Desk Guide on Trauma-Informed Mental Health for Child Welfare

Introduction to Trauma-Informed Mental Health for Child Welfare

Children and families who are involved in the child welfare system are likely to also interface with the mental health system either to address maltreatment issues or to address other general mental health concerns. Child traumatic stress refers to the physical and emotional responses of a child to events that threaten the life or physical integrity of the child or someone critically important to the child (e.g., a parent or sibling). Exposure to a single traumatic event that is limited in time (e.g., an auto accident, a gang shooting, or a natural disaster) is called an acute trauma. Chronic trauma refers to repeated assaults on the child's body and mind (e.g., chronic sexual or physical abuse, exposure to ongoing domestic violence, emotional or physical neglect). Finally, complex trauma is a term used by some trauma experts to describe both exposure to chronic trauma, often inflicted by parents or others who are supposed to care for and protect the child, and the immediate and long-term impact of such exposure on the child (Cook et al., 2005). Traumatic events may overwhelm a child's capacity to cope and may elicit intense emotional and physical reactions that can be as threatening to the child's physical and psychological sense of safety as the event itself.

Any child and/or adult who has experienced a traumatic event should be screened for traumatic stress symptoms. For those who are experiencing traumatic stress symptoms, a specialized mental health assessment may be necessary. Children who have experienced extreme trauma, such as repeated sexual abuse or witnessing the death of a caregiver may not need a screening and should be referred directly for an assessment. The assessment will determine the most appropriate treatment for the child, one that will help the child manage the trauma history and the associated cascade of impacts that follow. For a child, these effects may range from internal anxiety and stress, to adverse impacts on development, or externalizing symptoms that may be seen as behavioral or emotional disturbance, or both. Left unchecked, these symptoms can impair a child's ability to form secure attachments to caregivers, interact with others, learn in school, manage his/her emotions in ways that are socially acceptable, and to

> Resilience is the recovery of normal behavior after a traumatic event. It may be something that a child is born with, but it may also be built over time through repeated interactions with individuals who support and believe in them.

This guide is designed to assist child welfare workers and supervisors in understanding mental health services available for children and families in the child welfare system. Through their advocacy and support for appropriate services, child welfare professionals can help all children live in safe and stable homes and receive the support they need to thrive. The guide touches upon many subjects related to trauma and child welfare. There are also resource, glossary, and reference sections located at the end of this guide. In addition, there are two inserts that can be pulled out and displayed or placed in an area where they can be referred to on a regular basis. For more information about the topics covered in this guide, please visit www.ctisp.org to access the complete *Trauma-Informed Child Welfare Practice Toolkit*.

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CTISP Chadwick Trauma-Informed Systems Project

A Partner in NCTSN The National Child Traumatic Stress Network

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be safe from future maltreatment.

These trauma symptoms are sometimes misread by professionals as attention-deficit hyperactivity disorder (ADHD), conduct disorder, bipolar disorder, or other serious mental health disorders. On the other hand, trauma-exposed children in the child welfare system sometimes have more classic general mental health concerns, including behavioral problems (i.e., unrelated to trauma), depression, and anxiety, among others.

For parents involved in the child welfare system, the effects of trauma may range from depression, anxiety, and posttraumatic stress disorder (PTSD) symptoms (e.g., avoidance, re-experiencing, etc.), to an inability to regulate their emotions and control their anger, to engaging in high-risk behaviors such as substance abuse to cope with trauma triggers (Felitti et al., 1998). (Please see page 9 for more information on birth parents.)

It is important to note that, despite these challenges, many children and families are incredibly resilient. However, a child who is always quiet and may not be experiencing problems is not automatically resilient—they may be internalizing problems. Resilience in the face of trauma does not necessarily mean that the child was unaffected by the event. Rather, resilience is the recovery of normal behavior after a traumatic event. It may be something that a child is born with, but it may also be built over time through repeated interactions with individuals who support and believe in them.

Understanding how the mental health system is structured and the types of treatments that are provided, and ensuring that each individual child has access to the mental health intervention that meet his or her needs is critical for establishing and maintaining the safety, permanency, and well-being of children and families in the child welfare system. For more information on trauma and trauma-informed child welfare systems, please see the Background section in *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org.

Trauma and Development

A child's developmental age and stage has a substantial effect on how he/she perceives and processes a traumatic event. A traumatic event can lead to disruptions in a young child's overall development. A child's experience of and response to traumatic events may be affected by multiple factors and situations. Research has found that there are some common age-related patterns of response to trauma. However, due to developmental delays or due to children's tendency to display regressive behaviors in the face of trauma (e.g., a return to thumb sucking or bedwetting), many of these symptoms can occur at different times and/or overlap. See below and the next page for brief descriptions of how trauma can affect children at varying stages of development. For additional information on the impact of trauma on development, please see Chapter 1: The Role of Development in Vulnerability to and Responses to Traumatic Events in the *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* available in the toolkit or at www.ctisp.org.

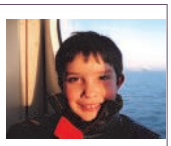
Infants and Toddlers

An infant or young child may be overwhelmed by events that an older child may not view as traumatic. A young child may become more quickly upset, agitated, and/or disorganized when talking about the event. This means that he/she may talk or play about the event and then quickly shift topic or activity when he/she becomes overwhelmed by the emotions associated with the trauma. Attachment plays a critical role in this stage of development. If a child receives attentive, soothing responses from her caregiver when distressed, she learns to develop her own coping skills and might be less likely to experience traumatic reactions after exposure to a traumatic event. A child whose caregiver is not attentive to his or her needs may develop an insecure or disorganized attachment and is likely to exhibit behavioral difficulties (e.g., aggression, withdrawal) and might be more difficult to soothe. These reactions can cause higher levels of frustration in his caregiver and, in turn, lead to maltreatment or attachment difficulties.

Preschool Children

A preschool child with traumatic stress symptoms may appear to lose skills or behaviors that had been previously mastered (e.g., bladder control) or may revert to behaviors that had been previously outgrown (e.g., thumb sucking). Similarly, a preschool child with traumatic stress symptoms may become clingy and may be unwilling to separate from familiar adults and resist leaving places where he/she feels safe (e.g., his/her home or classroom), or be afraid to go places that may cause a memory of a frightening experience to be remembered. Significant changes in eating and/or sleeping habits are also common, and a young child who has experienced trauma may complain of physical aches and pains (e.g., stomachaches and headaches) that have no medical basis. Attachment challenges, as noted in infants and toddlers above, may apply, and disruptive behaviors may also develop at this age, including early signs of attention and conduct difficulties.

Elementary School-Aged Children



An elementary school-aged child can more fully understand the meaning of a traumatic event, and this can result in feelings of depression, fear, anxiety, emotional "flatness," anger, or failure and/or guilt (Briggs-Gowan et al., 2010). Because of these feelings, a school-aged child may withdraw from his/her friends, show increased competition for attention, refuse to go to school, or behave more aggressively. He/she may also have difficulty concentrating, and his/her school performance may decline (Briggs-Gowan et al., 2010).

Adolescents

An adolescent who has experienced traumatic events may exhibit some of the same behavior changes seen in other age groups. However, an adolescent with traumatic stress symptoms may also isolate himself/herself, resist authority, or become highly disruptive. His/her distress, coupled with age-appropriate feelings of being invincible, may motivate him/her to experiment with high-risk behaviors such as substance use, promiscuous sexual behavior, or other risk-taking behaviors, such as driving at high speeds or picking fights.

The Role of Screening for Child Trauma and Referral to Mental Health

Given that many children in the child welfare system have trauma-related challenges, it is important that there is a way to identify the trauma-related needs of children through a screening process, and use this information to direct case planning efforts. The screening process itself is a therapeutic intervention and can set the stage for the assessment and treatment that follows. Many trauma screening tools are designed to be universal; that is, they are intended to be administered to every child within the child welfare system to determine if he/she should be referred for a comprehensive trauma assessment.

Trauma screening tools usually evaluate the presence of two critical elements: (1) exposure to potentially traumatic events/ experiences, and (2) presence of traumatic stress symptoms/ reactions. Other helpful information that can be gathered during the screening process is prenatal substance abuse, health concerns, and any developmental issues or concerns. Trauma screenings assist caseworkers in gaining a greater understanding of the types of traumatic events

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Developmental Corner
Trauma-Informed Care & Screening

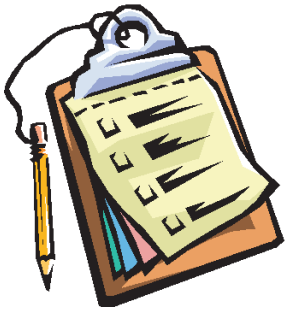
Approximately 40% of infants and toddlers and 50% of preschoolers involved in child welfare have serious developmental and/or behavioral problems (Stahmer, Collings, & Palinkas, 2005). These rates are much higher than in the general population, which range from 10-12% (First & Palfrey, 1994). It is very important that trauma-informed care includes all of the following:

1. Screening parents about their own developmental history (of speech delays/need for speech therapy, extra help in school including special education).
2. Screening the child directly for developmental problems.
3. Considering the trauma history of the child.

Genetics can contribute to delays in language and learning (Plomin, 2001), and trauma can also contribute greatly (Perry, 2001), so these children have more intensive needs for developmental screening, assessment, and treatment than children who have not been exposed to trauma and/or removed from their caregiver(s).

this child has experienced during his/her lifetime and to identify the types of events that may serve as trauma reminders for the child. Trauma screening information could also be informative to resource parents (e.g., foster, kinship, and adoptive parents), and along with special training, it might reduce the likelihood of a placement change request by helping resource parents manage the difficult behaviors. Finally, trauma screening plays a critical role in determining whether or not a child should be referred for general mental health treatment or trauma-focused treatment, or does not need treatment services at this time.

There are a number of ways to administer trauma screening tools, which may vary considerably based on local preference and the age and developmental stage of the child, as well as the child's relationship with the caregiver and other collateral informants in the child's life. These include a child-completed tool where the child is questioned directly, a caregiver-completed tool where the caregiver provides the information, and a provider-completed tool in which the provider uses existing data gathered from the investigation to determine the child's experiences and symptoms. There are pros and cons to each method. The type(s) of method chosen will depend on the age of the child, the presence and availability of caregivers who can provide reliable information on the child's history, and the availability of case files that provide information on the child's history and symptoms.



A number of commonly used trauma screening tools are available for use by child welfare workers for children across the developmental spectrum. With any tool that is used, it is important that the child welfare staff member who is completing the tool receives proper training and supervision in administration, scoring, and interpretation of the tools. Once the staff member has completed a trauma screening tool and determined that a child may benefit from a trauma assessment, he/she can refer the child to a mental health clinician. Sometimes, children may not display trauma symptoms early in the process. Therefore, periodic re-screening that coincides with a case review is a helpful way to ensure that children who exhibit trauma symptoms later in the process are identified as needed. For more information on screening, please see Chapter 9: Screening for Child Trauma within Child Welfare Jurisdictions in *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org.

Comprehensive Trauma-Focused Mental Health Assessment

Trauma-focused mental health assessment refers to a diagnostic process that is conducted by a trained trauma-informed mental health provider/clinician. This trauma assessment can determine whether a traumatic experience may be contributing to the child's symptoms, so that the child may benefit from a trauma -informed approach. The assessment can measure the severity of symptoms and impact on the child's functioning and also guide treatment planning. The assessment usually occurs over the first three

sessions, covers multiple domains, and includes several modes of data collection, including clinical interviews with the child/caregivers/collateral informants (e.g., teachers, clergy, etc.), administration of standardized measures, and behavioral observations. With young children who cannot report their own symptoms, more assessment sessions may be needed in order to observe the child with different caregivers and obtain reports of child functioning from multiple informants. A trauma-focused mental health assessment differs from other types of assessment, including a forensic assessment, as the information is used to identify and address the needs of children and families who have been impacted by trauma (Kisiel, Blaustein et al., 2009) and direct treatment planning efforts.

A first step in establishing assessment protocols may be to create an expectation within the child welfare community that an initial trauma assessment is a part of mental health best practices. Most treatment providers conduct some basic form of assessment when a child comes to treatment. This usually includes gathering demographic information, asking why the child and family are seeking help at the current time, and assessing the current problems and/or symptoms the child and his/her family are experiencing. In addition to these basic components, mental health professionals conducting trauma-focused assessments gather a thorough trauma history. In this type of assessment, the professionals attempt to identify all forms of traumatic events experienced or witnessed by the child (e.g., child abuse, any serious accidents, exposure to family or community violence, neglect by caregivers, painful medical procedures, or other types of traumatic experiences), when they were experienced, and any resulting behaviors or challenges.

Comprehensive trauma assessments conducted by mental health professionals use standardized clinical measures that are shown to be reliable (i.e., consistent over time) and valid (i.e., measure what they are supposed to be measuring). Using trauma-specific standardized clinical measures to identify the types and severity of symptoms the child is experiencing helps the mental health professional obtain a more thorough and focused history, devise an appropriate treatment plan, and track progress over time. Assessments help the mental health clinician gain a comprehensive understanding of the child as an individual with a unique history and family system, and evaluate his or her developmental, cognitive, and emotional functioning. For example, a comprehensive assessment assists the clinician in determining the co-morbidity of other diagnoses, such as Attention-Deficit Hyperactivity Disorder. From all of this, a *unique client picture* of the child is developed (Chadwick Center for Children & Families, 2009) and is used to determine the most appropriate treatment needs for the child. A child who can benefit from a specific evidence-based treatment can then be referred to the most appropriate intervention available in the community. When an evidence-based treatment approach does not exist for a certain cluster of symptoms or a more complex presenting problem, appropriate interventions can still be selected and utilized for the child (Chadwick Center for Children and Families, 2009). Assessment is an ongoing process, with periodic re-assessment occurring every 3 to 6 months to determine any changes in the child's behaviors, symptoms, or concerns.

It is important to note that in general, the purpose of a comprehensive assessment is NOT to provide recommendations regarding placement and visitation within the child welfare context. An assessment conducted as part of an intervention is usually very different from one that is conducted as part of a

Developmental Corner
Trauma-Informed Care & Assessment of Autism and/or Trauma

The symptoms of an Autism Spectrum Disorder (ASD) can look very similar to trauma symptoms and the two (autism and trauma) can co-occur (Rutter, Kreppner, & O'Connor, 2001). So it is important to ensure that the child with confusing symptoms receives an assessment with a clinician skilled to consider both autism and trauma or one that brings together skilled clinicians in each of these areas of expertise. Until it is clear, one must remain open and continually assessing the child's response to treatment. One may start with trauma treatment and ultimately need the behavioral approach that is more effective with ASD, or vice versa.

custody evaluation. For example, a custody evaluator generally interviews all relevant caregivers, lets the caregivers know they are being evaluated, and informs them that the assessment will be shared openly with the court. Therapists may work with only some family members and may not be in a position to make unbiased custody recommendations as they have not observed the child with the other caregivers.

Assessments help the mental health clinician gain a comprehensive understanding of the child as an individual with a unique history and family system, and evaluate his or her developmental, cognitive, and emotional functioning.

Therapists also try to ensure confidentiality, limiting what is shared with outside sources, so that family members feel safe enough to talk about and process traumatic experiences. When families feel that treatment information will be shared with the child welfare worker or courts, this may affect what they are willing to share with the therapist and may impede treatment progress. Therapists who work jointly with children and caregivers may not be able to share treatment details without the caregiver's consent since the caregiver retains his/her own rights to confidentiality even while minor's council may have the right to know about the child's treatment. Given all these factors, it is not recommended that therapists provide recommendations or suggestions for visitation or placement. Moreover, treatment is designed to be a source of support for the child and family and providing both custody recommendations and treatment would constitute a dual role for the therapist. A separate evaluation conducted by a different mental health professional with experience conducting such an evaluation should be done in order to answer questions related to placement and visitation. During this evaluation, however, therapist input should be sought. With appropriate consents, the therapist may be able to share information about treatment with an evaluator or minor's counsel.

As custody decisions are made, it is important to inform the therapist about potential changes in visitation so he/she can assist in preparing the child for these changes. For more information on trauma-focused mental health assessment, please see Chapter 10: Comprehensive Trauma-Focused Mental Health Assessment in *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org.

The Role of Trauma-Focused, Evidence-Based Mental Health Practices for Child Trauma

Children as young as six months can benefit from referral to a trauma-focused treatment provider.

Based on the results of the trauma-informed mental health assessment, a child may be referred for trauma-focused treatment. Children as young as six months can benefit from referral to a trauma-focused treatment provider as young children also display the effects of trauma through their interactions and attachment with their primary caregiver. The current research on treatment models for child traumatic stress suggests several common elements found in effective evidence-based trauma treatment. While many therapists may indicate that they are proficient at treating trauma because they have experience working with trauma-exposed children, that is not a guarantee that they are equipped to treat trauma-related symptoms. A trauma-informed treatment approach should include the following components:

- Parent support, conjoint therapy, or parent training (see pages 9-11 for working with parents/caregivers)
- A strong therapeutic relationship built over time
- Psycho-education (i.e., information on psychological principles that guide human behavior) to children and caregivers
- Emotional expression and regulation skills
- Anxiety management and relaxation skills
- Cognitive processing or reframing
- Strategies that allow exposure to traumatic

memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience
- Personal safety training and other important empowerment activities
- Resilience and closure

When talking with a therapist, a child welfare worker can listen for these components or ask the therapist to describe how he or she is incorporating these elements into the child's treatment plan (see Insert B for specific questions that a child welfare worker can ask).

While most mental health providers would be happy to have such a conversation, sometimes it may be difficult to engage a therapist in a conversation about a client's treatment goals, as some therapists may interpret questioning their treatment plan as questioning their professional judgment. Therefore, it is important for the child welfare worker to frame the conversation in a manner that reinforces the child and family as the priority, highlighting that the therapist and he/she share the same goals. It is appropriate for child welfare workers to ask therapists to discuss which treatment components they should expect the child to experience in the therapy. It is within the role of the child welfare worker to advocate for the child and ensure he or she is getting the right kind of therapy to address his or her specific needs.

It is also important that the child welfare worker has open communication with the therapist regarding the type of information the therapist will share with the child welfare worker. A goal of many trauma-informed treatments is to help family members openly talk about and process traumatic experiences and to enable caregivers to keep their children safe. In order to develop a relationship where caregivers feel safe enough to do this work and openly talk about traumatic experiences, many therapists only share information related to attendance and any required child abuse reports with child welfare workers.

Young Children, including Infants, Toddlers, and Preschoolers May Also Need Treatment

Research and clinical work clearly demonstrate that infants, toddlers, and preschoolers have the capacity to remember and be strongly affected by traumatic events (Gaensbauer, 2002; Peterson & Parsons, 2005). During the first five years of life, important brain structures and key hormonal stress response systems develop (Watamura, Donzella, Kertes, & Gunnar, 2004) as does the capacity to self-regulate, relate to others, and learn (Shonkoff & Phillips, 2000). Rather than being unaffected by trauma, young children may be especially vulnerable. Thus, it is critical that those working with young children recognize ways that they may respond to traumatic events and become familiar with effective treatments for young children.

Treatment should be individualized to meet the specific needs of the child receiving services. In some cases, a good treatment approach may blend together different treatments. In other cases, the child would benefit from an existing evidence-based practice that has research evidence (i.e., outcome studies published in a peer-reviewed journal) to support its use with the specific population. There are two terms which are often used interchangeably, but are actually different:

- Evidence-Based: Research evidence exists to support utilization of the entire practice with a specific population when joined with the best clinical experience and best fit to client and family values.
- Evidence-Informed: Research exists to support the use of components or pieces of the intervention.

One resource that looks at the research evidence for programs and assigns each program a rating is the California Evidence-Based Clearinghouse for Child Welfare (CEBC; www.cebc4cw.org, see box on next page). This website can help a child welfare professional learn about interventions therapists may use with their client(s) or that may be good for them in the future. On the CEBC, there are currently four trauma treatment programs for children and adolescents that are well-supported or supported by research evidence:

- Child-Parent Psychotherapy (CPP)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Prolonged Exposure Therapy for Adolescents (PE-A)
- Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

(CEBC, 2013)

While it is appropriate to request that the provider consider the suitability of a specific evidence-based model that appears to be a good fit with the child or

The California Evidence-Based Clearinghouse for Child Welfare
(www.cebc4cw.org)

This State of California-funded website launched in 2006 provides information on programs in over 35 topic areas pertaining to the child welfare system and the population they serve. For each program highlighted on the website, there is a standardized description along with, if applicable, a scientific rating based on the amount of research evidence (i.e., published, peer-reviewed research) the program has and an assigned level of relevance to the child welfare system. This website is accessed by over 12,000 unique visitors each month. The topic area on the website most related to trauma-informed mental health is Trauma Treatment (Child & Adolescent). The Trauma Treatment (Child & Adolescent) topic area has a few programs that are rated highly on the Scientific Rating Scale, see http://www.cebc4cw.org/topic/trauma-treatment-for-children/. While the title of the website would seem to indicate that all of the programs on the website are evidence-based, that is not the case. Over half of the programs are not able to be scientifically rated.

family, a competent mental health provider, who is knowledgeable about trauma and solid trauma assessment and skilled in evidence-based trauma treatment, should be given clinical discretion as to what model to employ and how to integrate various models and strategies. If no clinicians that have been trained on specific evidence-based practices exist within the child welfare jurisdiction, it is critical that therapists have at least received some training on the core components of trauma treatment and are able to integrate that knowledge into their work with children and families.

The duration of treatment is largely based on the type of treatment that is being provided. For example, the recommended length of treatment for children participating in Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is approximately 16-20 sessions. However, the length of treatment for children and families participating in Child-Parent Psychotherapy (CPP) is approximately 50 sessions. Further, for children with complicated and complex trauma histories, the duration of treatment may be longer to allow sufficient time for the child and therapist to build the therapeutic relationship, and help the child "master" the traumatic memories in tolerable doses and integrate them into his or her experience. Numerous other factors may affect the duration of treatment, including the engagement and participation of the child and family and complicating factors such as testifying in court, among others.

Treatment is considered complete when the client has met their treatment goals, which should be communicated clearly to the child welfare worker by the therapist. This means that the presenting symptoms, including trauma reactions, have been resolved. There may be times when the client will need to return to therapy, as trauma reactions can reappear during developmental or other life transitions. For example, if the child begins to exhibit symptoms of child traumatic stress, including difficulty eating or sleeping, difficulty concentrating, or trouble at school or with peers, it may indicate that the child should return to therapy. For more information on trauma-focused, evidence-based mental health practices, please see Chapter 11: Role of Trauma-Focused, Evidence-Based Mental Health Treatment for Child Trauma in *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org.

Developmental Corner
Trauma-Informed Care & Speech Delays or Cognitive Deficits

Children with speech delays or cognitive deficits will not progress as well or as expected in mental health therapy without having the developmental concerns addressed. Ideally, there is coordination of care between the speech/language therapist (if involved) and the mental health therapist, and the child can be expected to show improved progress with improvements in language development through treatment (Sroufe, 2012).

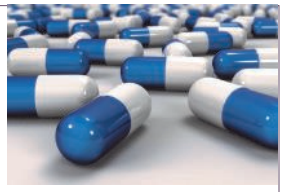
Certain children of trauma are particularly vulnerable to developmental delays that must be addressed as intensively as mental health treatment. For example, children with a Fatty Acids and Neurodevelopmental Disorder (FAND) or Fetal Alcohol Syndrome (FAS) have more problems with attention-deficit hyperactivity disorder (ADHD) whether or not related to trauma (O'Malley & Nanson, 2002), and great difficulties with math (Lebel et al., 2010). They are more likely to have cognitive deficits which should be known and considered when selecting the appropriate evidence-based practice for mental health/trauma treatment.

Trauma and Psychotropic Medication Among Children in Child Welfare

Trauma and psychotropic medication among children in child welfare is a complex issue. Children in the child welfare system have higher rates of developmental and mental health problems than the general public. Traumatic events often cause or exacerbate symptoms leading to mental health diagnoses, use of psychosocial interventions (i.e., interventions that use therapy alone), and, if warranted, use of psychopharmacological interventions (i.e., interventions that combine therapy and psychotropic medications), and yet treatment frequently fails to address the underlying trauma. Currently, there is no one medicine, or group of medicines, that are proven to be consistently effective for the treatment of trauma.

Generally, psychotropic medications are used as one treatment tool to reduce emotional suffering, improve safety from self-harm and harm to others, and improve functional abilities (e.g., attention span, impulse control, etc.). In addition, sometimes medications can help with the following symptoms:

- Irritable or angry mood
- Sleep problems
- Aggression
- Fear and anxiety
- Depression and sadness



Concerns about medication side effects, inadequate medical monitoring, excessive use of medications, and lack of expertise in prescribers add to the complexity. In 2012, an Information Memorandum from the Children's Bureau highlighted psychotropic medication usage among children in child welfare and many of the complexities of it. It can be found here: http://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf

As it can be difficult to be an expert in this set of issues, please see Chapter 12: Psychotropic Medication Use Among Children Exposed to Trauma in *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org. This chapter contains more information on the overall issue including types of medications and recommendations from the field, and includes a list of online resources.

Working with Birth Parents

Over the past several years, there has been a growing recognition that many parents who are involved in the child welfare system have their own histories of trauma and substance abuse. A recent study found that 61% of infants and 41% of older children in out-of-home care had a caregiver who reported active alcohol or drug abuse (Wulczyn, Ernst, & Fisher, 2011). Whether parents experienced the traumatic events during childhood or adulthood, these events can have a dramatic impact on their ability to engage in healthy and positive parent-child interactions, protect their children from harm, and help their children recover from traumatic events. A parent's trauma and substance abuse history may not only expose his or her child to higher risk for maltreatment, but can also impact the parent's ability to mitigate the impact of a trauma on the child. How a child responds and fares in the aftermath of a traumatic experience depends partly on his/her caregiver's ability to manage his/her own emotions related to the trauma, the caregiver's own trauma history, and the caregiver's ability to respond to the

Screening parents for trauma and substance abuse when they become involved with the child welfare system is a crucial step toward identifying those parents whose recent and/or past traumas continue to have a negative impact on their parenting and ability to protect their children from future harm.

child and re-establish safety (Ghosh Ippen & Lieberman, 2008). A parent who has an unresolved trauma history is less likely to be able to manage his/her own emotional reaction and, therefore, less likely to be able to support the child. In fact, it is common for a child's traumas to trigger his/her parent's own traumatic memories, which can interfere with the parent's ability to react to his/her child in a protective and supportive manner and could lead the parents to engaging in maladaptive coping mechanisms, such as engaging in substance abuse.

Child welfare system interventions, such as removal of children from their parents, can be highly distressing for parents and can serve as reminders of parents' past traumatic memories and further impede parent functioning. Across multiple studies (Linares et al., 2001; Lieberman, Van Horn, & Ozer, 2005), caregiver functioning has been found to be a major predictor of child functioning following the child's exposure to traumatic experiences. Thus, a trauma-informed child welfare system needs to support the caregivers and provide intervention for the caregivers' symptoms if it hopes to improve child outcomes. Failure to understand and address parent trauma can lead to:

- Failure to engage in treatment services
- An increase in symptoms
- An increase in management problems
- Re-traumatization
- An increase in relapse
- Withdrawal from service relationship
- Poor treatment outcomes

(Oben, Finkelstein, & Brown, 2011)

Screening parents for trauma and substance abuse when they become involved with the child welfare system is a crucial step toward identifying those parents whose recent and/or past traumas continue to have a negative impact on their parenting and ability to protect their children from future harm. For parents who have their own history of trauma and substance abuse, using the results of the screening to link them to evidence-based trauma treatments that attend to both their trauma and substance abuse needs will assist them in recognizing the impact of trauma on their current parenting. Examples of such practices include:

- Seeking Safety (Najavits, 2002)
- The Trauma Recovery and Empowerment Model (TREM: Harris & The Community Connections Trauma Work Group, 1998)
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET: Ford & Russo, 2006)
- Helping Women Recover/Beyond Trauma/Helping Men Recover (Covington, 2003; Covington, 2008; Covington, Griffin, & Dauer, 2011)

These treatment modalities can assist parents in overcoming past traumas and increase their ability to protect their children, thereby enhancing child safety, permanency, and well-being. For more information on birth parents, please see Chapter 13: Using Trauma-Informed Services to Increase Parental Protective Factors in *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org.

Working with Substitute Care Providers

Although the vast majority of children entering out-of-home care have trauma histories, most substitute care providers are not provided training on the impact of trauma or how to manage trauma reactions, nor are they given adequate support to help them cope with issues related to child traumatic stress. Substitute care providers include anyone who cares for a child in out-of-home care, including kin, resource parents, and group home workers among others. These care providers are often the ones who can have the biggest impact on a child's recovery from trauma, as they are usually the ones who are spending the most time with the child on a daily basis. They have a vital role in nurturing resiliency and healing in any child in their care who has experienced trauma. A child's trauma reactions can create serious challenges for caregivers, and if these reactions are not understood in the context of trauma, they can lead to placement

disruptions. As placement instability impedes a child's chances of reunifying or being adopted (Fisher, Kim, & Pears, 2009), it is imperative that the child welfare system provide appropriate education and support to substitute care providers to reduce the number of placement disruptions.

A child who has experienced trauma often overreacts to environmental stimuli that remind him/her of the trauma called trauma triggers. This behavior can be confusing and frustrating for substitute care providers who do not understand the source of the distress. Even when a child is placed in a safe environment, it may take a long time to regain a sense of psychological safety, or feeling safe. A child with a trauma history and related behavioral reactions is likely to exhibit a worsening of these reactions each time he/she has a disrupted placement (Newton, Litrownik, & Landsverk, 2000). A child with disrupted placements often blames himself/herself and comes to believe that he/she is unlovable and unwanted and that it is not safe to get close to substitute care providers for fear of further rejection or abandonment.

It is important that substitute care providers are viewed as true members of the child's team. Engaging substitute care providers early in the process and involving them in the case plan as appropriate is integral to providing a continuum of support and care for the child. Encouraging substitute care providers to be a part of the treatment process as well can help support the child, ensuring that they are receiving the same training and support from the therapy that the child is receiving. For example, substitute care providers can assist the child in practicing relaxation exercises when the child is anxious, or in helping them link their thought, feelings and behaviors and address cognitive distortions. For more information on substitute care providers, please see Chapter 14: Trauma-Informed Caregiving: Working with Substitute Care Providers in *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org.

Working with Mental Health Professionals

The mental health and child welfare systems are different cultures with different demands placed upon their time. However, they share a single priority of helping children recover from traumatic events. Effective communication across these systems is critical in meeting the needs of children in the child welfare system. While both systems strive to improve the quality of life for the child and family, they have separate mandates.

Typically, mental health professionals in community outpatient clinics see a large number of clients with various challenges and difficulties. These professionals usually have a *productivity* standard, which means that they are required to see a certain number of clients each week in order to meet their agency's budget expectations. For example, a full-time therapist at a community agency may be expected to meet with 26 clients a week to meet their productivity standard. Often, this means that they book 3-5 additional clients a week to ensure that they end the week having met with 26 clients to account for no-shows, cancellations, etc. Further, therapists often have expectations for supervision, agency meetings, and paperwork that amount to another 10 hours a week. Therefore, it is not uncommon for therapists to meet with clients back to back and spend the time in between sessions making collateral contacts, trying to return phone calls, or completing the necessary paperwork.

As with many helping professions, the paperwork demands on the mental health professional can be quite significant. Documentation requirements vary depending upon the funding source and across individual agencies. However, in general, therapists are required to write notes and bill for every client and collateral interaction, complete multiple treatment

plans, and complete initial and ongoing assessments for each client they see, and provide updates and letters to the other professionals in the child's life. This can amount to a significant amount of time that is devoted each week to meeting the necessary paperwork requirements.

Therefore, in order to better achieve positive outcomes for children and families, it is critical for child welfare and mental health to collaborate, understand each other's perspective, and hold each other accountable. While both systems have multiple expectations and challenges, their partnership is critical in better serving children and families.

Coordinating Services with Other Agencies

Children and families involved in the child welfare system are more likely than not to be involved with and receiving services from multiple individuals and agencies that may or may not be working in collaboration. In addition to public child welfare agencies, these may include mental health agencies, private non-profit child welfare and social service agencies, substance abuse and domestic violence programs, the courts, resource parents, child advocacy centers, schools, and public health, among many others. Effective collaboration occurs on both the community and individuals levels. On the community level, child welfare agencies must work with other child and family-serving agencies in their jurisdiction to ensure that they meet their common goals and provide collaborative care to children and families. On the individual level, caseworkers must work closely with other individuals involved in the case, such as the child's birth family, resource parents, and other individual providers serving the child and family, to ensure a continuum of care.

When safe and appropriate, individual coordination between the birth parent, child welfare caseworker, the mental health therapist, and the resource parent is critical in assisting the child and his/her family along a more positive trajectory. In cases where the birth parent has unsupervised visitation, it is incredibly helpful to integrate him/her into the therapy process to provide him/her with the tools and skills needed to manage some of the child's challenging behaviors. For example, if the child and his/her foster parent are receiving mental health services such as Parent-Child Interaction Therapy (PCIT; Eyberg, 1988) to assist the foster parent in managing the child's behavior, the birth parent should also have his/her own PCIT sessions with the child. In addition, it is helpful for the mental health therapist to inform the caseworker of the child's progress in therapy, since this input assists the caseworker in managing the case and making the best decisions regarding services for the child and his/her family. It should be noted that parental involvement will vary on an individual basis depending on safety issues. For example, in cases of domestic violence, involvement of the offending parent may lead to further risks within the family and also for the agency. Parent involvement should be carefully considered on a case-by-case basis.

It may be helpful to add that it is important that child welfare workers communicate to the therapist when the birth parents have completed their own services and are available to participate in their children's treatment. Sometime this information is not provided and parents can lose out on engaging in their children's treatment. For more information on coordinating services, please see Chapters 6: Applying a Trauma Lens to Child Welfare Practice and 15: Collaborating with Other Agencies in *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org.

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Online Database:

National Child Traumatic Stress Network Measures Review Database New: http://www.nctsn.org/resources/online-research/measures-review

Online Resources:

The Adverse Childhood Experiences (ACE) Study website: http://acestudy.org

California Evidence-Based Clearinghouse for Child Welfare (CEBC) website: http://www.cebc4cw.org/

National Children's Alliance website: www.nationalchildrensalliance.org

Substance Abuse and Mental Health Services Administration's National Registry of Effective Programs and Practices (NREPP) website: http://nrepp.samhsa.gov/

The Women, Co-Occurring Disorders, and Violence Study website: http://www.wcdvs.com/

Online Trainings:

Chadwick Center for Children and Families - Online training modules for the TAP Model (*Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model):* http://www.taptraining.net/

Medical University of South Carolina: Online training for Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT): http://tfcbt.musc.edu/

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Resources (cont.)

National Resource Center for Permanency and Family Connections: A Web-based Placement Stability Toolkit: http://www.nrcpfc.org/pst/index.htm

Organizations:

Zero to Three: National Center for Infants, Toddlers and Families website: http://www.zerotothree.org

National Child Traumatic Stress Network website - Early Childhood Trauma section: http://www.nctsn.org/trauma-types/early-childhood-trauma

National Child Traumatic Stress Network (NCTSN): Additional resources are also available through the NCTSN website: http://www.nctsn.org/

National Center on Substance Abuse and Child Welfare website: http://www.ncsacw.samhsa.gov/

Webinar:

Zero to Six Child Welfare Speaker Series: http://learn.nctsn.org/course/view.php?id=66

Glossary of Terms

Acute Trauma - Exposure to a single traumatic event that is limited in time (e.g., an auto accident, a gang shooting, illness/accident resulting in hospitalization, or a natural disaster).

Adverse Childhood Experiences (ACEs) - Certain life experiences that serve as major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. These include childhood experience of abuse, neglect, and family dysfunction.

Adverse Childhood Experiences (ACE) Study - One of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. It examined 17,000 Health Maintenance Organization (HMO) members who completed a questionnaire about their childhood experience of abuse, neglect, and family dysfunction. The findings suggested that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States.

Anxious-Ambivalent Attachment - A type of insecure attachment orientation in which the caregiver is unpredictable or out of sync with the child.

Anxious-Avoidant Attachment - A type of insecure attachment orientation in which the caregiver is emotionally unavailable or rejecting.

Attachment - The primary emotional relationship with a caregiver that serves as the basis for all later relationships. Children and parents are biologically wired to form attachments with each other. There are four types of attachment: Secure, Anxious-Ambivalent, Anxious-Avoidant, and Disorganized. (See separate definitions within this Glossary of Terms.)

Child Traumatic Stress - The physical and emotional responses of a child to events that threaten the life or physical integrity of the child or someone critically important to the child (e.g., a parent or sibling).

Childhood Trauma - Experiencing a serious injury to oneself or witnessing a serious injury to or the death of someone else during childhood. Also includes facing imminent threats of serious injury or death to oneself or others, or experiencing a violation of personal physical integrity during childhood.

Glossary of Terms (cont.)

Chronic Trauma - Repeated assaults on the child's body and mind (e.g., chronic sexual or physical abuse, exposure to ongoing domestic violence, emotional or physical neglect)

Complex Trauma - Describes both exposure to chronic trauma, often inflicted by parents or others who are supposed to care for and protect the child, and the immediate and long-term impact of such exposure on the child

Diagnostic and Statistical Manual of Mental Disorders - Manual written and published by the American Psychological Association in Washington, DC, which is used by mental health professionals to diagnose mental disorders in children and adults. It is usually abbreviated DSM and the Roman numeral following it designates which version of the manual the citation is referring to (e.g., DSM-III [1980], DSM-III-R [1987], DSM-IV [1994], DSM-IV-TR [2000]).

Disorganized Attachment - A type of insecure attachment orientation in which the caregiver is both a source of comfort and a source of fear.

Evidence-Based Practices - The Institute of Medicine (IOM) defines "evidence-based practice" as a combination of the following three factors: (1) Best research evidence; (2) Best clinical experience, and (3) Consistent with patient values.

Evidence-Informed Practices - A term used to describe useful practices. A promising practice indicates a practice or approach that has not been evaluated as rigorously as an evidence-based practice, but that still offers ideas about what works best in a given situation.

Externalizing Symptoms - These symptoms or behaviors are those that are directed outward. They include things such as aggression towards others, angry outbursts, law-breaking, or hyperactivity. Externalizing symptoms are more commonly seen in males and adolescents.

Internalizing Symptoms - These symptoms or behaviors are those that are turned inward. They include things such as depression, worry, fear, self-injury, and social withdrawal. Internalizing symptoms are more commonly seen in females and adolescents.

Play Therapy - A form of psychotherapy in which a child plays in a protected and structured environment with games and toys provided by a therapist, who observes the behavior, affect, and conversation of the child to gain insight into thoughts, feelings, and fantasies. As conflicts are discovered, the therapist often helps the child understand and work through them. Since children often communicate through play rather than words, play therapy plays a vital role in understanding a child's experiences and their responses to those experiences.

Posttraumatic Stress Disorder (PTSD) - A psychological reaction that occurs after experiencing a highly stressful event outside the range of normal human experience (such as wartime combat, physical violence, or a natural disaster) and that is usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the event. It is a specific diagnosis within the *Diagnostic and Statistical Manual of Mental Disorders.*

Protective Factors - Characteristics in individuals, families, communities, or the larger society that decrease risk in families and communities and increase the health and well-being of children and families. Examples are good family functioning, social support, and attachment.

Psychoeducation - Psychoeducation is the provision of education within the therapeutic environment. For example, in trauma-focused treatment, psychoeducation includes providing information on trauma and its effects and normal responses to trauma.

Psychological Safety - A sense of safety, or the ability to feel safe, within one's self and safe from external harm.

Glossary of Terms (cont.)

Reliability - The ability of a measure, test, instrument, or tool (or its specific items) to be consistent across time (test-retest) and independent raters (joint or interrater), as well as within the measure itself (internal consistency).

Resilience - Psychological resilience refers to an individual's capacity to withstand stressors and not manifest psychological dysfunction, such as mental illness or persistent negative mood. This is the mainstream psychological view of resilience, that is, resilience is defined in terms a person's capacity to avoid psychopathology despite difficult circumstances. Resilience is promoted by protective factors (see “protective factors.”)

Secure Attachment - The type of attachment that occurs when caregivers provide consistent, sensitive response.

Toxic Stress Response - Toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years.

Trauma Assessment - Trauma assessment refers to a comprehensive process of evaluation that is conducted by a trained mental health provider/clinician. A trauma assessment can determine whether clinical symptoms of traumatic stress are present as well as characterize the severity of symptoms and impact on the child’s functioning. While a trauma assessment may use information collected during the trauma screening process (and may include some of the same tools), it is more detailed and comprehensive and assesses multiple domains, including trauma and developmental history, traumatic stress symptoms, broader mental health symptoms, caregiver/family needs or difficulties, environmental/systems issues, and resources and strengths (for child, caregiver, family, and community). It typically includes several methods of data collection, including clinical interviews with the child/caregivers/collateral informants, administration of measures/questionnaires, and behavioral observations.

Trauma Reactions - There are short- and long-term reactions to trauma. Short-term reactions include shock, fear, and terror. Long-term reactions include three types: hyperarousal (e.g., hypervigilance, irritability and poor concentration), intrusive (e.g., nightmares, re-experiencing, and distressing memories), and avoidance (e.g., not talking about the trauma, avoiding trauma reminders, and emotional numbing).

Trauma Screening - Refers to a brief measure, test, instrument, or tool that is universally administered to children by CW workers, ideally during their initial contact with child welfare services. Trauma screening tools typically detect exposure to potentially traumatic events/experiences and/or endorsement of possible traumatic stress symptoms/reactions, they are not diagnostic. The format can be self-report or worker-administered. Information gathered from a trauma screening tool is used to determine if a child needs to be referred for a trauma assessment.

Validity - The degree of accuracy to which a measure, test, instrument, or tool (or its specific items) truly represents a psychological construct, domain or dimension of functioning. Various types of validity (e.g., face/construct, criterion/concurrent/predictive, content and convergent/divergent/discriminant) contribute to determining whether a measure is useful and meaningful.

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Definition of a Trauma-Informed Child Welfare System

A trauma-informed child welfare system is one in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, families, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery.

Overview of the Essential Elements of a Trauma-Informed Child Welfare System

Children and families become known to the child welfare system because of suspected abuse or neglect, experiences which—in combination with domestic violence, community violence, poverty and other stressors—can result in traumatic stress reactions and/or the development of posttraumatic stress disorder. Given the prevalence of trauma and traumatic stress reactions among child welfare system-involved children, families, caregivers, professionals, and other stakeholders, it is critical that child welfare professionals both link families with trauma-informed treatment and services and integrate an understanding of trauma into their own practice. The National Child Traumatic Stress Network considers the following to be essential elements of a trauma-informed child welfare system.

Maximize Physical and Psychological Safety for Children and Families

Psychological safety is a sense of safety, or the ability to feel safe, within one's self and safe from external harm. The child (and his/her siblings) may continue to feel psychologically unsafe long after the physical threat has been removed or he/she has been relocated to a physically safe environment, such as a relative's or foster parents' home. A child's sense of physical and psychological safety may continue to affect the child throughout their lives. For example, if the child is reunified, the child may return home to the biological parent and experience triggers through separation anxiety or fear of removal once again. This may lead to an increase in traumatic stress symptoms at key transition points.

Enhance Family Well-Being and Resilience

Providing trauma-informed education and services, including evidence-based or evidence-informed mental health interventions as needed, to caregivers (both birth and foster parents) enhances their protective capacities, thereby increasing the resiliency, safety, permanency, and well-being of the child.

Partner with Youth and Families

Youth and family members who have been involved in the child welfare system have a unique perspective and can also serve as partners by providing valuable feedback on how the system can better address trauma among children and families. These partnerships should occur at all levels of the organization, as youth and families can help shape trauma-informed practices and policies.

Identify Trauma-Related Needs of Children and Families

The child welfare workforce should be educated on trauma and how it affects an individual across development and culture, screen everyone for traumatic history and traumatic stress responses. For those who screen positive for trauma, a thorough trauma-focused assessment by a properly trained mental health provider can help guide subsequent treatment and intervention efforts.

Enhance Child Well-Being and Resilience

It is common for a trauma-exposed child to have significant symptoms that interfere with his/her ability to master developmental tasks, build and maintain relationships with caregivers and peers, succeed in school, and lead a productive and fulfilling life. A child's recovery from trauma often requires the support of caring adults in his/her life as well as the right evidence-based or evidence-informed mental health treatment, delivered by a skilled therapist.

Enhance the Well-Being and Resilience of Those Working in the System

Many professionals in the child welfare workforce experience secondary traumatic stress reactions, which are physical and emotional stress responses to working with children and families who have experienced their own trauma.

Partner with Agencies and Systems that Interact with Children and Families

No one agency can function alone, and in a trauma-informed system, child welfare must reach out and coordinate with other systems so they too can view and work with the child and family through a trauma lens.

Tips about Trauma-Informed Mental Health for Child Welfare Professionals

Screening

☑ Ensure children whose screening indicates that they need a trauma-specific mental health referral receive a comprehensive trauma-focused mental health assessment which encompasses different domains of functioning, given the broad range of reactions that traumatized children may exhibit beyond posttraumatic stress disorder (PTSD). This should include a developmental assessment to see if they are lagging in any key areas.

Assessment

☑ Work closely with local mental health providers to ensure they conduct a comprehensive trauma -focused assessment for each child that includes gathering information on symptoms and functioning, as well as strengths, which are all essential to developing a trauma-informed treatment or service plan. Do not be afraid to ask questions to determine if the mental health provider has conducted a trauma assessment (i.e., "What measures did you use?" "Based on your assessment, what other traumas has the child experienced?").

☑ Understand that if, after a comprehensive trauma assessment process, it is determined that a child does not currently display particular symptoms related to their traumas, they may not need to be referred for trauma-focused treatment.

☑ Since the assessment includes asking a number of very personal questions, the child and caregivers can be emotionally affected by disclosing this type of personal information. Child welfare staff can alleviate some of this impact by sending case reports ahead of time so that the mental health professional conducting the assessment can review them ahead of time and not overwhelm caregivers of children during the assessment process, etc.

Treatment

☑ Refer the child and family to the right provider. It is not enough to have skilled trauma treatment providers in a community if the right child is not referred to the right provider (i.e., a child who screens with trauma symptoms or traumatic experiences should not be referred to a general mental health provider and vice versa). Child welfare must have a system in place to link the child to the provider best suited to meet his/her unique needs.

☑ Gather information on any psychotropic medication the child may be taking, what it is used for, and whether or not it is effective.

Parental Protective Factors

☑ Refer parents to therapists who are trained to help them address and overcome their traumatic experiences. There are several evidence-informed adult trauma treatment models, many of which integrate issues of trauma, mental health problems, and substance abuse for more effective and comprehensive treatment (http://nrepp.samhsa.gov).

Working with Substitute Providers

☑ Try to ensure the new foster parent knows about the child's trauma history and how best to make the child feel safe through information provided by the caseworker. While the foster parent may not need to know about the child's entire history, it is important for the foster parent to understand what has happened to the child and potential triggers (i.e., events, loud voices, etc.) to assist them in developing skills and resources to manage the child's reaction to the triggers.

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Questions to Ask Therapists/Agencies who Provide Services

- Do you conduct a comprehensive trauma-focused mental health assessment?
    - What specific standardized measures are given?
    - What did your assessment show?
    - What were some of the major strengths and/or areas of concern?
- Do you provide trauma-specific or trauma-informed therapy? If so, how do you determine if the child needs a trauma-specific therapy?
- How familiar are you with evidence-based treatment models designed and tested for treatment of child trauma-related symptoms?
- Do you have specific training in an evidence-based trauma treatment model? If so, what model(s), when were you trained, where were you trained, by whom were you trained, how much training did you receive?
- Do you receive ongoing clinical supervision and consultation on any of the models that you have been trained in?
- How do you approach therapy with children and families who have been impacted by trauma (regardless of whether they indicate or request trauma-informed treatment)?
- What does a typical course of therapy entail? Can you describe the core components of your treatment approach?
- How are parent support, conjoint therapy, parent training, and/or psycho-education offered?
- How are cultural competency and special needs issues addressed?
- Are you willing to participate in the multidisciplinary team (MDT) meetings and in the court process, as appropriate?

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