NCTSN The National Child Traumatic Stress Network

DECEMBER 2011

FACTS FOR POLICYMAKERS

Child and Adolescent Trauma Exposure and Service Use Histories: Highlights from the NCCTS Core Data Set

BACKGROUND

Authorized by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a federally-funded child mental health service initiative designed to raise the standard of care of and increase access to services for traumatized children and their families across the United States.

The NCTSN is an interdisciplinary network comprised of community-, university-, and hospital-based practice and research centers. The NCTSN addresses a broad range of trauma types and serves all age groups ranging from early childhood to young adulthood (0 to 21 years). The centers provide trauma-informed, evidence-based mental health treatment and other services to children in diverse settings, including child mental health, child welfare, schools, primary care, and juvenile justice systems.

Between 2004 and 2010, the NCTSN's National Center for Child Traumatic Stress (NCCTS) collected data on 14,088 children and adolescents served by 56 NCTSN service centers across the country. This study examined the prevalence of trauma exposure and service use among these NCTSN care recipients.

STUDY RESULTS

- Nearly 80% of children referred for screening and evaluation reported experiencing at least one type of traumatic event.
- Of the 11,104 children and adolescents who reported trauma exposure, 77% had experienced more than one type of trauma, 27% had experienced 3 to 4 types of trauma, and 31% had experienced five or more types.
- Children who experience trauma are involved with many different kinds of child-serving systems. Of those who had received services, 65% had

Recommendations

1. Approach issues relating to risk screening, case identification, prevention, intervention, workforce development, and public policy with a clear appreciation for the prevalence, diversity, and density of trauma exposure in youth referred for evaluation for trauma exposure.
2. Identify distinct subgroups of this at-risk population, such as chronically or multiply traumatized children and adolescents, to help inform efforts to design better services, interventions, and health care policies.
3. Conduct routine screenings and data collection to further understand the consequences of traumatic exposure on specific populations and how limited resources should be prioritized.

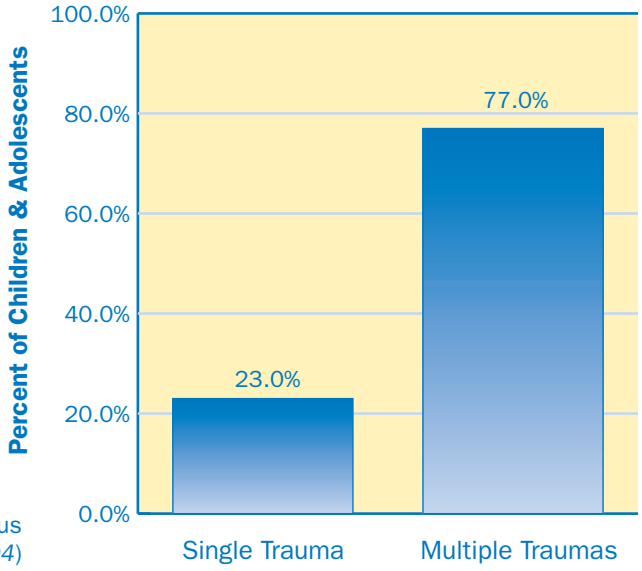


Figure 1. Percent of children who experienced single versus multiple trauma exposures (*n = 11,104*)

received social services and 35% had received school-based services (Briggs, Fairbank, Greeson, Steinberg, Amaya-Jackson, Ostrowski, Gerrity, Elmore, Belcher, & Pynoos, 2012).

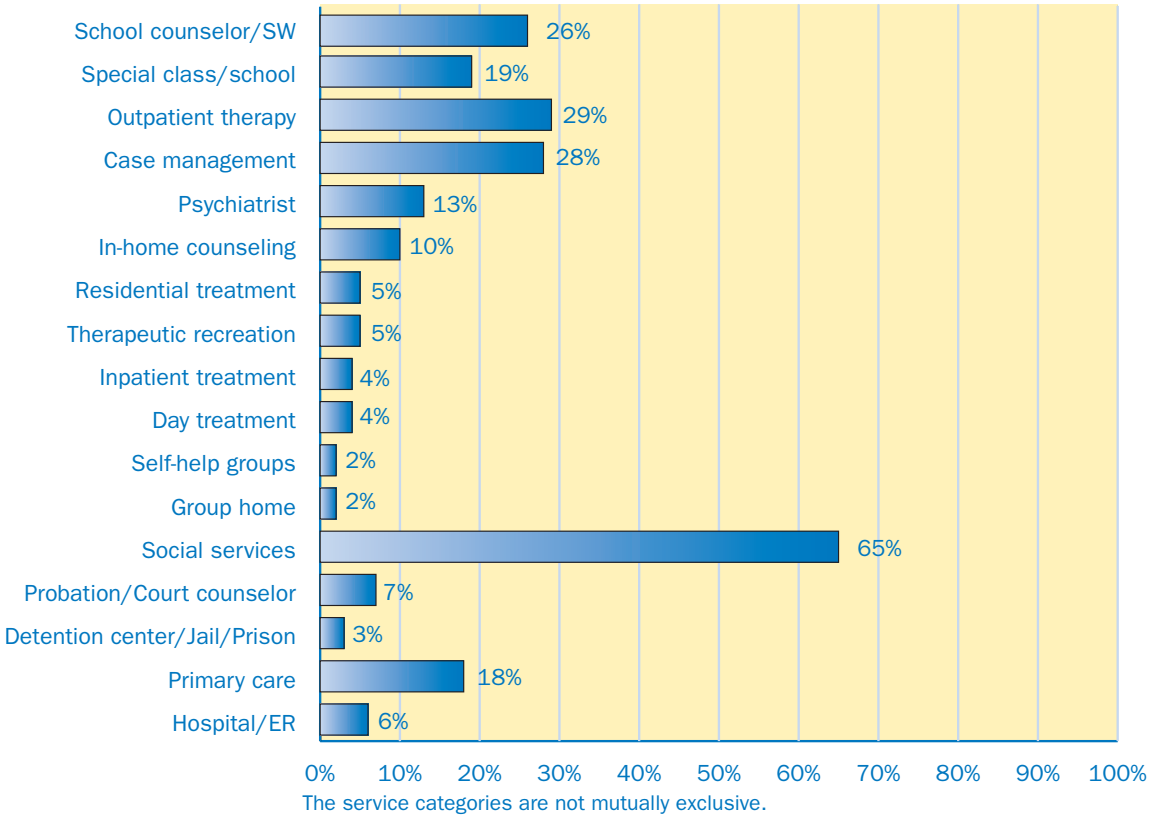
Although this high prevalence of lifetime trauma might be expected in a clinic-referred population, the density (number of types of trauma) and diversity in types of trauma exposures is striking.

These findings underscore the need for screening and assessment of high-risk populations to identify the number, types, and developmental timing of trauma exposures as well as targets for intervention (Layne, Ostrowski, Greeson, Briggs-King, & Olsen, 2010; Ostrowski, Greeson, Briggs-King et al., 2010).

POLICY IMPLICATIONS

The study's findings suggest that having a full understanding of the prevalence and diversity of trauma exposure in clinic-referred youth is an important guide in risk screening, prevention, intervention, workforce development, and public policy. Identifying distinct subgroups of this at-risk population, such as chronically or multiply traumatized youth, can inform our efforts to design better services, interventions, and health care policies and priorities.

Additionally, the findings underscore the need to conduct routine screenings and data collection to further understand the consequences of traumatic exposure on specific populations and to best prioritize the spending of limited resources. For example, children chronically exposed to trauma are especially susceptible to the effects of later trauma (APA Presidential Task Force, 2008) with both short- and long-term adverse consequences. Accordingly, we need to adopt systematic and comprehensive screening procedures so that, at intake, we identify children's trauma history—including the nature of their exposure and the implications for their development —and can select the appropriate evidence-based intervention. From studies of evidence-based interventions and recent findings that trauma-related, mental health conditions are highly treatable (Silverman, Ortiz, Viswesvaran et al., 2008), we know that adopting trauma-informed risk screening and triage procedures would be of benefit to children and youth receiving services. But children must first be identified and referred to appropriate care—steps that require an understanding of, and commitment to, routine trauma screening across all child-serving systems.



The service categories are not mutually exclusive.

Figure 2. Services utilized by children and adolescents during the 30 days prior to entering NCTSN center *(n = 11,104)*

Finally, the study reveals that children who experience trauma can be found in many different kinds of child-serving systems, not just mental health clinics. A commitment to screening and sharing information across settings will allow for early detection and opportunities for appropriate referral and follow-up care. Furthermore, we must educate child-serving professionals in all of these diverse settings about trauma-informed prevention and intervention efforts. A coordinated and collaborative team approach to care is especially beneficial for these vulnerable children and youth, who too often fall through the cracks, and whose trauma-related needs are unaddressed.

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