity as measured in sever­ al ways under varying conditions. Published research offers information on an instrument's psychometric properties as well as its utility in both research and clinical settings. For further information on a number of widely used trauma evaluation tools, see Appendix D and Antony, Orsillo, and Roemer's paper (2001).



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**Exhibit 1.4-2: Key Areas of Trauma Screening and Assessment**

**Trauma**

*Key question:* Did the client experience a trauma?

*Examples of measures:* Life Stressor Checklist-Revised (Wolfe & Kimerling, 1997); Trauma History Questionnaire (Green, 1996); Traumatic Life Events Questionnaire (Kubany et al., 2000).

*Note:* A good trauma measure identifies events a person experienced (e.g., rape, assault, accident) and also evaluates other trauma-related symptoms (e.g., presence of fear, helplessness, or horror).

**Acute Stress Disorder (ASD) and PTSD**

*Key question:* Does the client meet criteria for ASD or PTSD?

*Examples of measures:* Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990); Modified PTSD Symptom Scale (Falsetti, Resnick, Resnick, & Kilpatrick, 1993); PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993); Stanford Acute Stress Reaction Questionnaire (Cardena, Koopman, Classen, Waelde, & Spiegel, 2000).

*Note:* A PTSD diagnosis requires the person to meet criteria for having experienced a trauma; some measures include this, but others do not and require use of a separate trauma measure. The CAPS is an interview; the others listed are self-report questionnaires and take less time.

**Other Trauma-Related Symptoms**

*Key question:* Does the client have other symptoms related to trauma? These include depressive symptoms, self-harm, dissociation, sexuality problems, and relationship issues, such as distrust.

*Examples of measures:* Beck Depression Inventory II (Beck, 1993; Beck et al., 1993); Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993); Impact of Event Scale (measures intrusion and avoidance due to exposure to traumatic events; Horowitz, Wilner, & Alvarez, 1979; Weiss & Marmar, 1997); Trauma Symptom Inventory (Briere, 1995); Trauma Symptom Checklist for Children (Briere, 19966); Modified PTSD Symptom Scale (Falsetti et al., 1993).

*Note:* These measures can be helpful for clinical purposes and for outcome assessment because they gauge *levels* of symptoms. Trauma-related symptoms are broader than diagnostic criteria and thus useful to measure, even if the patient doesn't meet criteria for any specific diagnoses.

**Other Trauma-Related Diagnoses**

*Key question:* Does the client have other disorders related to trauma? These include mood disor­ ders, anxiety disorders besides traumatic stress disorders, and dissociative disorders.

*Examples of measures:* Mental Health Screening Form Ill (Carroll & McGinley, 2001); The Mini­ International Neuropsychiatric Interview **(M.I.N.I.)** Structured Clinical Interview for DSM-IV-TR, Pa­ tient Edition (First, Spitzer, Gibbon, & Williams, revised 2011); Structured Clinical Interview for DSM­ IV-TR, Non-Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011a).

*Note:* For complex symptoms and diagnoses such as dissociation and dissociative disorders, inter­ views are recommended. Look for measures that incorporate DSM-5 criteria.

*Sources: Antony* et *al., 2001; Najavits, 2004.*

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Practical Issues

Is the instrument freely and readily available, or is there a fee? Is costly and extensive train­ ing required to administer it? Is the instru­ ment too lengthy to be used in the clinical setting? Is it easily administered and scored with accompanying manuals and/or other training materials? How will results be pre­ sented to or used with the client? Is technical support available for difficulties in administra­ tion, scoring, or interpretation of results? Is special equipment required such as a micro­ phone, a video camera, or a touch-screen com­ puter with audio?

##### Trauma-Informed Screening and Assessment

The following sections focus on initial screen­ ing. For more information on screening and assessment tools, including structured inter­ views, see Exhibit 1.4-2. Screening is only as good as the actions taken afterward to address a positive screen (when clients acknowledge that they experience symptoms or have en­ countered events highlighted within the screening). Once a screening is complete and a positive screen is acquired, the client then needs referral for a more indepth assessment

to ensure development of an appropriate treatment plan that matches his or her pre­ senting problems.

Establish a History of Trauma

A person cannot have **ASD, PTSD,** or any trauma-related symptoms without experienc­ ing trauma; therefore, it is necessary to inquire about painful, difficult, or overwhelming past experiences. Initial information should be gathered in a way that is minimally intrusive yet clear. Brief questionnaires can be less threatening to a client than face-to-face inter­ views, but interviews should be an integral part of any screening and assessment process.

If the client initially denies a history of trauma (or minimizes it), administer the questionnaire later or delay additional trauma-related ques­ tions until the client has perhaps developed more trust in the treatment setting and feels safer with the thoughts and emotions that might arise in discussing his or her trauma experiences.

The Stressful Life Experiences (SLE) screen (Exhibit 1.4-3) is a checklist of traumas that also considers the client's view of the impact of those events on life functioning. Using the SLE can foster the client-counselor relation­ ship. By going over the answers with the cli­ ent, you can gain a deep understanding of your client, and the client receives a demonstration of your sensitivity and concern for what the client has experienced. The National Center for PTSD Web site offers similar instruments ([http://www.](http://www/) ptsd.va.gov/professional/ pages/as sessments/assessment.asp).

In addition to broad screening tools that cap­ ture various traumatic experiences and symp­ toms, other screening tools, such as the Combat Exposure Scale (Keane et al., 1989) and the Intimate Partner Violence Screening Tool (Exhibit 1.4-4), focus on acknowledging a specific type of traumatic event.

**Screen for Trauma-Related Symptoms and Disorders in Clients With Histories of Trauma** This step evaluates whether the client's trauma resulted in subclinical or diagnosable disor­ ders. The counselor can ask such questions as, "Have you received any counseling or therapy? Have you ever been diagnosed or treated for a psychological disorder in the past? Have you ever been prescribed medications for your emotions in the past?" Screening is typically conducted by a wide variety of behavioral health service providers with different levels

of training and education; however, all

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**Exhibit 1.4-3: SLE Screening**

Please fill in the number that best represents how much the following statements describe your experiences. You will need to use l\ o scales, one for how" ell the statement describes your experiences and one for how stressful you found this experience. The two scales are below.

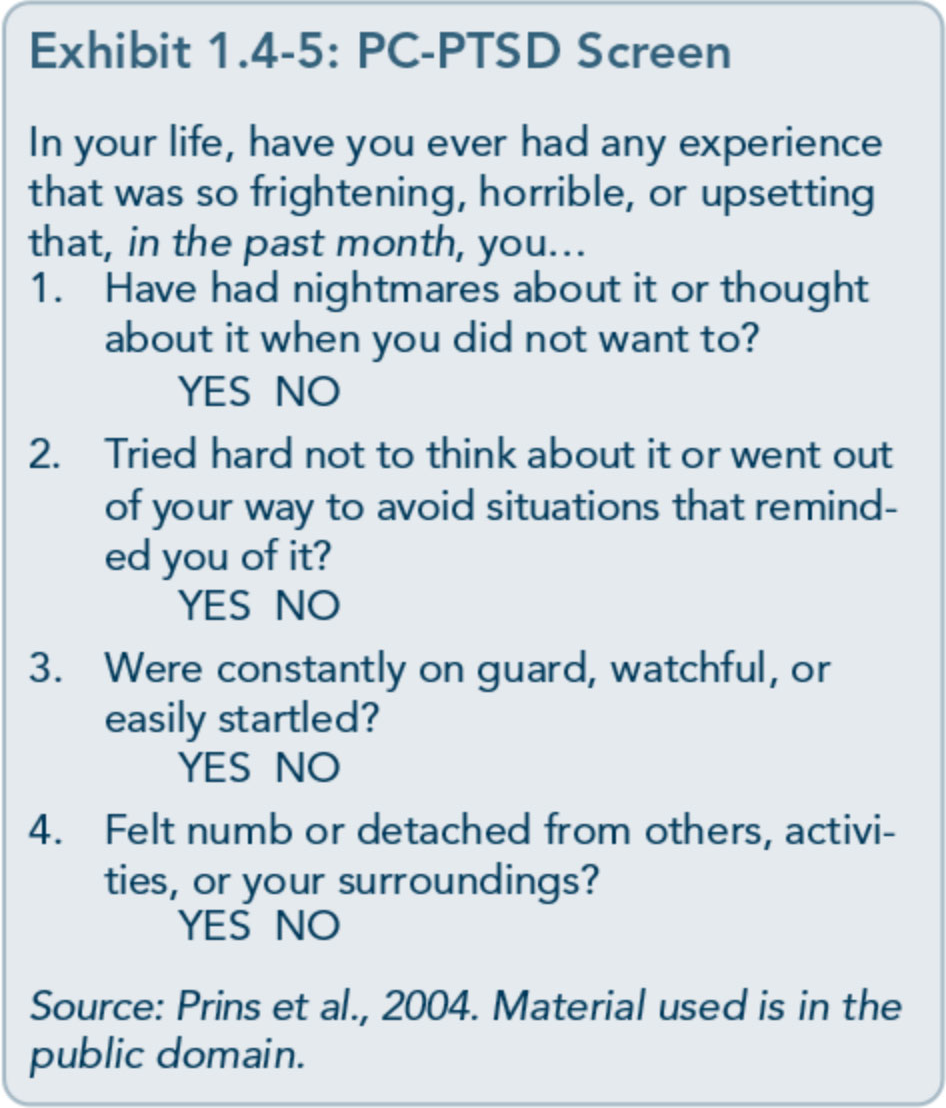
|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Describes your Experience: | | | | | | | | | | |
| 0 | I | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| O1dno1  experience tlu, | a hllle hke my expencnccs |  |  |  | ',Ome\\ hat hke my experiences |  |  |  |  | exactly hke my expcnences |
| Stressfulness of Experience: | | | | | | | | | | |
| 0 | I | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
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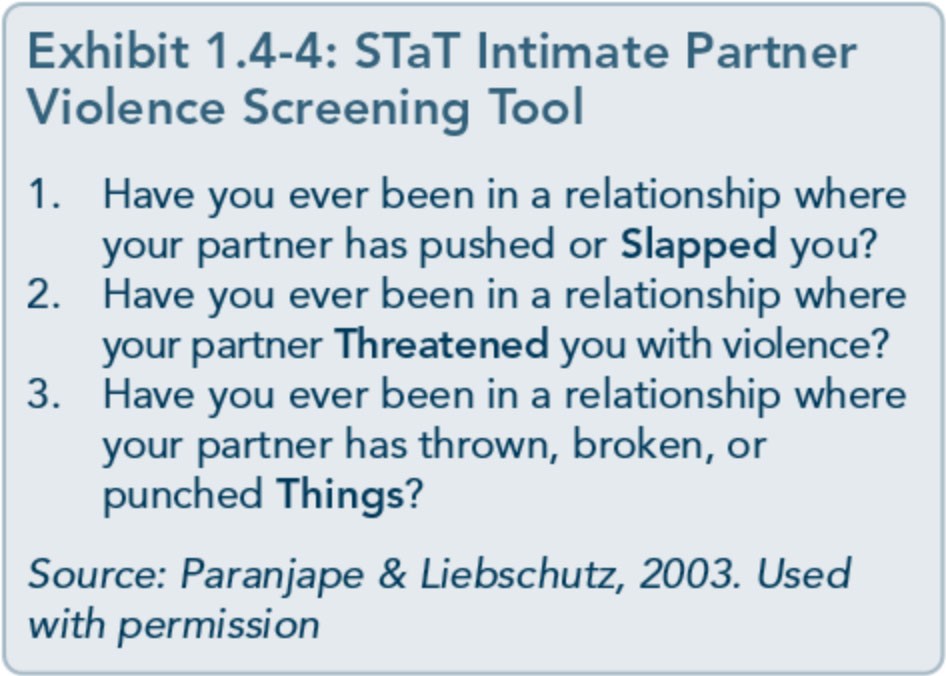
|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Describe, your Experience | Life Experience  I have witnessed or experienced a natural disaster; like a hurricane or earthquake. | Strc,sfulncss  !hen |  | Strcssfulnc.s  0\\ |
|  | I ha e witnessed or experienced a human made disaster like a plane crash or industrial disaster. |  |  |  |
|  | I have witnessed or experienced a serious accident or injury. |  |  |  |
|  | I have witnessed or experienced chemical or radiation exposure haooening to me, a close friend or a family member. |  |  |  |
|  | I ha e witnessed or experienced a life threatening illness  haooening to me, a close friend or a family member. |  |  |  |
|  | I have witnessed or experienced the death of my spouse or child. |  |  |  |
|  | I ha e witnessed or experienced the death of a close friend or  family member (other than my spouse or child). |  |  |  |
|  | I or a close friend or family member has been kidnapped or taken hostage. |  |  |  |
|  | I or a close friend or family member has been the ictim ofa  terrorist auack or torture. |  |  |  |
|  | I ha e been involved in combat or a war or Ii ed in a war alTccted area. |  |  |  |
|  | I have seen or handled dead bodies other than at a funeral. |  |  |  |
|  | I ha e felt responsible for the serious injury or death of another oerson. |  |  |  |
|  | I have witnessed or been attacked with a weapon other than in  combat or family setting |  |  |  |
|  | As a child/teen I was hit, spanked, choked or pushed hard enoue.h to cause injurv |  |  |  |
|  | As an adult, I was hit, choked or pushed hard enough to cause injury. |  |  |  |
|  | As an adult or child, I have witnessed someone else being  choked, hit, spanked, or pushed hard enough to cause injury. |  |  |  |
|  | As a child/teen I was forced to have unwanted sexual contact. |  |  |  |
|  | As an adult I was forced to have unwanted sexual contact. |  |  |  |
|  | As a child or adult I have witnessed someone else being forced to have unwanted sexual contact |  |  |  |
|  | I have witnessed or experienced an extremely stressful event not already mentioned. Please Explain: |  |  |  |

*Sources: Hudnall* Stamm, *1996, 1997. Used with permission.*

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individuals who administer screenings, regard­ less of education level and experience, should be aware of trauma-related symptoms, grounding techniques, ways of creating safety for the client, proper methods for introducing screening tools, and the protocol to follow when a positive screen is obtained. (See Ap­ pendix **D** for information on specific instru­ ments.) Exhibit 1.4-5 is an example of a screening instrument for trauma symptoms, the Primary Care PTSD (PC-PTSD) Screen. Current research (Prins et al., 2004) suggests that the optimal cutoff score for the **PC-PTSD** is 3. If sensitivity is of greater concern than efficiency, a cutoff score of 2 is recommended.

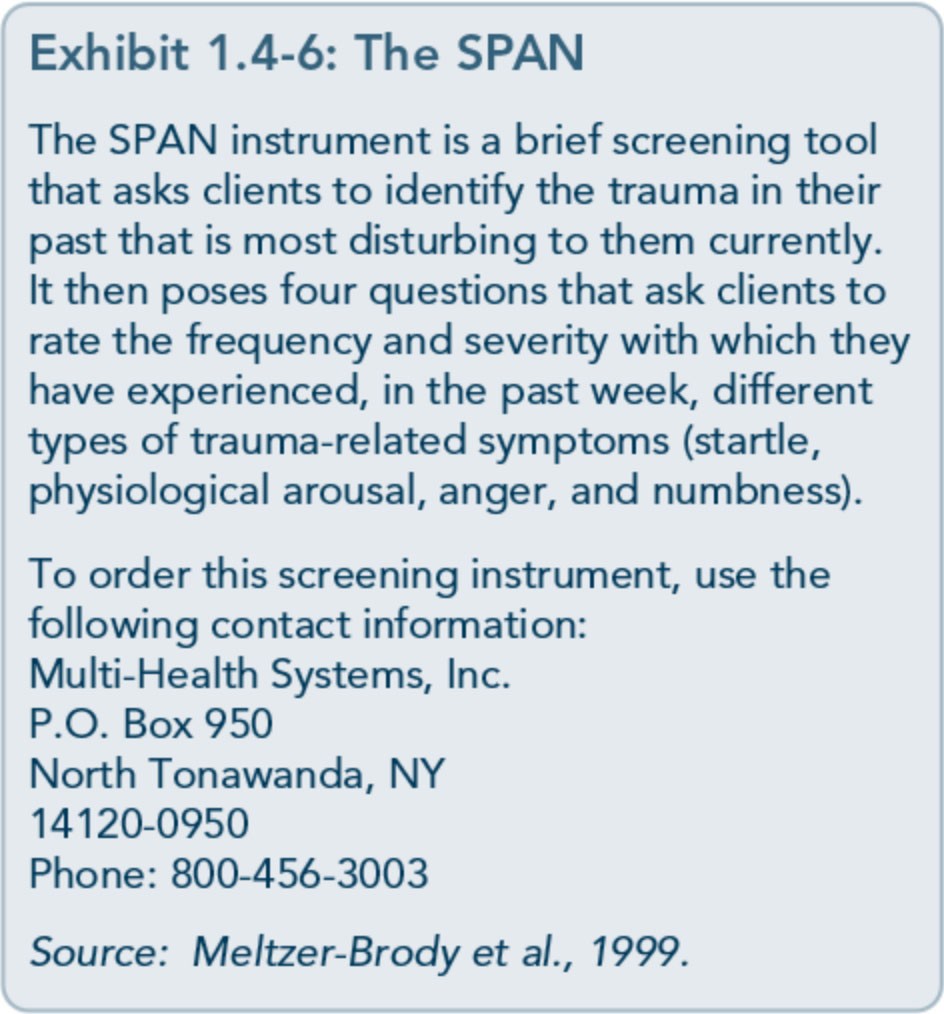
Another instrument that can screen for trau­ matic stress symptoms is the four-item self­ report **SPAN,** summarized in Exhibit 1.4-6, which is derived from the 17-item Davidson Trauma Scale (DTS). SPAN is an acronym for the four items the screening addresses: startle, physiological arousal, anger, and numbness. It was developed using a small, diverse sample of adult patients (N=243; 72 percent women;

17.4 percent African American; average age = 37 years) participating in several clinical stud­ ies, including a family study of rape trauma, combat veterans, and Hurricane Andrew sur­ vivors, among others.

The SPAN has a high diagnostic accuracy of

0.80 to 0.88, with sensitivity (percentage of true positive instances) of 0.84 and specificity (percentage of true negative instances) of0.91 (Meltzer-Brody, Churchill, & Davidson, 1999). SPAN scores correlated highly with the full DTS (r = 0.96) and other measures, such as the Impact of Events Scale (r = 0.85) and the Sheehan Disability Scale (r = 0.87).

The PTSD Checklist (Exhibit 1.4-7), devel­ oped by the National Center for PTSD, is in the public domain. Originally developed for combat veterans of the Vietnam and Persian



Part 1, Chapter 4-Screening and Assessment

Exhibit 1.4-7: The PTSD Checklist

**Instructions to Client:** Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully and circle the number that indi­ cates how much you have been bothered by that problem *in the* past *month.*

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   2. Repeated, disturbing dreams of a stressful experience?
      1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
      1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   4. Feeling very upset when something reminded you of a stressful experience?
      1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when some­ thing reminded you of a stressful experience?
      1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?
      1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   7. Avoiding activities or situations because they reminded you of a stressful experience?
      1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   8. Trouble remembering important parts of a stressful experience?
      1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   9. Loss of interest in activities that you used to enjoy?
      1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   10. Feeling distant or cut off from other people?
       1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
       1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   12. Feeling as if your future will somehow be cut short?
       1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
   13. Trouble falling or staying asleep?
       1. Not at all 2. A little bit 3. Moderately
   14. Feeling irritable or having angry outbursts?
       1. Not at all 2. A little bit 3. Moderately
   15. Having difficulty concentrating?
       1. Not at all 2. A little bit 3. Moderately
   16. Being "super-alert" or watchful or on guard?
       1. Not at all 2. A little bit 3. Moderately
   17. Feeling jumpy or easily startled?
       1. Not at all 2. A little bit 3. Moderately

4. Quite a bit 5. Extremely

4. Quite a bit 5. Extremely

4. Quite a bit 5. Extremely

4. Quite a bit 5. Extremely

4. Quite a bit 5. Extremely

*Source: Weathers* et *al., 1993. Material* used is *in the public domain.*

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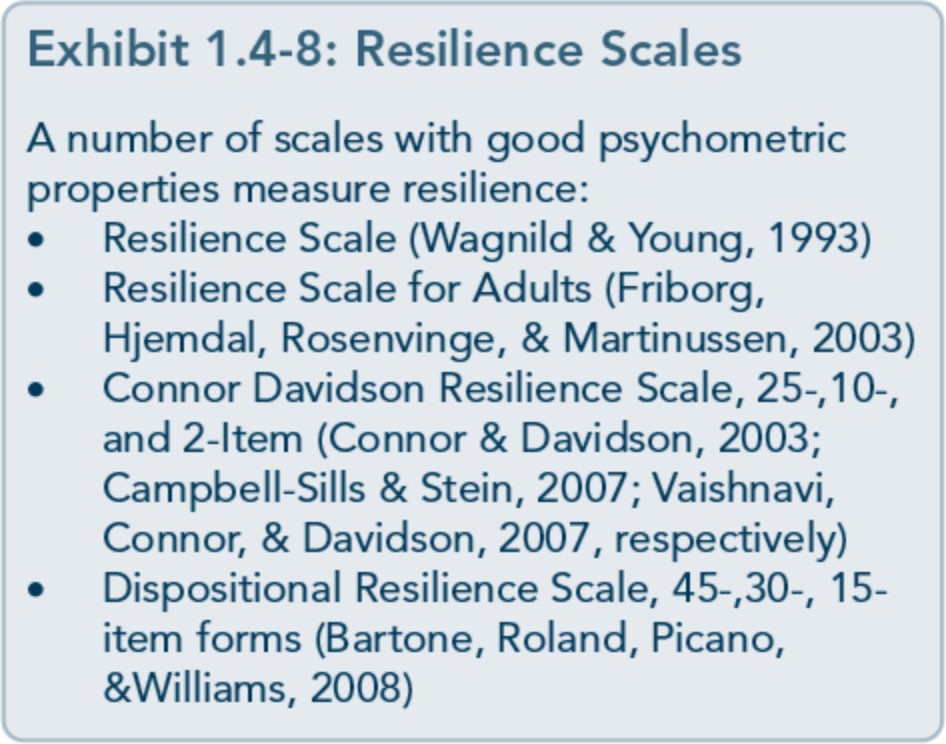
GulfWars, it has since been validated on a variety of noncombat traumas (Keane, Brief, Pratt, &Miller, 2007). When using the checklist, identify a specific trauma first and then have the client answer questions in rela­ tion to that one specific trauma.

Other Screening and Resilience Measures

Along with identifying the presence of trauma-related symptoms that warrant as­ sessment to determine the severity of symp­ toms as well as whether or not the individual possesses subclinical symptoms or has met criteria for a trauma-related disorder, clients should receive other screenings for symptoms associated with trauma (e.g., depression, sui­ cidality). It is important that screenings ad­

dress both external and internal resources (e.g., support systems, strengths, coping styles).

Knowing the client's strengths can significant­ ly shape the treatment planning process by allowing you to use strategies that have already worked for the client and incorporating strat­ egies to build resilience (Exhibit 1.4-8).



Preliminary research shows improvement of individual resilience through treatment inter­ ventions in other populations (Lavretsky, Siddarth, & Irwin, 2010).

***Screen for suicidality***

All clients-particularly those who have expe­ rienced trauma-should be screened for sui­ cidality by asking, "In the past, have you ever had suicidal thoughts, had intention to com­ mit suicide, or made a suicide attempt? Do you have any of those feelings now? Have you had any such feelings recently?" Behavioral

health service providers should receive training to screen for suicide. Additionally, clients with substance use disorders and a history of psy­ chological trauma are at heightened risk for suicidal thoughts and behaviors; thus, screen­ ing for suicidality is indicated. See TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a). For additional descriptions of screening processes for suicidality, see TIP 42 (CSAT, 2005c).

**Concluding Note**

Screenings are only beneficial if there are follow-up procedures and resources for han­ dling positive screens, such as the ability to review results with and provide feedback to the individual after the screening, sufficient resources to complete a thorough assessment or to make an appropriate referral for an as­ sessment, treatment planning processes that can easily incorporate additional trauma­ informed care objectives and goals, and availa­ bility and access to trauma-specific services

that match the client's needs. Screening is only the first step!

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