TRAUMA-INFORMED PRACTICE AND THE BRIEF TRAUMA QUESTIONNAIRE (BTQ)

ECDMH Training Collaborative

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Bureau of Justice Assistance, US Department of Justice

Erie County Department of Mental Health

Primary Care Research Institute, University at Buffalo

Hope of Erie County

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AGENDA

- Purpose and Scope of the BTQ
- Types of Trauma Captured by the BTQ
- Trauma-Informed Framework
- Trauma-Informed Administration of the BTQ
- BTQ Responses to Inform Decision-making
- Clinical and Ethical Considerations

PURPOSE AND SCOPE

HISTORY

Developed in 1999 by Schnurr et. al.

Created as a brief, structured way to identify trauma exposure without a full interview

Used in research, primary care, behavioral health and any trauma-informed setting

Identifies lifetime exposure to traumatic events

Uses a brief, structured set of questions

Focuses on exposure-not diagnosis or symptoms

Serves as an entry point for further screening and decision making

PURPOSE: WHAT THE BTQ DOES

SCOPE: WHAT THE BTQ DOES NOT DO

The BTQ does NOT require details or narrative

- It is not an interview
- It does not ask for stories or descriptions
- It avoids deep probing to protect emotional safety

The BTQ does NOT replace clinical judgment

- It is a starting point, not the full picture
- Results should be followed by: Clinical conversation/additional screening (if needed)

The BTQ

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)	No Yes	No Yes	No Yes
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, orchemical spill?	No Yes	No Yes	No Yes
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	*N/A*
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No Yes	No Yes	No Yes
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? Note: By sexual contact we mean any contact between someone else and your private parts or between you and some else's private parts	No Yes	No Yes	No Yes
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No Yes	*N/A*	No Yes
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No Yes	*N/A*	No Yes
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? Note: Do not answer "yes" for any event you already reported in Questions 1-9	No Yes	*N/A*	*N/A*

TRAUMA EXPOSURE SCREENING VS. DIAGNOSTIC ASSESSMENT

Exposure Screening	Diagnostic Assessment
What happened	How is this affecting you now
Identifies Exposure	Evaluates symptoms
Brief (y/n)	In-depth
NO symptoms assessed or diagnosis	Determines diagnosis
Guides planning and engagement	Guides treatment

WHO IS THIS FOR?

- Behavioral health → informs treatment planning
- Courts → improves compliance & outcomes, inform realistic expectations
- Probation/Parole → explains noncompliance and engagement challenges
- Police → supports safer, more informed interactions
- DSS/Children's Services → helps understand family instability and risk
- Homeless services → connects trauma to housing instability

TRAUMA INFORMED FRAMEWORK

WHY TRAUMA-INFORMED SCREENING MATTERS

Trauma is common in the populations we serve

Trauma often goes undisclosed unless it is asked about

Trauma-informed screening helps us respond appropriately

CORE PRINCIPLE: SAFETY

Physical and emotional safety are prioritized

People should feel secure, respected, and not threatened by the environment or process

Predictability and calm interactions help support engagement

BTQ SAFETY

No requirement for detailed recounting

Can be paused or stopped at any time

Why it matters:

Early service and other environments are already stressful

The BTQ avoids adding emotional risk during assessment

CORE PRINCIPLE: TRUSTWORTHINESS AND TRANSPARENCY

Be clear about what is happening and why

Communicate openly about expectations, decisions, and next steps

Consistency and honesty help build and maintain trust

BTQ TRUST & TRANSPARENCY

How the tool is introduced builds trust:

Clear explanation of purpose

Honest about how information will be used

No hidden agenda

This matters especially in where trust may already be low

Peer	Peer support and mutual self-help are key vehicles for establishing safety and hope
Strengthen	Lived experience can strengthen trust, connection, and engagement
Reduce	Peer relationships can reduce isolation and support recovery and healing

CORE PRINCIPLE: PEER SUPPORT

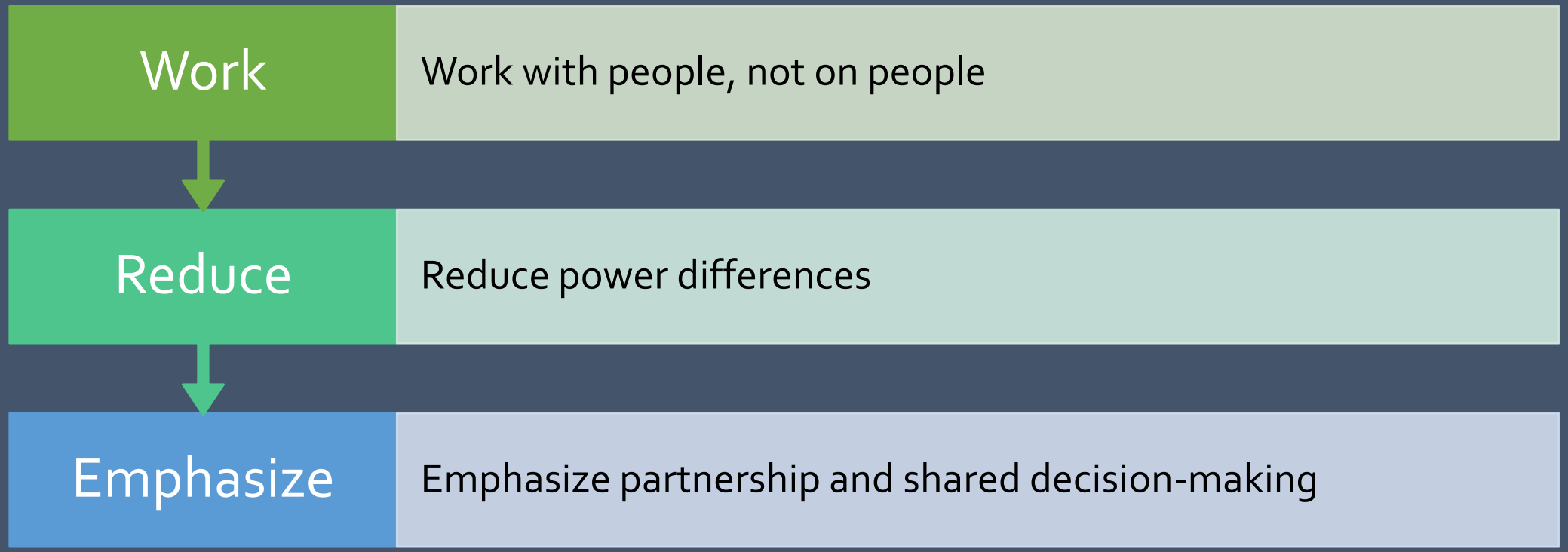
PEER SUPPORT & THE BTQ

Peers can support the BTQ process by helping clients feel safer, more understood, and more willing to stay engaged

In some programs, trained peers may help administer or support the screening process

If peers are not administering the BTQ, they can still be nearby for support

CORE PRINCIPLE: COLLABORATION AND MUTUALITY



BTQ COLLABORATION & MUTUALITY

It can be introduced as a shared process, not an interrogation

- It's a tool to help the team and the client better understand what supports may be helpful, rather than something being "done to" the person

It allows the person to participate with choice and control

It shifts the staff role from authority to partnership

- "Given what you've been through, what kind of support might help?"

CORE PRINCIPLE: EMPOWERMENT, VOICE &CHOICE

People should have a say in what happens to them

Focus on strengths, resilience, and capacity for recovery

Offer realistic choices and support autonomy whenever possible

BTQ CHOICE & AUTONOMY

The individual retains control throughout the process

Can skip questions

Can decline to answer

Can control pacing

Trauma-informed shift:

From mandated disclosure → to supported choice

Recognize	Recognize the impact of culture, identity, and lived experience
Be	Be aware of historical trauma, bias, discrimination, and systemic harm
Deliver	Deliver services in a way that is responsive, respectful, and equitable

CORE PRINCIPLE: CULTURAL, HISTORICAL, AND GENDER ISSUES

BTQ CONSISTENCY & FAIRNESS

The structured format ensures:

Same questions for everyone

Reduced bias from staff interpretation

Consistent thresholds for trauma exposure

Trauma-informed impact:

More equitable treatment across individuals

Less reliance on subjective judgment

TRAUMA INFORMED FRAMEWORK

- Promotes emotional safety through clear, structured, and predictable questions
- Limits unnecessary detail to reduce risk of re-traumatization
- Shifts the focus to “what happened” rather than “what’s wrong”
- Normalizes trauma exposure within a respectful, non-judgmental process
- Supports trust by creating consistency and transparency in screening
- Provides a foundation for person-centered, trauma-informed care planning
- Promotes choice and autonomy in how individuals engage and respond

TRAUMA-INFORMED ADMINISTRATION OF THE BTQ

INTRODUCE THE PURPOSE CLEARLY

Explain why you're asking

Set expectations: brief, yes/no, no details needed

"I'm going to ask a few yes/no questions about experiences that can help us understand what supports might be helpful."

USE NEUTRAL, SUPPORTIVE LANGUAGE

Stay calm and non-reactive

Avoid:

Pressure

Judgmental tone

Reactivity

DO NOT ASK FOR DETAILS

Probe

Ask follow-up narrative questions

Look for:

Withdrawal

Agitation

Silence

If needed:

Pause

Offer grounding

Reassure control

WATCH FOR DISTRESS

RESPOND, DON'T REACT

Do not:

Over-process

Try to treat in the moment

Instead: "I appreciate you letting me know."

CLOSE THE PROCESS SAFELY

Normalize experience

Reinforce next steps

“This helps us make sure you’re connected to the right supports.”

DO NOT

What NOT to Do

❌ “Tell me what happened”

❌ “Why didn’t you…?”

❌ Showing shock or judgment

❌ Pushing through distress

USING BTQ RESPONSES TO INFORM DECISION-MAKING

IDENTIFY NEED FOR FURTHER SCREENING

"Do we need to look deeper?"

Multiple exposures → referral or screen for PTSD symptoms

Trauma + substance use → referral or assess co-occurring disorders

High-risk events → consider safety assessment

Do we need to pay closer attention, slow things down, or bring in more support

DISTINGUISH EXPOSURE FROM SYMPTOMS

BTQ = history of exposure
Does NOT tell us:
Current distress
Diagnosis
Functioning
Decision:
Do not assume PTSD
Do refer or assess impact if indicated

INFORM LEVEL OF CARE AND PRIORITY

Patterns to look for:
Multiple or repeated trauma → ↑ clinical attention
Interpersonal violence → ↑ complexity
Early-life trauma → potential long-term impact
Decision:
Adjust intensity of services
Who needs more structure, more support, or more flexibility

CAN GUIDE REFERRALS

BTQ responses can point to:
Trauma-specific therapy
Substance use treatment
Peer support or recovery services
Case management / stabilization supports
Decision:
Who needs what kind of support

SHAPE ENGAGEMENT APPROACH

Use BTQ to inform:
Pace of services
Communication style
Expectations
Example:
If Trauma history → emphasize predictability, trust, flexibility

ACROSS SYSTEMS

- Courts → more realistic expectations, graduated responses
- Probation → supervision strategies that account for instability
- Police → de-escalation awareness
- Case managers → prioritizing stabilization (housing, basic needs)
- Peers → increased engagement and trust-building

SUPPORT CASE PLANNING

Integrate into:
Treatment plans
Reentry planning
Court decisions
Field interactions
Focus on:
Stabilization
Safety
Appropriate referrals

DIFFERENT ROLES, SAME GOAL

- Understand behavior more accurately
- Respond more effectively
- Keep people engaged
- Improve outcomes across systems

WHAT NOT TO DO WITH BTQ RESULTS

❌ Assume PTSD

❌ Label based on exposure alone

❌ Skip further assessment

❌ Ignore the information

CLINICAL & ETHICAL CONSIDERATIONS

AVOID RE-TRAUMATIZATION

- Do not ask for details or narratives
- Do not push for disclosure
- Monitor for distress and respond appropriately

👉 Principle: Do no harm during screening

CULTURAL HUMILITY AND CONTEXT

- Trauma is shaped by culture, identity, community, and historical experience
- Different people may understand, describe, or minimize trauma differently
- Staff should avoid imposing their own definition or interpretation too quickly

👉Trauma must be understood in context

RESPECT CHOICE AND AUTONOMY

- Participation is voluntary
- Clients can skip or stop at any time
- Avoid coercion or pressure

👉 Principle: Clients remain in control

MAINTAIN APPROPRIATE BOUNDARIES

- The BTQ is not therapy
- Do not process trauma during screening
- Stay within your role

👉 Principle: Screen, don’t treat

INFORMED CONSENT / CLEAR PURPOSE

- People should understand why the BTQ is being used
- They should know how the information may be used
- Screening should not feel misleading or hidden

👉Be clear about purpose before asking sensitive questions

CONFIDENTIALITY AND INFORMATION SHARING

- Be honest about who will see the information
- Clarify limits of confidentiality if applicable
- Avoid collecting trauma information that will not be protected or used responsibly

👉Sensitive information should be handled carefully and transparently

ROLE CLARITY

- The BTQ is a screening tool, not therapy
- Staff should stay within their role
- Trauma processing, diagnosis, and treatment planning may require a licensed clinician

👉Know the difference between screening, supporting, and treating

FOLLOW-UP RESPONSIBILITY

Screening creates an obligation to respond appropriately

If trauma exposure is identified, there should be a plan for:

- Referral
- Further screening
- Support
- Safety follow-up if needed

👉Don’t screen for trauma if there is no plan for what comes next.

MANDATORY REPORTING / SAFETY ISSUES

Some disclosures may raise:

- Child abuse concerns
- Elder abuse concerns
- Imminent safety concerns
- Staff should know reporting laws, procedures, and agency policy

👉Trauma screening may uncover issues that require action

AVOIDING OVER-INTERPRETATION

- A high BTQ score does not mean PTSD, and trauma history alone does not explain everything

- Staff should avoid making assumptions about diagnosis, risk, or motivation based on trauma exposure alone

👉Exposure gives context — it does not tell the whole story

TIMING AND READINESS

Avoid administering the BTQ when someone is:

- Highly dysregulated
- Intoxicated
- In acute crisis
- Medically unstable

👉Good screening also depends on good timing

SECONDARY TRAUMA / STAFF WELLNESS

Programs should support:

- Supervision
- Consultation
- Debriefing
- Boundaries

👉Trauma-informed systems *must* also support the workforce

INSIGHTS FROM HOPE –WHAT THE DATA SHOWS

TRAUMA EXPOSURE ≠ FAILURE—BUT IT PREDICTS COMPLEXITY

Higher BTQ scores (4+) =

- More missed appointments
- More relapse
- More crisis/housing instability
- More mental health diagnoses

Lower BTQ scores (0–2) =

- Stable engagement
- Faster completion
- Fewer relapses

Trauma doesn't mean someone won't succeed—it means they may need more support to get there

ENGAGEMENT IS THE STRONGEST PREDICTOR OF OUTCOMES—NOT TRAUMA HISTORY ALONE

Across all BTQ levels:

- Consistent engagement = success

Even high-trauma clients improved when:

  - They stayed connected
  - Used peer support
  - Had structure

THE BEHAVIOR WE SEE IS OFTEN THE IMPACT OF TRAUMA—NOT RESISTANCE TO THE PROGRAM.

High BTQ clients often had:

- "Noncompliance"
- Missed court and other appointments
- Avoidance
- Relapse tied to stress or triggers

IT'S NOT JUST WHAT SERVICES WE OFFER—IT'S HOW WE DELIVER THEM

Improved outcomes:

- Peer support
- Consistent case management
- Flexible engagement
- Trauma-informed approach

WHAT WE SEE IN THE DATA

Higher trauma → more complex needs, not less motivation

Engagement predicts success across all groups

Trauma often shows up as behavior, not disclosure

Trauma-informed approaches improve outcomes

Bottom Line

The BTQ doesn't just identify trauma—it helps us understand behavior and respond more effectively

REAL LIFE: KHAYLA

Case Timeline:

Entered care with multiple behavioral health and legal stressors after multiple DWI's and inpatient treatment

Referred via BDTC while balancing parenting, work, and court obligations.

Early instability included housing loss, transportation barriers, and inconsistent attendance to court and appointments.

Faced barriers including insurance lapse, financial stress, legal pressure, and marijuana-related mood struggles.

Recovery was uneven, with some reported substance-use setbacks, particularly around marijuana

HOW THE BTQ HELPED GUIDE US

IT IDENTIFIED TRAUMA THE CLIENT DID NOT INITIALLY RECOGNIZE

- The questionnaire helped surface a high trauma score and identified exposure to a serious MVA, a natural disaster, ACEs, assault, a serious injury, family violence, and witnessed a serious injury or death

IT CHANGED HOW WE UNDERSTOOD THE CASE

- Instead of seeing the case only as a substance use or court compliance issue, the BTQ suggested there were also trauma-related factors shaping the client's engagement and needs.

IT HELPED GUIDE LEVEL OF SUPPORT

The BTQ guided the level of support through trauma-informed case management, +peer support, and dual recovery therapy

IT HELPED SHAPE OUR INTERVENTION FOCUS

As the case progressed, the care plan emphasized things like:

- Mental health stabilization
- Trigger identification
- Coping strategies
- Time management
- Support-building

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IT HELPED EXPLAIN WHY PROGRESS WAS UNEVEN

The BTQ helped frame that uneven progress within a trauma-informed understanding of instability and competing stressors, instead of seeing setbacks as simply a lack of effort.

RESULTS

She stayed engaged in treatment and recovery planning

She engaged in DRT and used it productively and gained insight into trauma that she had not previously recognized

She worked toward reducing substance use, especially marijuana, and has had consistent negative toxicology screens

She showed motivation for change, improved money management, and regained license

She developed more self-awareness about the connection between trauma, mental health, and substance use

She progressed enough that she is preparing for graduation from court and Hope

REAL LIFE: CHARLES

Extensive trauma history: sexual assault and repeated violence

Severe MH/SUD complexity and chronic medical issues

Housing instability, legal problems, and repeated crises

Distrust of providers and fragmented engagement

Needed intensive, trauma-informed, cross-system support

BTQ'S ROLE

The BTQ helped frame the case as one with significant trauma burden, not just mental health and legal instability
It helped explain why the client showed distrust, anger, avoidance, and repeated crises across systems
It gave the team a stronger reason to approach the case with trauma-informed structure, persistence, and coordination, rather than relying only on compliance-based responses
It reinforced the need for intensive case management, crisis planning, housing advocacy, medication continuity, and cross-system collaboration

WHAT HELPED

Charles required intensive case management

The team coordinated across multiple systems, including parole, law enforcement, crisis services, APS, housing resources, benefits supports, and behavioral health agencies

Support efforts included motivational interviewing, crisis referrals, housing advocacy, SSI/HEAP assistance, anger-management efforts, medication access help, and transportation problem-solving

The team kept working toward routines, stability, and practical supports, rather than depending on one service to solve everything

SIGNS OF PROGRESS

- Even in a very unstable case, there were still small but meaningful signs of progress
- Charles showed some improved self-advocacy, including around rides and appointments
- He developed some new routines, including use of planners and structure, which suggested small gains in organization and self-management
- He adopted a cat, “Kitty,” which became an important source of emotional support and stabilization
- He had moments of gratitude and insight, even though the case remained highly challenging overall

RESULTS / FINAL TAKEAWAY

Charles remained high risk for decompensation, housing loss, and legal consequences

The case continued to involve cycles of anger, disengagement, distrust, and crisis, even with strong support

But the trauma-informed perspective helped the team focus on containment, coordination, and realistic support, rather than assuming the person was simply refusing help

This case shows that trauma-informed care is especially important in high-acuity, high-instability situations, where simple compliance approaches are often not enough

DISCUSSION

What stood out most to you from today's presentation?

How might the BTQ help us understand behavior differently?

What are the ethical risks of trauma screening if it is done poorly?

How often do you think trauma is present in the populations you work with, even when it is not directly disclosed?

What do you see as the biggest value of using the BTQ in your setting?

THANK YOU FOR YOUR TIME!

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SPECIAL THANKS TO OUR PARTNER ECDMH