Child Abuse & Neglect 101 (2020) 104327

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg

Two-generational trauma-informed assessment improves documentation and service referral frequency in a child protection program

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ARTICLE INFO

Keywords:
Adverse childhood experiences
Trauma
Child abuse
Child neglect
Trauma-informed care
Trauma-informed assessment

ABSTRACT

Background: Two-generational trauma-informed assessment (TIA) helps providers conduct holistic family well-being assessment (FWbA). This tool makes it possible to use families' trauma history in the case-finding process.

Objective: This study compares the documentation and frequency of adverse childhood experiences (ACEs) and service referral rates for index children and their caretakers in two groups of families evaluated in a child abuse clinic (CAC).

Participants and setting: The sample consisted of 364 children stratified into two groups: Group 1 - children seen in the CAC after implementation of FWbA in years 2014, 2015, 2016 and Group 2 - children seen in the CAC prior to implementation of FWbA in years 2011, 2012, 2013.

Methods: Researchers utilized retrospective chart review method and analyzed data regarding ACEs and service referrals for patients and their caregivers.

Results: Documentation of ACEs was higher in Group 1 for children (77.7 % vs 26.6 %, $p < 0.0001$) and caretakers (60.7 % vs 7.3 % $p < 0.0001$). Caretakers in Group 1 had a higher rate of four or more ACEs (47.0 % vs 5.1 % $p < 0.001$) while the increase for children was not statistically significant (61.4 % vs 51.1 %, $p = 0.110$). Both children and caretakers were referred to more services in Group 1 (2.7 $\pm$ 1.5 vs 1.5 $\pm$ 1.3, and 3.0 $\pm$ 1.9 vs 1.2 $\pm$ 1.2, respectively, $p < 0.0001$).

Conclusions: In families evaluated for child abuse and neglect, conducting TIA in addition to

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https://doi.org/10.1016/j.chiabu.2019.104327
Received 12 July 2019; Received in revised form 21 November 2019; Accepted 10 December 2019

conventional psychosocial evaluation increased documentation regarding trauma history, which led to increased referral rates.

1. Introduction

The Adverse Childhood Experiences (ACE) Study has provided a framework for examining the effects of childhood trauma on neurodevelopment and behavioral, social, mental and physical health later in life (Blodget, 2015; Brooks-Gunn & Duncan, 1997; Centers for Disease Control and Prevention (CDC) (2010); Cronholm et al., 2015; Felitti et al., 1998). In their initial ACEs study, Felitti et al. (1998) surveyed patients seen at an obesity clinic in California to identify exposure to ACEs. The ACEs studied included physical, sexual, verbal, or emotional abuse, physical or emotional neglect, witnessing violence or substance abuse in the home, parental separation, and growing up with someone affected by mental illness or criminal behavior. They reported that the more ACEs a person was exposed to, the higher the association with poor health outcomes was as other authors concurred (Felitti et al., 1998).

Negative health outcomes associated with ACE exposure are the result of the toxic stress created by chronic trauma (Committee on Psychosocial Aspects of Child & Family Health et al., 2012; Middlebrooks & Audage, 2008). Toxic stress is defined as prolonged activation of stress response systems in the absence of protective relationships (National Scientific Council on the Developing Child, 2014). During times of toxic stress, brain circuit development and metabolic systems are disrupted due to adaptive neurobiological changes (Committee on Psychosocial Aspects of Child & Family Health et al., 2012; Elenkov & Chrousos, 2007; Johnson, Riley, Granger, & Riis, 2013; National Scientific Council on the Developing Child, 2014; TB et al., 2011). As a result of these changes, children have a harder time regulating their stress response and learning new skills including the development of age-appropriate problem solving skills (Committee on Psychosocial Aspects of Child & Family Health et al., 2012). Perpetuation of health risk behaviors may repeat the cycle of childhood adversity, child abuse and neglect, and these children face the risk of becoming adults with poor parenting behaviors (Ben-David, Jonson-Reid, Drake, & Kohl, 2015; Burke, Hellman, Scott, Weems, & Carrion, 2011; Felitti et al., 1998; Mersky, Topitzes, & Reynolds, 2013; Newcomb & Locke, 2001).

Many researchers and practitioners in the health care system have recognized that Trauma Informed Care (TIC) may be the needed paradigm shift to prevent ACEs and their impact on health (Burke et al., 2011; DeCandia, Guarino, & Clervil, 2014; Harris & Fallot, 2001; Huang et al., 2014; Oral et al., 2016). Trauma-informed care involves the following five techniques: 1) understanding the health effects of trauma, 2) patient-centered communication and care, 3) screening practices, 4) interprofessional collaboration, and 5) understanding the staff's own trauma history and reactions (DeCandia et al., 2014; Huang et al., 2014; Raja, Hasnain, Hoersch, Gove-Yin, & Rajagopalan, 2015). It is a multilevel, organizational framework to understand and to respond to the impact of trauma on both survivors and providers.

Trauma informed assessment (TIA) is a form of TIC and defined as conducting diagnostic assessments with a trauma informed, trauma sensitive, and resiliency focused approach by collaborating with the patients in interventional decision-making (Oral et al., 2016). In this care model, providers take into account trauma history, survival skills, and resilience in addition to the chief complaint. This allows the providers to find the most relevant services to resolve potential root cause problems in the treatment of illness. In addition, cognizance of an individual's previous trauma exposure may inform providers about their attitudes towards the provider-

Table 1
Documentation of ACEs among Child Participants and Their Caretakers by Group Designation.

			p
Documentation rate % (x+) of ACEs in children			
	Group 1^ (n = 176)*	Group 2 (n = 188)*	
	(n: 176 × 18 = 3168)**	(n: 87 × 18 = 1566) **	
	77.7 (2233) +	26.6 (899) +	< 0.0001
Documentation rate % of ACEs in primary caretakers			
	Group 1 (n = 322)***	Group 2 (n = 362) ***	
	(n: 322 × 18 = 5796)**	(n: 362 × 18 = 6516)**	
	61.5 (3563)+	7.2 (471)+	< 0.0001
Documentation rate % of ACEs in ALL caretakers			
	Group 1 (n = 370) ****	Group 2 (n = 376)****	
	(n: 370 × 18 = 6660)	(n:376 × 18 = 6768)**	
	60.7 (4039) +	7.3 (513) +	< 0.0001

ACEs: Adverse Childhood Experiences. x+ Number of all items on Family Well being Assessment trauma screening form that were not documented within group) ^ Group 1: Clients that received trauma informed Family Well-being Assessment in addition to conventional psychosocial assessment Group 2: Clients that received only conventional psychosocial assessment * n = number of child patients, whose chart was reviewed. ** n = The number of total possible answers to 18 documentable ACEs each chart was surveyed for. *** n = number of primary caretakers (mother, father, mother's or father's significant other) for child patients, whose chart was reviewed. **** n = number of all caretakers (mother, father, mother's or father's significant other, grandparents, other relatives) for child patients, whose chart was reviewed.