



**CREATING
TRAUMA-INFORMED
CHILD WELFARE
SYSTEMS:
A GUIDE FOR
ADMINISTRATORS**



C T I S P
Chadwick Trauma-Informed Systems Project

Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators

By

The Chadwick Trauma-Informed Systems Project



Chadwick Center for Children and Families, Rady Children’s Hospital, San Diego

The Chadwick Center is a child advocacy center with facilities located on the campus of Rady Children’s Hospital in San Diego, CA, and throughout San Diego County. It is one of the largest centers of its kind and is staffed with more than 75 professionals and para-professionals in the field of medicine, social work, psychology, child development, nursing, and education technology. The center has made lasting differences in the lives of thousands of children and families since opening our doors in 1976. The staff is committed to family-centered care and a multidisciplinary approach to child abuse and family violence. The center’s Mission is to promote the health and well-being of abused and traumatized children and their families. This is accomplished through excellence and leadership in evaluation, treatment, prevention, education, advocacy, and research. The Chadwick Center’s Vision is to create a world where children and families are healthy and free from abuse and neglect.

The National Child Traumatic Stress Network (NCTSN)

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

The Network is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services through a congressional initiative: the Donald J. Cohen National Child Traumatic Stress Initiative. As of February 2013, the Network comprises over 30 funded members. Affiliate members—sites that were formerly funded—and individuals currently or previously associated with those sites continue to be active in the Network as well.

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Foreword



Why Trauma-Informed Systems Help Child Welfare

Experiencing terror or extreme fear for anyone creates a sense of disabling emotional, and sometimes physical, helplessness and hopelessness. Extreme fear creates rapid heart rates and memories that may make temporary or extended physical changes to a person's brain and may then affect normal development. Often, unhealthy coping habits result from these experiences. Practices uninformed about trauma can create unnecessary and avoidable harm. Helping everyone connected to the child welfare system understand trauma and how it affects children and the professionals committed to helping children is the goal of this work. This is a goal everyone should embrace.

Giving children an honest sense of safety and giving parents the information they need to rebuild their families is the message of hope that each of them need. Giving this message to children in an age-appropriate, developmentally, and culturally appropriate way can speed the healing process. The sooner children feel safe, the sooner they will avoid the development of unhealthy coping habits. The sooner parents understand themselves, their children, and their responsibilities, the sooner newer and healthier visions for their family can be formed. Then when professionals see the expedited healing or the avoided harm that children and families experience from trauma-informed involvement, professional hope and confidence is fostered.

This document was created with the assistance of the National Advisory Committee of the Chadwick Trauma-Informed Systems Project (CTISP). The National Advisory Committee members selected to consult on this effort have brought their clinical, legal, social, cultural, and personal experiences together to create this invaluable tool. It is the shared hope of all committee members that this tool, and our shared contribution to it, helps you...as together we find healthier ways to help children, families, and professionals heal.

Howard H. Hendrick

Director, Oklahoma Department of Human Services (1998-2012)
Chair of the CTISP National Advisory Committee

Overview of the Project



In April 2010, in an effort to improve services for children involved in the child welfare system who have experienced traumatic events, the Chadwick Center for Children and Families at Rady Children's Hospital and Health Center in San Diego, California, created the Chadwick Trauma-Informed Systems Project (CTISP) as a Category II Center within the National Child Traumatic Stress Network (NCTSN), with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). CTISP strives to support the evolution of public child welfare agencies into trauma-informed organizations while also supporting the agencies' efforts to serve as facilitators of change in their communities. Through these efforts, CTISP is striving to help transform the wider community child welfare system, which includes all the major systems that impact children and families involved with public child welfare, including children's mental health, into a multi-dimensional, trauma-informed, and evidence-based system better able to meet the unique needs of abused and trauma-exposed children.

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The goal of CTISP is that trauma-informed child welfare systems will understand how:

- Childhood traumatic stress impacts children.
- The system can either help mitigate the impact of trauma or inadvertently add new traumatic experiences.
- The culture of the child and family influences the child's response to trauma.
- Child and family resiliency after trauma can be enhanced.
- Current and past trauma impacts the families with whom child welfare workers interact.
- Adult trauma interferes with adult caregivers' ability to care and support their children.
- Vicarious trauma impacts the child welfare workforce.
- Exposure to trauma is part of the child welfare job.
- Trauma has shaped the culture of the child welfare system, the same way trauma shapes the world view of child victims.
- Trauma-informed systems will integrate a range of evidence-based and trauma-specific treatments and practices.

Chapter Format

For *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators*, CTISP National Advisory Committee Members were asked to provide the CTISP staff members at the Chadwick Center with a series of key bullet points and resources reflecting updated research and practice in the area of trauma-informed child welfare. Chadwick staff members then completed a literature review and generated a draft of each chapter. Within each chapter, the following domains are covered:

- **Why is this Important to Child Welfare?:** Child welfare administrators and professionals in the broader child welfare system from around the country wrote a paragraph highlighting why the information in this chapter is important to administrators striving to make child welfare systems more trauma-informed.

- **Brief Summary:** This section contains an extremely succinct review of the information and is designed to provide the reader with a snapshot of the issue and encourage them to read more, if interested.
- **Background:** The information contained in this section includes a brief literature review providing some history of the problem, and current status of the field related to this topic.
- **Recommendations from the Field:** This section provides concrete suggestions on how administrators can integrate the information contained within this chapter into their child welfare jurisdictions on a policy and practice level.
- **Resources:** This section provides a list of print and web-based resources that the reader is encouraged to review to gather more information on this topic.



Intended Audience

Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators was designed as a tool for administrators across the child welfare and other child-serving systems who are interested in having their systems become more trauma-informed and responsive to the needs of children and families within the child welfare system who have experienced traumatic events. This guide is part of a larger *Trauma-Informed Child Welfare Practice Toolkit* that contains multiple resources designed to assist the child welfare and mental health workforce in creating a more trauma-informed child welfare system. These additional resources include:

- The *Trauma System Readiness Tool (TSRT)* – A community assessment tool that can be completed by individuals within the child welfare workforce to determine the trauma-informed nature of their system.
- *Desk Guide on Trauma-Informed Mental Health for Child Welfare* – This guide is designed to assist child welfare workers and supervisors in understanding mental health services available for children 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.
- *Desk Guide on Trauma-Informed Child Welfare for Child Mental Health Practitioners* – This guide is designed to assist child mental health professionals in increasing their knowledge of the policies, practices, and culture of the child welfare system. This increased understanding will assist both child welfare and child mental health providers in delivering the best services for the children and families they see.
- *Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model* – These guidelines are designed to be a resource for child welfare agencies as they strive to update or articulate their current practice model. The guidelines will provide concrete strategies on how to update the common aspects of a practice model so that it may become more trauma-informed.

Background



Henry

Henry is five years old. He has heard and seen his parents fighting for his entire life. He feels scared and confused when they fight, but he loves his parents dearly. One night, he woke up to the sound of screaming coming from the kitchen. He became frightened and wondered if they were fighting because he had gotten in trouble at school earlier that day. He crept downstairs to find his mommy bleeding on the kitchen floor. Moments later, three big police officers burst through the front door with their guns raised. Henry heard a lot of yelling, and then one of the police officers was leading his dad out the front door in handcuffs. Another officer took Henry to the police car and began to drive away. Henry did not get to say good-bye to his mom, did not know if she was okay, and had no idea what was happening or where he was being taken.

After spending a few long hours at the police station, a lady came to take him to a house where he was met by a man and woman he had never met. The lady dropped him off, and the man and woman put him into a bed that felt big and unfamiliar. He cried himself to sleep. The next day, the woman took him to a new school for kindergarten. He had to wear someone else's clothes that were a little too small. He didn't know anyone at the school and felt scared and shy. At school, he had a hard time concentrating on the teacher and following the class rules. Sometimes he got in trouble for this and became really scared that his teacher would become angry at him and yell, just like his daddy used to.



A few days later, a new lady came to the house and asked him a lot of questions. Henry asked about his parents and was told his mommy was in the hospital and his daddy was in jail. Henry did not get to talk to his mom or dad or see them for what felt like a very long time. He felt angry and confused. He had a hard time sleeping and when he did sleep, he had bad dreams and wet his bed at night. The man and woman would yell at him for this, which reminded him of when his daddy would yell at his mommy. He felt scared when they yelled and would hide under the table. Soon the lady came back and took him to a new house. He didn't know if it was because he had done something bad. Henry wondered how many different houses he would have to go to and if he would ever get to see his parents again.

Statement of the Need for Trauma-Informed Child Welfare Systems

While there is a considerable amount of literature and research documenting the long-term effects of adverse childhood experiences including abuse and neglect (Felitti et al., 1998), there has been a lack of exploration of how to integrate trauma-informed practice within the fabric of the child welfare system. Recognizing trauma and its potentially pervasive effects on children and families presents a critical challenge to the child welfare agency. Mismanagement of trauma reduces the likelihood of reunification (Rubin, O'Reilly, Luan & Localio, 2007), increases placement instability (Hartnett, Leathers, Falconnier & Testa, 1999), results in the application of increasingly more restrictive placements (Pecora et al., 2005), increases the likelihood of administration of strong psychotropic medicines (Raghavan et al., 2005), and increases the likelihood that the child will carry on an intergenerational cycle of abuse or neglect upon becoming a parent (Fang & Corso, 2007).

Definition of Trauma and Child Traumatic Stress

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).

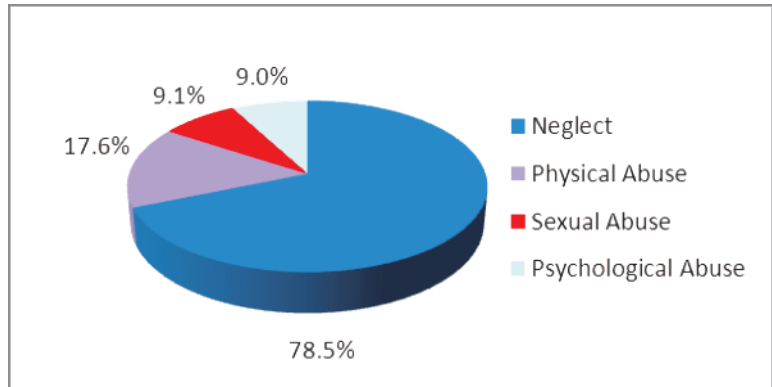
As a general rule, traumatic events overwhelm a child's capacity to cope and elicit intense emotional and physical reactions, such as those listed below, that can be as threatening to the child's physical and psychological sense of safety as the event itself.

Common Reactions to Traumatic Stress	
<u>Emotional</u>	<u>Physical</u>
<ul style="list-style-type: none">• Terror• Intense Fear• Horror• Helplessness• Disorganized or Agitated Behavior	<ul style="list-style-type: none">• Rapid Heart Rate• Trembling• Dizziness• Loss of Bladder or Bowel Control

In addition, they may elicit adaptive responses, such as dissociation (i.e., feeling outside of your body or feeling that an actual event is not real) that may become fixed and interrupt healthy development. Trauma can refer to an isolated event, but the body responds to the developmental accumulation of traumatic stressors long after the event is over.

Types and Prevalence of Child Trauma

In 2011, child protective services (CPS) departments across the country received 3.4 million referrals involving the alleged maltreatment of 6.2 million children (U.S. Department of Health and Human Services [DHHS], 2012). Of these children, 676,569 were victims of at least one instance of child abuse and neglect. The chart to the right shows the percentage of these children exposed to neglect, physical abuse, sexual abuse, and psychological maltreatment¹. The total of all the pie pieces is higher than 100% due to children who experienced a combination of neglect and/or abuse types.



Children under age 6 are disproportionately exposed to trauma, particularly interpersonal violence (Chu & Lieberman, 2010; Ghosh Ippen & Lieberman, 2008). Of victims, 27% were under age 3, and 47% were under age 6 (U.S. DHHS, 2012).

How Do Children Experience Trauma?

Children are at increased vulnerability when compared to adults for developing negative outcomes after trauma. Separation and loss, although not life-threatening, may be perceived as so to children, especially very young children. Child traumatic stress may manifest in destructive and maladaptive ways that can impair the child's ability to relate to others, to succeed in school, and to control his/her emotions and behaviors. A number of factors influence how a child experiences and reacts to traumatic events. A child's reactions to trauma can vary depending on the number and severity of traumatic episodes, and the time period of exposure to the event(s). A child is also affected by his/her proximity to the event (i.e., if it happened to a friend or family member), and the event's personal significance for him/her.

A child's responses to trauma are also shaped by the extent to which his/her support system is disrupted during and after the trauma. For instance, being separated from non-offending caregiver during or after the trauma can often affect a child's reactions. Other factors that can influence a child's responses to trauma include the following:

- The child's age and developmental stage
- Preexisting psychopathology
- The child's perception of the danger faced or sense of threat
- Whether the child was the victim or a witness
- The child's relationship to the victim or perpetrator
- Parental psychopathology and distress
- The adversities the child faces in the aftermath of the trauma
- The presence/availability of adults who can offer help and protection
- Interactions with first responders and other helping professionals
- Genetic predisposition (Bradley et al., 2008)
- Previous history of traumatic experiences

¹ According to the National Child Abuse and Neglect Database system (NCANDS), psychological maltreatment is often the code used to describe a child's exposure to domestic violence.

Immediate, Delayed, and Long-Term Reactions to Child Traumatic Stress

Children's reactions to trauma are varied and complex, and may manifest at different periods following the event or their removal from the traumatic situation. Not all children who experience trauma are adversely affected. How a child responds and how long reactions linger are a result of the objective nature of the events plus the child's subjective response to those events. However, research has shown that trauma-related stress is associated with a varied group of short- and long-term adverse outcomes (Pecora et al., 2005; Fang & Corso, 2007). As explained below, responses immediately following the event may vary. Delayed reactions may include posttraumatic stress disorder (PTSD) or other disorders. In addition, long-term effects on learning and physical and psychological health can last into adulthood. The construct of PTSD is constantly evolving in order to be more accurate in reflecting the experience of children. For example, many professionals think of PTSD as an injury, rather than a disorder, since it reflects the over-sensitization of what otherwise is a normal fear response system (Scheeringa, Zeanah, Myers, & Putnam, 2003).

Immediate Reactions to Traumatic Stress

Children's immediate reactions to traumatic stress may vary. A child who was not physically hurt, or who has no idea that what he/she experienced at the hands of others was wrong, may exhibit little or no immediate reaction. This may change when the child is placed in a safer environment; the new context may facilitate learning that helps the child understand what happened to him/her, and he/she may react behaviorally and emotionally. A child who experienced pain or knows that the abuse was wrong may, in the short-term, display intense reactions, such as:

- Expressed longing/concern for his/her non-offending caregivers
- Being easily reminded of the trauma
- Numbness
- Detachment
- Disbelief
- A frozen ("deer in the headlights") state
- Intense anger
- Emotional lability (i.e., a condition of excessive emotional reactions and frequent mood changes)
- Tearfulness
- Agitation
- Excitement
- Clinginess with caregivers

These reactions can be normalized by reassurance from the caregiver. If reactions persist over time, professional intervention may be required. Cognitive distortions, which are inaccurate or unhelpful beliefs, are common among children who have experienced trauma, especially self-blame.

Symptoms of Posttraumatic Stress Disorder (PTSD) and Other Disorders

Not all children who have experienced traumatic events develop symptoms of PTSD. While many children may exhibit traumatic stress symptoms, only a small portion meet the criteria for PTSD. Full-scale PTSD is most common in children and adolescents who have experienced severe, chronic, or interpersonal trauma. Guilt resulting from cognitive distortions related to the traumatic event is a predictor of developing posttraumatic symptoms (Kletter, Weems, & Carrion, 2009). Symptoms of posttraumatic disorder are not only symptoms of anxiety, but also of mood and thought. Although most children who have experienced trauma do not develop full-scale PTSD, many will display one or more symptoms of the disorder. In addition, some children and adolescents with traumatic stress

reactions may meet the criteria for other psychiatric disorders, such as acute stress or adjustment disorder. Looking at how a child is functioning is a better indicator of how he/she is doing than diagnosing the problem.

Long-Term Reactions to Child Traumatic Stress

It is important to recognize and understand the significant longer-term consequences of exposure to trauma. A major research project, called The Adverse Childhood Experiences (ACE) Study (Felitti, et al., 1998), investigated the relationship between adverse childhood experiences and adult health decades later. The authors found that adults who had experienced multiple adverse childhood experiences (e.g., recurrent physical abuse, recurrent emotional abuse, sexual abuse) were at increased risk of developing adverse health behaviors such as smoking, alcohol abuse, drug abuse, depression, suicide attempts, and having over 50 sexual partners. The authors infer that individuals who engage in these high-risk behaviors are at higher risk for developing serious health problems, such as obesity, heart disease, cancer, and sexually transmitted diseases. Follow-up research suggests that individuals with a high number of adverse childhood experiences (six or more) have elevated prevalence of premature death relative to those without such experiences (Anda et al., 2009). Putnam (2003, p. 271) cites studies showing that among those who have suffered the trauma of sexual abuse as a child, there is a stronger likelihood of developing a psychological disorder later in life including “major depression, borderline personality disorder, somatization disorder, substance abuse disorders, posttraumatic stress disorder (PTSD), dissociative identity disorder, and bulimia nervosa.” Victims of child sexual abuse, says Putnam, also manifest many “problematic behaviors and . . . neurobiological alterations” (Putnam, 2003, p. 271).

Complicating Factors

In addition to the aforementioned reactions to child traumatic stress, there are a few complicating factors that surface in the lives of these children in the child welfare system. These factors may increase the probability that a child will experience traumatic events due to increased stress in their birth homes. As a result, these children are more vulnerable to traumatic stress.

Child Traumatic Stress and Substance Abuse

A study from Chapin Hall in 2011 reported that almost 61 percent of infants and about 41 percent of older children in out-of-home care had a primary and/or secondary caregiver that reported active alcohol and/or drug abuse (Wulczyn, Ernst, & Fisher, 2011). Children who are exposed to homes with substance abuse experience:

- Chaotic and unpredictable home lives
- Inconsistent parenting and lack of supervision
- Inconsistent emotional responses from parents
- Parental abandonment
- Physical or emotional abuse (Breshears, Yeh, & Young, 2005)

These experiences in the home can place the child at risk for traumatic stress.

Child Traumatic Stress and Learning Impairments

Exposure to trauma can also impair a child’s ability to learn. A study by Sullivan and Knutson (1998)

found that maltreated boys were more likely to have impairments that would affect learning, see table below.

Type of Impairment	Maltreated	Control
Language/Speech	12.6%	8.4%
Mental Retardation	9.1%	1.3%
Hearing	9.0%	7.5%
Learning Disability	7.4%	2.6%
Attention-Deficit Disorder (ADD)	3.9%	0.8%

For at least the mental retardation impairment, it is not known if the impairments put the boys at a higher risk for abuse or if the impairment is a result of the trauma. The impact on learning may be related to the role trauma plays in the development of the brain (See Chapter 3: *Impact of Trauma on the Brain*). In some cases of child abuse and neglect, areas of the brain fail to develop properly, which impairs physical, mental, and emotional development (Perry, 2002). In cases of chronic abuse, the stress experienced by the victim may result in the increased activation of certain areas of the brain, which may then facilitate anxiety, sleep disturbances, and hyperactivity. In behavioral terms, this increased activation renders children more vulnerable to developing PTSD, attention-deficit disorder (ADD), attention-deficit hyperactivity disorder (ADHD), conduct disorder, and learning and memory problems (Perry, 2009). Proper diagnostic assessment is essential for the most appropriate treatment (See Chapter 10: *Comprehensive Trauma-Focused Mental Health Assessment*).

Trauma and the Child Welfare System

Children involved in the child welfare system are particularly vulnerable to traumatic events, whether it is by virtue of the events that brought them into the system, or through the process of removal by child protective services and/or law enforcement and placement (sometimes several different placements) with substitute caregivers. Children who are seen in the child welfare system generally have experienced multiple traumatic events and are likely to have more complex symptom pictures (Kisiel, Fehrenbach, Small, & Lyons, 2009). While many children in the child welfare system have experienced traumatic events and may be exhibiting symptoms of traumatic stress, few of these children meet the full criteria for PTSD. In fact, recent research (Kolko et al., 2010) has found that, among children in the child welfare system, the prevalence of posttraumatic stress symptoms was only 11.7%. It is noteworthy, however, that children with no diagnosis of PTSD and fewer symptoms may be as functionally impaired, in terms of distress, personal relations, and schooling, as those with the full diagnosis (Carrion, Weems, Ray, & Reiss, 2002).

For a younger child, separation from a caregiver may be considered a traumatic event when he/she is not emotionally developed enough. For many individuals, contact with the child welfare system may serve as a trauma reminder and bring back memories of prior personal and family experiences with the child welfare system. Separation from a child is also likely to be traumatic for the caregiver. For individuals who are part of groups that have historically experienced the forced removal of children from parents (e.g., Native Americans, African Americans, and Alaska Natives), involvement with the child welfare system may serve as a reminder of historical trauma and may be associated with strong emotions and a reduced sense of safety.

Trauma also often results in ruptured relationships. Within the child welfare system, there are likely to

be both ruptures and conflicts among family members who are seeking to care for a child, resource parents, and child welfare workers. Of particular concern are youth who have a high number of placements, as each placement may strengthen the child's experience of rejection and lack of constancy and predictability. A trauma-informed child welfare system actively acts to reduce these conflicts and to help caregivers work jointly to create an environment that supports the child's relationship with all caregivers who are important to the child's life and development.

Creating a Trauma-Informed Child Welfare System

While the effects of trauma highlighted above are prevalent and far-reaching among children in the child welfare system and impact casework practice at multiple levels, trauma and its effects have historically been overlooked or not well-understood in day-to-day child welfare practice. As a result, many children who have experienced trauma may not receive the types of supports and services that are necessary to help them achieve safety, permanency, and well-being. On the contrary, many well-meaning child welfare agencies may participate in actions that exacerbate a child's trauma, such as multiple placements or removing a child from his/her community or school. Recently, the Children's Bureau has expressed particular interest in addressing the social and emotional well-being needs of children in care. In April 2012, they published an Information Memorandum which provides guidance to child welfare agencies looking to expand their capacity to make meaningful and measurable changes in social and emotional well-being for children who have experienced maltreatment, trauma, and/or exposure to violence. This can be accessed at http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/2012/im1204.pdf.

Just in the past five years, researchers have started to identify the need to apply a trauma-informed approach across child-serving systems, such as child welfare, juvenile justice, education, and others. The forerunners of this movement have been members of the National Child Traumatic Stress Network (NCTSN). In 2008, NCTSN colleagues introduced the concept of addressing the needs of children who have experienced trauma across multiple systems in an article that reviewed how various service systems approach trauma services differently. It also provided recommendations for how to make each of these service systems more trauma-informed (Ko et al., 2008). Adopting a trauma-informed approach to child-serving systems provides benefits on multiple levels. It equips staff members and leadership with the tools and skills necessary to manage their own secondary traumatic stress and assist the children and families in their care. It also provides a framework for educating the workforce and affiliated stakeholders on the impact of trauma and provides them with strategies to manage a child's difficult behaviors and overwhelming emotions and ensuring that the child receives the services he/she needs.

After its formation in mid-2010, the CTISP National Advisory Committee (see page iii), created and formalized the 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.

Taking this a step further, the NCTSN Child Welfare Committee has defined the following *Essential Elements of a Trauma-Informed Child Welfare System* (Child Welfare Collaborative Group, National Child Traumatic Stress Network, personal communication, October 29, 2012), as the graphic below shows:

Essential Elements of a Trauma-Informed Child Welfare System



These essential elements, as described in the following paragraphs, are intended to provide a guiding framework for child welfare administrators striving to infuse trauma-informed knowledge and practice into their existing systems.

Maximize
Physical and
Psychological
Safety for
Children and
Families

While child welfare has always had a focus on the physical safety of the child, a trauma-informed child welfare system must go further and recognize that psychological safety of both the child and his/her family is extraordinarily important to the child's and family's long-term recovery and social and emotional well-being. Psychological safety is a sense of safety, or the ability to feel safe, within one's self and safe from external harm. This type of safety has direct implications for physical safety and permanence, and is critical for functioning as well as physical and emotional growth. A lack of psychological safety can impact a child's and family's interactions with all other individuals, including those trying to help them, and can lead to a variety of maladaptive strategies for coping with the anxiety associated with feeling unsafe. These "survival strategies" may include high-risk behaviors, such as substance abuse and self-mutilation. 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. The child's parent(s) may feel psychologically unsafe for a number of reasons including his/her own possible history of trauma, or the uncertainty regarding his/her child's well-being that emerges following removal.

Even after the child and/or parent gains some degree of security, a *trigger* such as a person, place, or event may unexpectedly remind him/her of the trauma and draw his/her attention back to intense and disturbing memories that overwhelm his/her ability to cope again. Other times, a seemingly innocent event or maybe a smell, sound, touch, taste, or particular scene may act as a trigger and be a subconscious reminder of the trauma that produces a physical response due to the body's biochemical system reacting as if the trauma was happening again. A trauma-informed child welfare system understands that these pressures may help to explain a child's or parent's behavior and can use this knowledge to help him/her better manage triggers and to feel safe.

Identify
Trauma-
Related
Needs of
Children and
Families

The child welfare workforce should be educated on trauma and how it affects an individual at any stage of development and intersects with his/her culture. The system should screen everyone for traumatic history and traumatic stress responses which would assist the workers in understanding a child's and family's history and potential triggers and in creating a trauma-informed case plan. For those who screen positive for trauma, a thorough trauma-focused assessment by a properly trained mental health provider can identify a child's or parent's reactions and how his/her behaviors are connected to the traumatic experience and help guide subsequent treatment and intervention efforts.

Enhance
Child
Well-Being
and
Resilience

A child's recovery from trauma often requires the right evidence-based or evidence-informed mental health treatment, delivered by a skilled therapist, that helps the child reduce overwhelming emotion related to the trauma, cope with trauma triggers, and make new meaning of his/her trauma history. But to truly address the child's trauma and subsequent changes in his/her behavior, development, and relationships, the child needs the support of caring adults in his/her life. 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. Case planning must focus on giving the child the tools to manage the lingering effects of trauma exposure and to help him/her build supportive relationships so that the child can take advantage of opportunities as he/she grows and matures. By helping him/her develop these skills in a clinical setting and build supportive relationships, mental health and child welfare professionals enhance the child's natural resilience (i.e., strength and ability to overcome adversity).

Enhance Family Well-Being and Resilience

Most birth families with whom child welfare interacts have also experienced trauma; including past childhood trauma, community violence, and domestic violence that may still be ongoing. Providing trauma-informed education and services, including evidence-based or evidence-informed mental health interventions as needed, to birth parents enhances their protective capacities, thereby increasing the resilience, safety, permanency, and well-being of the child. In addition, both birth and resource parents should also be offered training and support to help them manage secondary trauma related to caring for a child who has experienced trauma and his/her siblings.

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

Working within the child welfare system can be a dangerous business and professionals in the workforce may be confronted with threats or violence in their daily work. Adding to these stressors, many workers experience *secondary traumatic stress reactions*, which are physical and emotional stress responses to working with a highly traumatized population. When working with children who have experienced maltreatment, parents who have acted in abusive or neglectful ways, and systems that do not always meet the needs of families, feelings of helplessness, anger, and fear are common. A trauma-informed system must acknowledge the impact of primary and secondary trauma on the workforce and develop organizational strategies to enhance resilience in the individual members of it.

Partner with Youth and Families

Youth and family members who have experienced traumatic events often feel like powerless “pawns” in the system, reinforcing feelings of powerlessness felt at the time of the trauma. Treating youth and families as partners by providing them with choices and a voice in their care plays a pivotal role in helping them to reclaim the power that was taken away from them during the trauma and tap into their own resilience.

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.

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. This partnering includes:

- Teaming with law enforcement to minimize the number of front-end interviews a child must experience
- Working with mental health agencies to ensure therapists are trained in specialized trauma assessment and evidence-based or evidence-informed trauma treatments
- Coordination with schools, the courts, and attorneys.

Such coordination is necessary to prevent one part of the system undoing the good trauma-informed work of another part of the system.

The concepts in each chapter of this guide address one or more of these essential elements. The essential elements addressed in each chapter in the last section of these guidelines are colorfully displayed at the bottom of the chapter’s first page. Those not addressed are still listed, but with no color and faded out text.

Recommendations from the Field



Child-serving system administrators play a critical role in helping transform their child welfare system into one that effectively addresses the impact of trauma on the children and families served, as well as on the professionals and organizations who work with them. The following are some recommended strategies that administrators may use in this process:



- ☑ **Provide forums for training all child welfare staff on types of trauma, reactions to traumatic events, and short- and long-term impact of trauma** at the most basic level since a child's reactions to a traumatic event are varied and complex. This is beneficial in helping caseworkers and supervisors understand that any child in the child welfare system has been affected by trauma.
- ☑ **Consider the full trauma history of the child and family** since this is a critical step in developing effective, tailored interventions unique to each child and family. Although many child welfare agencies focus on the investigation of one allegation of abuse, there are a number of ways in which to gather full trauma information. See Chapter 9: *Screening for Child Trauma within the Child Welfare System* for a discussion about screening for trauma within the child welfare agency.
- ☑ **Recommend and/or provide interventions that comprehensively address the child's needs beyond the initial abuse investigation.** Services that are tailored to meet the specific needs of the child and his/her family will be more effective and therefore more likely to help achieve positive outcomes for the child and family. Social workers can play a critical role in mitigating the impact of trauma on the child and his/her family. Their active involvement and support can help reduce trauma to families.
- ☑ **Attempt to minimize caregiver-child separations whenever safe and possible** and consider alternate strategies for monitoring child safety.
- ☑ **Minimize separation-related distress** by developing systems that allow for liberal visitation when the caregiver is not thought to present an active danger to the child.
- ☑ **Integrate trauma-informed child welfare into the fabric of existing child welfare practice approaches** to avoid the *initiative fatigue* that workers may begin to experience due to child welfare agencies often integrating new and innovative initiatives into their daily practice. Many of the common initiatives associated with good child welfare practice (such as Family Group Decision Making, Signs of Safety, etc.) are consistent with a trauma-informed framework. Dialogues and discussions related to how trauma intersects with current initiatives can be helpful in identifying existing practices that could be considered to be trauma-informed and adopting new practices that are consistent with the agency's mission and values.
- ☑ **Identify staff who can serve as *trauma champions* within the child welfare agency to provide the voice of trauma throughout supervision, family meetings, and group meetings.** For example, when a caseworker presents a case during supervision or during a team meeting, it is helpful to have one individual designated to provide the trauma perspective and invite the rest of the team to view the case through a trauma lens.





Section 1: Cross-Cutting Issues

The Role of Development in Vulnerability to and
Responses to Traumatic Events

Influence of Culture on Responses to Traumatic Events

The Impact of Trauma on the Brain

Addressing Secondary Traumatic Stress and Vicarious
Trauma in the Child Welfare Workforce

Promoting Child and Family Resilience in the
Aftermath of Trauma

Chapter 1: The Role of Development in Vulnerability to and Responses to Traumatic Events



Why is this Important to Child Welfare?

The Role of Development in Vulnerability to and Responses to Traumatic Events is important to child welfare because exposure to severe and/or prolonged trauma in childhood can have serious and long-lasting effects on a child’s development, affecting multiple domains of functioning. An infant or very young child may be delayed in acquiring such skills as language and motor skills, or he/she may developmentally regress and lose skills previously obtained. The infant or young child may have problems with eating and sleeping, may resist being held, and may be difficult to soothe. An older



“The ability to self-regulate emotions and behaviors is one way in which trauma greatly impacts a child at any age.”

child or adolescent exposed to trauma is more likely to engage in risky behaviors and often display mood swings, impulsivity, emotional irritability, anger, aggression, anxiety, and depression. The ability to self-regulate emotions and behaviors is one way in which trauma greatly impacts a child at any age. As a child gets older, exposure to trauma causes significant risk of school failure, substance use and mental health disorders, and health problems. The Adverse Childhood Effects (ACE) study clearly shows that exposure to trauma in childhood not only impacts the child’s health and well-being at the time of exposure, but is likely to continue to have an impact across the lifespan (see page 9). Child welfare agencies, caretakers, and health and education professionals all play a critical role in addressing trauma and fostering the healthy development of any child exposed to traumatic events. This chapter provides a description of the impact of trauma at each major developmental stage in addition to recommendations of what administrators can do to address the impact of trauma on development within the child welfare system.



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Essential Elements of a Trauma-Informed Child Welfare System Addressed



Brief Summary

A child's developmental age and stage has a substantial effect on how he/she perceives and processes a traumatic event. For example, some events that might not be considered traumatic to an older child may be to a younger child since he/she has not developed enough emotionally. This traumatic event can lead to disruptions in the young child's overall development. This child is likely to process the event through symbolic play, rather than speaking directly about his/her experience and may not develop attachments to a caregiver like a typical young child would. On the other hand, a school-age child is more likely to display traumatic stress responses such as regression, somatic complaints, difficulties in school, or through internalizing or acting out behaviors. An adolescent may exhibit behaviors similar to other groups, such as acting out, somatic complaints, and difficulties in school and social relationships. He/she may also exhibit behaviors specific his/her age group, such as high-risk sexual behavior and substance abuse.

Background

Developmental Differences in Children's Responses to Trauma

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.



Prenatal Stressors and Substance Abuse and the Effects on Children

Prenatal stressors (i.e., the exposure of an expectant mother and unborn child to stressors) compound the impact of prenatal drug exposure on infant development. In addition to the well-documented neurotoxic effects of [prenatal substance abuse] on the brain, there is emerging evidence that prenatal stressors compound the effects of postnatal adversity [i.e., adverse living conditions after birth) on the development and functioning of the HPA [Hypothalamus, Pituitary, Adrenal] axis and on other brain and biological systems affected by chronic stress (Wulczyn, Ernst, & Fisher, 2011). Prenatal cocaine exposure has been found to adversely impact social-emotional interactions between infants and their mothers, which may have long-term negative impacts on child development (Tronick et al., 2005). Prenatal cocaine exposure has also been found to be associated with difficulty in sustaining attention and behaviorally managing emotion in school-aged children (Ackerman, Riggins, & Black, 2010). This inhibited ability to manage negatively impacts a child's ability to respond to stressful environments. A child who is prenatally exposed to stressors and drugs is likely to suffer from brain development deficits and difficulties that can then begin a chain reaction of events, including his or her own substance abuse and mental health disorders, juvenile justice system involvement, and school difficulties.



Infants and Toddlers

A child exposed to trauma in early childhood can have a difficult time coping with loss, although it may not be as easy to identify as in other age groups. It has the potential to hinder a child's normal development (Ghosh Ippen & Lieberman, 2008). A young child's brain has the capacity to remember traumatic events even when he/she has not yet developed the ability to develop explicit memories. There is significant clinical evidence that a young child can retain

physical body-based memories of the event which may become triggered (i.e., occur again unexpectedly) by trauma reminders even when he/she does not have conscious memories of what he/she has experienced. An infant or young child is at particularly high risk of later mental health problems because his/her abilities to manage his/her emotions and use his/her own coping skills are not fully developed. In addition, the infant or young child may be overwhelmed by events that an older child may not view as traumatic. Because he/she is younger, he/she is more dependent on caregivers for protection. A young child may become more quickly dysregulated when talking about the event. This means that he/she may talk about the event and then quickly shift activities (e.g., become more active, engage in nurturing play, become aggressive) when he/she becomes triggered. It is important to recognize this pattern, because this can affect the way one understands how a young child responds to questioning regarding incidents of potential traumatic experiences.



Preschool Children

A preschool child often has a difficult time adjusting to change and loss. The child often feels helpless and powerless, and is unable to protect himself/herself (De Young, Kenardy, & Cobham, 2011). A child in this age range is still developing the skills necessary to cope with stressful situations. He/she is dependent on the protection and support of caregiving adults. A preschool child tends to be strongly affected by the reactions that his/her parents or caregivers have to the traumatic event. The more severely their parents or caregivers react to the event, the more likely the child is to show traumatic stress-related difficulties (Crusto et al., 2010). Research has shown that a preschool child exposed to interparental violence is at a greater risk of the exposure causing harm than an older child is. (Kitzmann, Gaylord, Hold, & Kenny, 2003). Data also suggest that the consequences of violence exposure in early childhood may be long lasting and may lead to later depression, separation anxiety, posttraumatic stress, and conduct problems (Briggs-Gowan et al., 2010).

It is common for a preschool child with traumatic stress symptoms to show regressive behaviors. This means he/she might appear to lose skills or behaviors that had been previously mastered (e.g., bladder control) or that he/she might revert to behaviors that had been previously outgrown (e.g., thumb sucking). Similarly, a traumatized preschool child often becomes clingy and may be unwilling to separate from familiar adults, including teachers. The child may also 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 (Briggs-Gowan et al., 2010). Additional behaviors that traumatized preschool children may show include:

- Crying, whimpering, screaming
- Appearing to be frozen
- Moving aimlessly
- Trembling
- Speech difficulties
- Irritability
- Repetitive reenactment of trauma themes in play or other activities
- Fearful avoidance and phobic reactions
- Magical thinking related to trauma (e.g., "...and then I jumped out the window and flew away.")



Elementary School-Aged Children

An elementary school-aged child may also exhibit regressive behaviors such as asking adults to feed or dress them (Briggs-Gowan et al., 2010). He/she may report unexplained physical symptoms, just as a preschool child exposed to trauma might. However, 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 feelings of 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 be unable to concentrate and his/her school performance may decline (Briggs-Gowan et al., 2010).

Additional behaviors that an elementary school-aged child with traumatic stress symptoms may exhibit include:

- Sadness and crying
- Poor concentration and other behaviors commonly seen in attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)
- Irritability
- Fear of personal harm, or other anxieties and fears (e.g., fear of the dark)
- Nightmares and/or sleep disruption
- Bedwetting
- Eating difficulties
- Attention-seeking behaviors
- Trauma themes in play/art/conversation

Although an elementary school-aged child understands what occurred more fully than a younger child might, he/she is not always able to understand why the event occurred. Therefore, an elementary school-aged child may be preoccupied with the details of the event and want to talk about it continually, or may act it out in play (De Young et al., 2011). Repetition of the event is one way a child might unconsciously attempt to come to terms with what he/she experienced.

Adolescents



An adolescent who has experienced traumatic events may exhibit some behavior changes also seen in other age groups. For example, an adolescent may report vague physical complaints; seek attention from parents, caregivers, and teachers; withdraw from others; experience sleep difficulties; avoid school; and show regressive behaviors, such as an inability to handle tasks and chores that he/she had formerly mastered (Briggs-Gowan et al., 2010).

However, an adolescent with traumatic stress symptoms faces other challenges that are specific to his/her developmental stage. An adolescent will tend to place more importance on peer groups, to rebel against authority, and to feel immune from physical danger. These qualities can complicate the adolescent’s efforts to come to terms with traumatic events. An adolescent with traumatic stress symptoms may isolate himself/herself, resist authority, or become highly disruptive. His/her distress, coupled with age-appropriate feelings of immortality, may motivate him/her to experiment with high-

risk behaviors such as substance use, promiscuous sexual behavior, or other at-risk behaviors, such as driving at high speeds or picking fights (Substance Abuse Mental Health Services Administration [SAMHSA], 2002). An adolescent may also:

- Feel extreme guilt if he/she were not able to prevent injury to or loss of loved ones.
- Fantasize about revenge against those he/she feels/knows caused the trauma.
- Be reluctant to discuss his/her feelings or even deny any emotional reactions to the trauma, in part because an adolescent will typically feel a very strong need to fit in with his/her peers.
- Show traumatic responses similar to those seen in adults, including flashbacks, nightmares, emotional numbing, avoidance of reminders of the trauma, depression, suicidal thoughts, and difficulties with peer relationships (Briggs-Gowan et al., 2010).

In addition, an adolescent with traumatic stress symptoms may begin to exhibit:

- Delinquent and/or self-destructive behaviors
- Changes in school performance
- Detachment and denial
- Shame about feeling afraid and vulnerable
- Abrupt changes in or abandonment of former friendships
- Pseudomature actions, such as getting pregnant, leaving school, or getting married

The Role of Developmental Delays



Studies indicate that developmental delays are extremely common among children younger than the age of 5 years in out-of-home care, with estimated rates of children exhibiting some developmental delay ranging from 13 to 62% compared with the prevalence of delay in the general pediatric population (4-10%) (Leslie et al., 2005). All areas of development are closely intertwined in the early years, so physical harm can damage emotional, social, cognitive, and language development (Zero to Three, 2011). A maltreated infant or toddler typically exhibits differences relative to his/her non-maltreated peers across most domains of functioning. He/she achieves developmental milestones later (e.g., walking and talking), is rated by caregivers as difficult to soothe, and may even show signs of “failure to thrive,” a condition that includes small physical stature and reduced head circumference (Wulczyn et al., 2011).

A children with a disability (CWD) is more likely to be a victim of child abuse, but may have more difficulty than a typically developing peer reporting his/her experiences due to his/her delayed development (Hershkowitz, Lamb, & Horowitz, 2007; Hibbard, Desch, American Academy of Pediatrics Committee on Child Abuse and Neglect, & American Academy of Pediatrics Council on Children With Disabilities, 2007). A child who is prenatally exposed to substances is at greater risk of additional developmental delays. Cutting-edge research indicates that exposure to illicit drugs and alcohol during pregnancy combined with early trauma and neglect may damage the child’s developing nervous system, calling for preventative, integrated systems of care (Chasnoff, 2010). Prenatal drug exposure puts the child at greater risk for developmental delays, which then increases risk of child maltreatment and related traumatic stress. Having a higher level of disability was associated with increased risk of sexual abuse. Both the possibility of a heightened incidence of severe abuse among and the failure to disclose abuse by a CWD should be sources of considerable concern to social welfare and criminal justice agencies (Hershkowitz et al., 2007). Increased risk includes (a) higher

emotional, physical, economic, and social demands on his/her family; (b) greater caregiver stress because a children with a disability may not respond to traditional means of reinforcement, and sometimes the child's behavioral characteristics (e.g., aggressiveness, noncompliance, and communication problems) may become quite frustrating; (c) intellectual limitations may prevent the child from being able to discern an experience as abuse and impaired communication abilities may prevent him/her from disclosing abuse (Hibbard et al, 2007). There is a lack of expertise and research related to being able to accurately diagnose a child as having a reactive attachment disorder, PTSD, or a pervasive developmental disorder (PDD). In particular, the symptoms of a PDD and trauma-related symptoms can be confusing and may not be sorted out until after a period of treatment which is focused on either the PDD or the trauma. More study and greater expertise is needed to figure out a way to properly diagnose a child prior to treatment and then select the appropriate treatment pathway. Certain evidence-based practices (EBPs) may not be the best choice depending upon an accurate diagnosis, and whether both trauma and a PDD (or autism spectrum disorder) exist. For example, a child who has experienced repeated changes in placement or primary caregiver is at risk for lack of secure attachment and might not benefit from an EBP where active ignoring is a strategy. This is complicated even further if the child is on the autistic spectrum and is quite content to be ignored.

Trauma and Attachment

Attachment refers to an individual's ability to bond with another person. When a child has a *secure* attachment with his/her primary caregiver(s), this provides a *safe haven* in which the child knows he/she can return for comfort and soothing when needed. In this, the caregiver provides a *secure base* in which the child can feel free to explore his/her world and learn and grow. According to Bowlby (1969), how a child forms attachment relationships with his/her primary caregiver early in life has a tremendous impact on how the child forms significant relationships with others throughout his/her life. There are critical periods during which bonding experiences must be present for the brain systems responsible for attachment to develop normally. These critical periods appear to be in the first year of life and are related to the ability of the infant and caregiver to develop a positive interactive relationship (Perry, 2009).



However, attachment disruptions, which can be caused by a traumatic event itself as well as subsequent removal from caregivers, impacts child development in many areas. A young child depends exclusively on parents/caregivers for survival and protection—both physical and emotional. This relationship is critical in assisting the child to develop safe and trusting relationships with their caregivers and to rely on them to provide a *protective shield* (Freud, 1920/1955). When a child experiences a traumatic event during his/her early years, the child's trust in his/her caregivers' ability to protect him/her is compromised and can shatter this protective shield. When trauma also impacts the parent/caregiver, the relationship between that person and the child may be strongly affected. Without the support of a trusted parent/caregiver to help the child manage his/her strong emotions, he/she may experience overwhelming stress (Zero to Six Collaborative Group, National Child Traumatic Stress Network, 2010). Specific problems that can be seen in a maltreated child with attachment problems include developmental delays, eating, soothing behavior, limited or impaired social-emotional functioning, inappropriate modeling, and aggression (Perry, 2009).

Recommendations from the Field



Early identification and intervention techniques, such as those listed below, are critical, and can decrease the impact on development:

- ☑ **Assess the child’s developmental status, including cognitive, linguistic, gross and fine motor, emotional, and social competence along with a full medical history, including any prenatal substance exposure, during investigations of suspected child abuse or neglect.** This could be accomplished through closer collaboration between child welfare services and early intervention programs for children with developmental delays or disabilities, as mandated by the Keeping Children and Families Safe Act of 2003 and the recent reauthorization of the Individuals with Disabilities Education Act (IDEA; National Scientific Council on the Developing Child, 2005). The Child Abuse Prevention and Treatment Act (CAPTA) represents an effort to ensure timely and early referrals into part C services (i.e., requirement to refer victims of abuse and neglect up to age 3 for developmental assessments and early intervention).
- ☑ **Incorporate expertise in the identification and assessment of young children with serious, trauma-related mental health problems so that a young child may be referred into an existing clinical treatment program that addresses these complex and widely unmet needs. It is also imperative that caregivers receive the mental health assessment and treatment they need in order to be emotionally available to the child.** (National Scientific Council on the Developing Child, 2005)
- ☑ **Ensure that training for child welfare staff, resource parents, and other system stakeholders includes information about brain development and how sensitive and responsive caretakers can help mediate stress experienced by a child.** (National Scientific Council on the Developing Child, 2005).
- ☑ **Educate professionals and parents that the quality of the care and education a young child receives in a day care setting (i.e., any place where the young child may spend many hours each day while the parent/caregiver is at work) also plays an important role in whether, and to what extent, their brains are exposed to elevated stress hormones early in life** (National Scientific Council on the Developing Child, 2005).

Resources

Document:

Dicker, S., Gordon, E., & Knitzer, J. (2001). *Improving the odds for the healthy development of young children in foster care*. New York: Columbia University, National Center for Children in Poverty. Retrieved from <http://www.ithaca.edu/mbentley/pdf/dicker.pdf>

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 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>

Chapter 2: Influence of Culture on Responses to Traumatic Events



Why is this Important to Child Welfare?

“...a trauma-informed child welfare system will only be effective if it fully accounts for cultural factors...”

The Influence of Culture on Responses to Traumatic Events is important to child welfare because approximately 60% of the foster care population in the United States is comprised of children of color, representing families with extraordinarily diverse views of the world and cultural, socio-economic, and educational backgrounds. There are well-documented disparities (i.e., differences) in outcomes and access to relevant services experienced by children of color and their families. The topic of this chapter is of critical importance to the child-serving system administrator in so far as a trauma-informed child welfare system will only be effective if it fully accounts for cultural factors in the development and implementation of policies and practices. Although there is much room for improvement, the fields of child welfare and trauma-informed practice have evolved considerably in their awareness, understanding, and practice implications of working effectively with children and families of color. This chapter provides a solid road-map and contextual base that can offer the administrator guidance in ensuring that cultural factors are built in to the design of the trauma-informed system.

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Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize Physical and Psychological Safety for Children and Families

Identify Trauma-Related Needs of Children and Families

Enhance Child Well-Being and Resilience

Enhance Family Well-Being and Resilience

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

Partner with Youth and Families

Partner with Agencies and Systems that Interact with Children and Families

Brief Summary

Culture is a social factor that greatly influences a child's risk for and experience of trauma. Culture impacts the way a child and his/her family views and heals from traumatic events. Therefore, a family in the child welfare system must be viewed and treated in its cultural context. This chapter will discuss the importance of understanding and addressing the intersection of trauma and culture, and will explore issues related to immigration, historical trauma, and racial disparity and disproportionality in child welfare. Organizational strategies for achieving cultural competence and reducing racial disparity and disproportionality will be presented as well.

Background

Culture is an integrated pattern of human behavior that is transmitted across generations within a racial, ethnic, religious, social, or political group. It includes:

- Thoughts
- Beliefs
- Values
- Worldview
- Spirituality
- Communications
- Languages
- Traditions
- Practices
- Customs
- Rituals
- Manners of interacting
- Social roles
- Relationships
- Expected behaviors

Cultural values and practices can serve as protective factors for a child and family and can help them cope with stressors and traumatic events. Cultural identity and cultural references can be influential in shaping the ways in which a child and his/her family identifies the threat posed by traumatic events, interpret them, and manifest distress. Culture also shapes the healing process in the aftermath of trauma and loss in the form of rituals and healing practices. As the Spanish saying goes, *la cultura cura*.

Cultural competence can be defined as the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (Davis, 1997). Acquiring cultural competency involves:

- Recognizing that culture has a broad impact.
- Respecting a family as the expert on its members' needs and priorities.
- Increasing sensitivity to behavior that can be alienating.
- Including family and community members in decision-making processes.
- Committing to structural and policy changes that support cultural diversity.
- Allowing for fluidity in policies and practices to adapt to changes over time.

(Regional Research Institute for Human Services, 2003)



A child from an ethnic minority may be more vulnerable in the face of trauma due to prior history of trauma, stressors related to poverty, and less access to resources (Ko, 2005). An immigrant family may come to this country as refugees and often experience persecution and trauma in their home country as well as during the migration process. "Immigrant families may be at particularly high risk of

poor outcomes in the child welfare system because the effects of traumatic experiences may be exacerbated by highly stressful conditions such as poverty, social marginalization, isolation, inadequate housing and changes in family structure and functioning. Some of the sources of toxic stress for immigrant families are perimigration trauma and migration stress, post-migration or resettlement stress, acculturation stress, domestic violence and fear of deportation” (Cohen, 2010, p. 3).

Historical trauma is the cumulative exposure to traumatic events that not only affect the individual exposed, but continue to affect subsequent generations. These events include the legacy of slavery among African Americans and the continued impact of massacres, removal from homelands, and forced boarding school placements among American Indians and Alaskan Natives. Historical trauma can exacerbate the impact of present-day trauma for a family involved in the child welfare system, especially when system actions such as removal of children serve as triggers or unexpected reminders of the historical trauma for parents and family members.

Racial disparity in child welfare is the term used to describe racial differences in children’s or families’ experiences with the child welfare system and their access to care, service utilization, or quality of care. Racial disproportionality refers to the overrepresentation of children of color in foster care and disparate outcomes such as longer stays in out-of-home care and lower rates of reunification and adoption. African-American and American Indian/Alaskan Native (AI/AN) children are three times more likely to be in foster care compared to Caucasian children, and Latino/Hispanic children are overrepresented in the child welfare system in 10 states; and Asian/Pacific Islander and Caucasian children are underrepresented in the child welfare system (Sudol, 2009). African-American children stay in foster care for an average of nine months longer than their Caucasian counterparts (McRoy, 2008). Possible causes of racial disproportionality include poverty, classism, racism, organizational culture, service strategy, and resources (Casey Family Programs, 2005).

Ensuring appropriate services for racial and ethnic minorities requires an understanding of the disparities in knowledge about, access to, utilization of, and quality of services available. It also requires a willingness to continue to expand research, improve access to services, reduce barriers, and improve the quality of services provided. Cultural stigma related to mental health treatment and other services needs to be well-understood and addressed.

The cultural background of the child welfare staff member and the culture of the organization can also influence a worker’s perceptions of child traumatic stress and how to intervene. A staff member who is not culturally competent may over identify abuse and neglect in races or ethnic minorities different than his/her own. Therefore, assessments in child welfare should reflect cultural knowledge and competence and always take into account the cultural background and modes of communication of both the assessor and the child/family. All staff members should also be aware that even speaking about child maltreatment or sexual issues is taboo in some cultures, so the discussion should be approached with sensitivity and awareness regarding these issues.

Recommendations from the Field



The National Center on Cultural Competence at Georgetown University (http://cijr.georgetown.edu/pdfs/cijr_ch_final.pdf) has made numerous recommendations for organizations to achieve cultural competence. These recommendations include to:

- ☑ **Value diversity.**
- ☑ **Conduct a cultural self-assessment.**
- ☑ **Identify cross-cultural dynamics.**
- ☑ **Institutionalize cultural knowledge.**
- ☑ **Adapt service delivery to diversity within and between cultures.**

Additional recommendations from the field include:

- ☑ **Incorporate cultural knowledge related to the intersection of culture and trauma into policy making, infrastructure, and practice** thereby embracing equal access and non-discriminatory practice in service delivery.
- ☑ **Tailor or match services to the unique trauma-related needs of the individuals, children, families, organizations, and communities served.** Identify and understand the needs and help-seeking behaviors of individuals and families who have experienced trauma. Practice is driven in service delivery systems by client-preferred choices, not by culturally blind or culturally free interventions.
- ☑ **Ask cultural brokers, consultants, or liaisons who are members of the ethnic community to serve as a bridge between children and families, communities, and the child welfare agency.** These brokers should also be involved in planning trauma-informed initiatives and trainings to ensure cultural appropriateness.
- ☑ **Incorporate bilingual and bicultural staff in the child welfare agency as well as training all staff in cultural competency.** Training is recommended for child welfare staff to develop knowledge and skills in working with children and families from diverse socio-ethnic backgrounds and understanding cultural values, practices, and healing rituals related to trauma. This kind of training helps staff promote both cultural protective factors that prevent families from needing out-of-home placement and cultural healing practices that facilitate trauma recovery. Training should also include recognition of how a worker's own background, cultural lens, and perspective impact decision making and service delivery. Administrators can take the lead in ensuring that the agency culture is one that acknowledges, respects, and makes room for individuals with different backgrounds and viewpoints.
- ☑ **Work collaboratively with members of the community to understand the needs at hand** so that resources and services are appropriately matched to the trauma-related needs of each family. Agency policies should promote referrals to culturally and linguistically competent, trauma-informed mental health and other service providers. If the community lacks sufficient numbers of these providers, administrators can collaborate with their mental health partners to obtain resources to increase training in cultural competence and trauma-specific interventions.

Strategies for reducing disparity and disproportionality in public child welfare agencies include to:

- ☑ **Collect data about which disparities prevent certain groups from accessing, using, or receiving needed services, including trauma-specific services.**
- ☑ **Promote protective factors from various cultures that prevent families from needing out-of-home placement.**
- ☑ **Examine how to make agency policies, regulations, training, supervision, and practices both culturally relevant and trauma-informed for all families served by the system.**
- ☑ **Minimize biased decision-making by public child welfare personnel.**
- ☑ **Form strategic partnerships with local, regional, state, and national agencies in education, juvenile justice, health, and mental health systems.**
- ☑ **Redirect more resources to the most needy communities in a strategic way.**
- ☑ **Develop a comprehensive, systemic approach that combines several of these strategies** (American Public Human Services Association, 2010).
- ☑ **Focus change efforts on key areas including: administrative practices, budget and finance, change management, communications, information management, leadership, the practice model, public policy, research, strategic partnerships, strategy, technology, and the workforce** (American Public Human Services Association, 2010). The Disproportionality Diagnostic Tool (National Association of Public Child Welfare Administrators: <http://www.napcwa.org/DDT/tools.asp>) can be used to examine social, systematic, and individual factors that contribute to racial disparity and disproportionality.

Resources

Documents:

American Public Human Services Association. (2010). *Disparity and disproportionality guidance. Positioning public child welfare guidance: Strengthening families in the 21st century*. Washington, DC: Author.

Chapin Hall Center for Children. (2008). *Understanding racial and ethnic disparity in child welfare and juvenile justice*. Retrieved from the Center for Juvenile Justice Reform website: http://cjjr.georgetown.edu/pdfs/cjjr_ch_final.pdf

Child Welfare League of America. (2002). *Cultural Competence Agency Self-Assessment Instrument*. Washington, DC: CWLA Press.

Child Welfare League of America. (2003). *Cultural competence: A revised guide*. Washington, DC: CWLA Press.

Cohen, E. (2010). *A social worker's tool kit for working with immigrant families-healing the damage: Trauma and immigrant families in the child welfare system: Executive summary*. Retrieved from American Humane Association website: <http://www.americanhumane.org/assets/pdfs/children/pc-execsummary-trauma-immigrant-families.pdf>

Resources (cont.)

Velazquez, J., Jr., McPhatter, A. R., & Yang, K. (Eds.) (2003). Preface. Perspectives on cultural competence [Special issue]. *Child Welfare Journal of Policy, Practice, and Programs*, 82(2), 101-102.

The Workgroup on Adapting Latino Services. (2008). *Adaptation guidelines for serving Latino children and families affected by trauma* (1st ed.). San Diego, CA: Chadwick Center for Children and Families. Available at <http://www.chadwickcenter.org/WALS/wals.htm>

Online Resources:

Child Welfare Information Gateway website: Disproportionality page - <https://www.childwelfare.gov/systemwide/cultural/disporp/>

Organizations:

Child Welfare League of America (CWLA), Division of Cultural Competency website: <http://cwla.org/programs/culturalcompetence/default.htm>

National Child Resource Center for Tribes website: <http://www.nrc4tribes.org/>

The National Indian Child Welfare Association (NICWA) website: <http://www.nicwa.org>

Chapter 3: The Impact of Trauma on the Brain



Why is this Important to Child Welfare?

The Impact of Trauma on the Brain is important to child welfare because many children and families involved in the child welfare system have experienced significant trauma that can have a negative impact on their neurological systems. At birth, the brain is not fully formed and contains twice as many nerve cells as there will be at age 6. Which cells survive and thrive and which ones do not is determined by a combination of effects involving a person's genes and experiences. By age 6, the cells which have survived will have formed thousands of connections with other cells. With repeated experience and stimulation, these connections and influences can lead to regulation (i.e., management) of the cells' functions. Important brain functions such as frustration tolerance, ability to pay attention and learn, sleeping, eating, social relations, and arousal of the nervous system are regulated by these connections and influence. This process of experience impacting the formation of connections between cells and influencing their function continues throughout life. Trauma (such as excessive stress for too long, too often, or too intensely severe) has biological consequences on the regulation of brain functions, the way brain cells connect, and the way they influence each other. These biological effects damage the child's or adult's ability to control himself/herself, calmly interact properly with others, pay attention and learn, and take care of his/her health. This chapter will provide the administrator with a greater understanding of these processes and the importance of identifying and treating those individuals (both children and caregivers) involved in the child welfare system that have damaged neurological regulatory systems (i.e., systems that manage brain functions).

“Trauma...has biological consequences on the regulation of brain functions...”

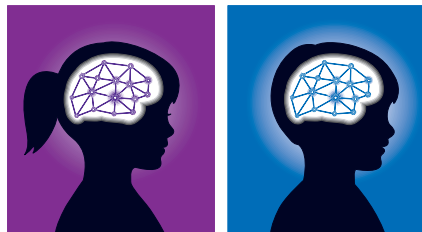
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Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize Physical and Psychological Safety for Children and Families

Identify Trauma-Related Needs of Children and Families

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Enhance Family Well-Being and Resilience

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Partner with Youth and Families

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Brief Summary

There is an increasing body of literature affirming that trauma, including neglect, has a significant impact on brain development, particularly during sensitive periods, such as infancy or adolescence. Recent brain research has established a foundation for many of the physical, cognitive, social, and emotional difficulties exhibited by children who experienced maltreatment in their early years. Maltreatment (e.g., child abuse or neglect) during infancy and early childhood has been shown to negatively affect early brain development and can have lasting effects into adolescence and adulthood (Child Welfare Information Gateway, 2011). Children involved in the child welfare system are usually not exposed to a single traumatic event. Rather, they experience multiple chronic and additive types of trauma that negatively impact their brain development. For families where there is intergenerational involvement in the system, the birth parents may also have been impacted in the same way. This chapter will provide a brief description of the impact of trauma on the brain.

Background

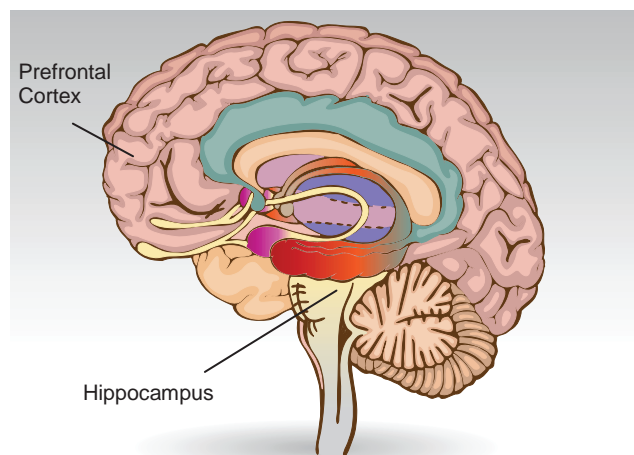
A child who has experienced chronic and complex trauma endures an overwhelming amount of stress that impacts his/her brain's ability to develop along a normal course. For this child, an enormous amount of energy is devoted to survival and developing skills to navigate situations that are perceived, many times realistically, as life-threatening. As a result, these adaptive (i.e., survival type) responses can become fixed and these can occur during non-threatening situations, therefore exhibiting a maladaptive (i.e., atypical) response to an ordinary situation. This process may be similar to how traumatic stress alters brain functioning. It is likely that a complex interaction between environmental experiences, including poor caregiving, and a child's genetic make-up influences neurobiological development (i.e., biological development of the brain) across infancy and childhood, which in turn sets the stage for a child's psychological and emotional development. Some studies, however, suggest that upon a certain amount of trauma severity, any genetic vulnerabilities the child possesses may be less relevant since almost all individuals can develop posttraumatic reactions that cause problems with how the brain functions.

Neurobiological Effects and Mechanisms in PTSD

Two specific areas of the brain related to processing cognitive information (e.g., thoughts) and learning appear to be affected when a child experiences PTSD [or trauma]:

- The hippocampus, which affects memory processing, storage, and retrieval
- The prefrontal cortex, the area that addresses attention and executive functions (e.g., planning, strategizing, organizing, setting goals, and paying attention to the important details)

These alterations may lead to the poor concentration, lack of motivation, and problems with attention that affect learning and school performance.



When a human being perceives environmental stress, a chemical reaction occurs that leads to high levels of cortisol (a chemical hormone produced by your body to manage stress) secretion. A growing body of research is demonstrating that cortisol, secreted under trauma and stress, can damage the brain (Carrion, Weems, & Reiss, 2007). Likewise, symptoms of depression often follow experiences of victimization. At a neurobiological level, they are related to lower activity levels in the prefrontal cortex and to the generation of fewer thoughts (Damasio et al., 2002). Other symptoms of emotional distress, such as anxiety, are associated with activation in the limbic system where the hippocampus resides. Stress handicaps one's ability to retain working memory, to focus attention at will, and to organize information in an effective manner – fundamental cognitive operations (i.e., thought processes) required for learning (Noteboom et al., 2001).

A young child who is neglected or maltreated has abnormal patterns of cortisol production that can last even after the child has been moved to a safe and loving home. Frequent or sustained activation of brain systems that respond to stress can lead to heightened vulnerability to a range of behavioral and physiological disorders over a lifetime. These undesirable outcomes can include a number of stress-related disorders affecting both mental (e.g., depression, anxiety disorders, alcoholism, drug abuse) and physical (e.g., cardiovascular disease, diabetes, stroke) health (National Scientific Council on the Developing Child, 2005).

Recommendations from the Field



- ☑ **Realize that many of the children who come into contact with the child welfare system have experienced chronic and complex trauma which has detrimentally impacted their brain development.** It is critical that the child welfare system understand that many of the troubling and difficult behaviors exhibited by children in the child welfare system (e.g., acting out, depression, etc.) are directly related to their brain functioning and that they are doing the very best they can.
- ☑ **Realize that many responses are characterized by altered physiology.** Dissociation (i.e., the process in which a child “checks out”), trembling, and fear are some of the behavioral outcomes that may result from altered brain function.
- ☑ **Understand that there are potential mechanisms (e.g., when a child is repeatedly exposed to stressful events) by which the fear response is strengthened and by which one can see associated symptoms and problems (e.g., impulsivity and anxiety).** These potential markers may serve as a guide to develop more focused treatments and gain empirical evidence for current treatment modalities.
- ☑ **Understand that many of the core components of trauma treatment are not only designed to cognitively impact children, but can also support their developing brain and help it to get “back on track.”** (See Chapter 11: Role of Trauma-Focused, Evidence-Based Mental Health Treatment for Child Trauma)
- ☑ **Understand that knowledge into the underlying brain processing will help guide behavioral interventions.** For example, some behavioral interventions are recommended based on the child's current brain functioning and are able to be tailored to match his/her functioning.
- ☑ **Promote policies that create corrective and healing experiences for children impacted by trauma.** Even though brain development is impacted by negative experiences in the environment, it is also affected by positive experiences such as good placement, nurturing, and encouragement.

Resources

Documents:

Carrion, V. G., Haas, B. W., Garrett, A., Song, S., & Reiss, A. L. (2010). Reduced hippocampal activity in youth with posttraumatic stress symptoms: An fMRI study. *Journal of Pediatric Psychology, 35*(5), 559-569.

Carrion, V. G., Weems, C. F., & Bradley, T. (2010). Natural disasters and the neurodevelopmental response to trauma in childhood: A brief overview and call to action. *Future Neurology, 5*(5), 667-674.

McCrary, E., De Brito, S. A., & Viding, E. (2010). Research review: The neurobiology and genetics of maltreatment and adversity. *The Journal of Child Psychology and Psychiatry, 51*(10), 1079-1095.

Chapter 4: Addressing Secondary Traumatic Stress and Vicarious Trauma in the Child Welfare Workforce



Why is this Important to Child Welfare?

Addressing Secondary Traumatic Stress and Vicarious Trauma on the Child Welfare Workforce is important to child welfare because working with children and families who have experienced trauma can have a negative impact on both professionals and foster parents, which can eventually lead to poor practice, burnout, and high turnover. Taking care of the child welfare workforce includes not only taking care of child welfare staff, but also foster and adoptive parents, counselors/therapists, court personnel, etc. In doing this work, they experience every possible emotion - they worry, they cry, they feel frustrated, they feel hopeless, and they feel scared. But they also feel hope, they laugh, they celebrate successes, they dream, and they encourage children and families to succeed. Administrators expect the child welfare workforce to accomplish so much and they expect them to support the most vulnerable population yet they have not historically done much to care for them. These administrators know how important it is to have qualified and dedicated professionals to really make a difference in children's lives. Therefore, administrators must build systems that support these professionals in taking care of their own health. In this, it is critical for administrators to understand the strategies and resources that exist to better support the child welfare workforce and others serving children and families involved in the child welfare system. This chapter will provide a background on secondary traumatic stress and all of its possible effects on those who work with traumatized children and adults and recommendations that can be implemented in child welfare systems across the country.

“...working with children and families who have experienced trauma can have a negative impact...”

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Essential Elements of a Trauma-Informed Child Welfare System Addressed



Brief Summary

Secondary traumatic stress (STS) and vicarious trauma (VT) have a significant impact on the child welfare workforce. As exposure to chronic, and often severe, child maltreatment is part of the daily work of child welfare professionals, secondary traumatic stress is an occupational hazard that can impact workers' and supervisors' ability to do their jobs and to remain in the field. The effects of STS on worker performance and retention can have negative effects on organizational functioning and can lead to poor outcomes for the children and families served. It is therefore imperative that administrators understand and recognize the impact that STS has on the child welfare workforce and that agencies implement policies and strategies to help mitigate the effects of STS.

Background

Secondary traumatic stress is the distress that results from hearing about the firsthand trauma experiences of others. Symptoms of STS are similar to, but usually less severe than, posttraumatic stress symptoms experienced by direct trauma victims. Symptoms of STS in child welfare workers include:

- Cynicism, anger, or irritability
- Anxiety, fearfulness
- Emotional detachment or numbing
- Sadness, depression
- Intrusive imagery or thoughts about clients' traumas
- Nightmares and sleep disturbance

- Social withdrawal
- Pessimistic worldview
- Diminished self-care
- Increased physical complaints and illness
- Use of alcohol/drugs to "forget about work"

(Osofsky, Putnam, & Lederman, 2008)

Anyone who is exposed to the traumatic stories of others (e.g., by listening or reading documents) is at risk for STS. Risk increases when traumatic exposure is unexpected and among professionals who lack adequate preparation and training. STS can occur after indirect exposure to a single traumatic event or a series of traumas. Sources of STS in child welfare include:



- Experiencing the death of a child or family member from an active or recently closed case.
- Investigating horrific abuse and neglect cases (e.g., those involving torture).
- Working in violent communities.
- Working continuously with families with extensive abuse histories.
- Removing a child from his/her home under distressing circumstances.
- Encountering system frustrations such as court decisions that may pose risk to children.
- Confronting verbal or physical assault by parents or community members. (Friedman, 2002)

Organizational factors can also contribute to secondary traumatization in the field of child welfare. These include:

- High caseload
 - Inadequate resources
 - Role conflict
 - Lack of job recognition
 - Lack of supervisory and peer support
 - Excessive workload/paperwork
 - Risks to personal safety
 - Personal liability for job-related decisions
- (Osofsky et al., 2008)

As child welfare agencies frequently experience crises, negative media attention, and public scrutiny, agencies themselves may react in a traumatized manner, creating a negative, high-conflict, fearful, distrusting, and unsupportive work environment.

High rates of STS among child welfare staff have a negative impact on organizational functioning. Some of the documented organizational effects of STS include:

<ul style="list-style-type: none"> • Increased absenteeism • Impaired judgment • Lack of willingness to accept extra work or assume responsibility • Low motivation • Lower productivity 	<ul style="list-style-type: none"> • Poor quality of work • Decreased compliance with organizational requirements • Greater staff friction • High staff turnover <p style="text-align: right;">(Osofsky et al., 2008)</p>
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Studies that have examined STS among child welfare workers have found this problem to be prevalent, with almost half of workers reporting high to very high levels of STS (Cornille & Woodard-Meyers, 1999; Conrad & Kellar-Guenther, 2006). A survey in New York City found that 60% of child welfare workers who were exposed to a highly distressing work-related event reported clinically significant symptoms of posttraumatic stress directly following the event, and 30% reported trauma symptoms two years later (Tullberg, 2008).

Vicarious trauma (VT) is a similar phenomenon, but refers to internal changes in worldview and perception of self and others due to chronic exposure to traumatic material. VT is cumulative, in other words, the impact on workers intensifies over time when exposed to multiple traumatic accounts. The effects of VT can exist in and spread through all areas of a worker’s life, including their sense of trust, safety, control, esteem, and intimacy. Symptoms of VT include:

<ul style="list-style-type: none"> • Feeling powerless or inadequate • Feeling “infected” by trauma • Feeling hopeless or depressed • Adopting a pessimistic or cynical outlook on life • Seeing the world as unsafe • Difficulty with trust • Social withdrawal 	<ul style="list-style-type: none"> • Feeling estranged • Difficulty separating work from personal life • Fatigue • Decreased interest in self-care and/or pleasurable activities • Increased absence from work
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Awareness and a plan that promotes positive coping strategies and increases organizational support are critical to minimizing the potential risk that VT and STS poses to staff, to the agency, and its clients. Child welfare administrators need to advocate for their staff who work with victims of traumatic events by creating programs to increase awareness of STS and VT and support systems that help prevent stress-related problems. These efforts promote workforce well-being, better job performance, and worker retention, thereby improving the quality of services delivered to children and families.

Recommendations from the Field



It is crucial that CW administrators take this issue seriously and implement agency policies and supports to help reduce the impact of STS and VT on child welfare staff. While some agencies provide critical incident debriefing after a crisis such as a child death and others offer one-time workshops on STS or self-care, very few jurisdictions have a systematic approach to address the impact on child welfare professionals of daily exposure to trauma (Collins, 2009).

Recommended organizational changes to reduce the impact of STS include to:



- ☑ **Understand and recognize the risk of STS for all staff members and the agency as a whole.**
- ☑ **Understand the importance of consistently helping staff identify and manage the difficulties associated with their jobs.**
- ☑ **Communicate this awareness of STS to their staff and help staff realized that these reactions are normal for professionals who work with traumatized families.**
- ☑ **Assess the current impact of STS on staff and how they are coping.** Self-administered checklists can be useful for assessment (Bride, Robinson, Yegidis, & Figley, 2004; Stamm, 2009). Supervisors and managers can also assist in the evaluation of how STS is affecting their workers and the quality of work in their units. Administrators can survey workers and supervisors on what supportive services they would find helpful and would utilize, if offered. Assessment helps inform leadership as to the need for a plan to address STS and how to best meet the needs of staff.
- ☑ **Plan and implement a set of policies and strategies designed to prevent and address the effects of STS on staff and the agency.**
- ☑ **Encourage ongoing discussion of STS among staff and administration** (Osofsky et al., 2008).
- ☑ **Reduce caseloads** (Osofsky et al., 2008).
- ☑ **Provide adequate supervision, coverage, and backup for staff** (Osofsky et al., 2008).
- ☑ **Ensure high-quality mental health coverage is available** (Osofsky et al., 2008).
- ☑ **Consider implementation of a multi-level, systemic, and ongoing plan to reduce secondary traumatization among their child welfare staff** (such as the Resilience Alliance Project, ACS-NYU Children's Trauma Institute - see resources on next page).

Some important elements of an STS prevention and intervention plan include to:

- ☑ **Provide ongoing education about STS, starting with orientation/pre-service training.**
- ☑ **Promote self-care and well-being through policies and communications with staff.**
- ☑ **Ensure that staff members receive adequate pay, benefits, vacation, and personal leave.**
- ☑ **Offer positive coping skills and stress management training.**
- ☑ **Provide staff with specialized trauma training to equip them with skills to better address trauma issues among the children and families they serve.**
- ☑ **Offer accessible and confidential on-the-job support systems (e.g., through Employee Assistance Programs or contracted mental health professionals) that provide staff opportunities to process their experiences and reactions individually or in groups.**
- ☑ **Provide critical incident debriefing automatically to affected staff and supervisors so that this intervention becomes routine protocol, and free of stigma.**
- ☑ **Create and maintain a work environment that conveys respect and appreciation, that is safe and confidential, and that provides support for continuing education, supervision, collaboration, consultation, and planned mental health breaks.**

Resources

Documents:

ACS-NYU Children's Trauma Institute. (2011). *The resilience alliance: Promoting resilience and reducing secondary trauma among child welfare staff*. New York: NYU Langone Medical Center.

Hendricks, A. (2012). Secondary traumatic stress in child welfare: Multi-level prevention and intervention strategies. *CW360°*, 12-13. Retrieved from http://www.cehd.umn.edu/ssw/cascw/attributes/PDF/publications/CW360_2012.pdf

LaLiberte, T., & Crudo, T. (Eds.). (2012). Secondary trauma and the child welfare workforce. *CW360°*. Retrieved from http://www.cehd.umn.edu/ssw/cascw/attributes/PDF/publications/CW360_2012.pdf

National Child Traumatic Stress Network: *Child Welfare Trauma Training Toolkit*: <http://www.nctsn.org/products/child-welfare-trauma-training-toolkit-2008>

Pryce, J. G., Shackelford, K .K., & Pryce, D. H. (2007). *Secondary traumatic stress and the child welfare professional*. Chicago: Lyceum Books, Inc.

Sprang, G., Craig, C., & Clark, J. (2011). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare*, 90(6), 149-168.

Organization:

National Child Traumatic Stress Network website: <http://www.nctsn.org>

Chapter 5: Promoting Child and Family Resilience in the Aftermath of Trauma



Why is this Important to Child Welfare?

Any child who enters the child welfare system has experienced some degree of trauma and adverse life situations. Promoting Child and Family Resilience in the Aftermath of Trauma is important to child

welfare because an administrator could easily become focused only on the trauma and lose sight of the sources of resilience (i.e., strength in adverse conditions) and protective processes (i.e., ways a person protects themselves) that can help buffer a child and family from the harmful effects of trauma. There is a growing awareness and increasing research on how protective factors (see page 46) can help a child and family recover from the harmful effects of trauma. An administrator can create organizational environments that allow the child and family to develop secure attachments by minimizing social worker changes or by focusing on ensuring that team decision making meetings occur prior to any placement move, in an effort to minimize placement moves. Ensuring that family finding activities occur for every child as soon as they enter care and that every child can identify at least one secure relationship with a trusting adult are also practices that ensure that stronger protective factors are in place for any child who has experienced trauma. An agency that ensures that the child and family are engaged in decision-making opportunities that allow them to master new

“An agency that ensures that the child and family are engaged in decision-making opportunities... will enhance protective factors...”

skills and experiences will enhance protective factors by increasing self-esteem and self-efficacy. Because protective factors include individual, social, and community factors, an administrator needs to promote policies and practices at multiple levels to increase the likelihood of positive outcomes for the child and family. Administrators know that any child and family they see may have experienced trauma, but this chapter highlights tools that allow them to help the child and family make new meaning of their trauma. This is done by focusing organizational efforts on the hope that is created by the advances in the system’s understanding of child and family resilience.

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Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize Physical and Psychological Safety for Children and Families

Identify Trauma-Related Needs of Children and Families

Enhance Child Well-Being and Resilience

Enhance Family Well-Being and Resilience

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

Partner with Youth and Families

Partner with Agencies and Systems that Interact with Children and Families

Brief Summary

The majority of children and families in the child welfare system have been exposed to multiple adverse life events, many of which are traumatic in nature. There has been a growing body of research on the potential negative physical and psychological consequences of trauma over the past few decades. However, all children who are at risk also have the capacity to be resilient, which describes the ability to master age-appropriate developmental tasks despite serious threats to adaptation (Masten, 2001). Fortunately, there is also an increasing awareness of the sources of resilience and protective processes that can help buffer children and families from the harmful effects of trauma and can also enhance their ability to recover from trauma. Advances in understanding child and family resilience in the face of multiple risk factors and exposure to traumatic events offer new hope to children and families in the child welfare system, and to the professionals who work with them.

Background

Children and families who are involved in the child welfare system are exposed to numerous risk factors that threaten their functioning and well-being. Risk factors for children include:

- Child abuse or neglect in the home
- Parental discord
- Low education level of parents
- Parental substance abuse
- Parental mental illness
- Large family size
- Racism
- Living in violent and impoverished communities
- Difficult temperament
- Low IQ



(National Child Welfare Resource Center for Family-Centered Practice, 2003)

Children who have been maltreated are especially at risk for problems such as:

- Serious emotional disorders
- Delinquency
- Substance abuse
- Homelessness
- Suicidal or self-destructive behaviors

Two children exposed to similar traumatic experiences can have very different reactions and outcomes. While there are several reasons for these individual differences, a higher number of co-occurring risk factors is associated with poorer outcomes (Rutter, 1985). On the other hand, the presence of multiple protective factors can help buffer children in the face of trauma. Protective factors can be individual, family, or community characteristics such as those listed on the next page.

Protective Factors		
Individual characteristics: <ul style="list-style-type: none"> • Cognitive ability (i.e., thought processes) • Self-efficacy (i.e., belief in one's ability to succeed in a particular situation) • Internal locus of control (i.e., a sense of having control over one's life and destiny) • Temperament • Social skills 	Family characteristics: <ul style="list-style-type: none"> • Family connection • Supportive parent-child interaction • Social support (e.g., extended family support) (Benzies & Mychasiuk, 2008)	Community characteristics: <ul style="list-style-type: none"> • Positive school experiences • Community resources • Supportive peers and/or mentors (Koball et al., 2011)



Child and family resilience are optimized when protective factors are strengthened at all three levels: individual, family, and community. Personal strengths may not be enough to help children adapt and function in multi-problem families facing numerous risk factors (Jaffee, Caspi, Moffitt, Polo-Tomas, & Taylor, 2007). Therefore, it is important for child welfare administrators to promote policies and practices that enhance resilience at multiple levels to increase the likelihood of positive outcomes for children and families.

Recommendations from the Field



- Understand that all children and families who come into the child welfare system have areas of strength and resilience.** Staff training and supervision can help child welfare workers identify not only risk factors, but also protective factors for each child and family on their caseload. Assessments and service plans should include child, parent, and family strengths as well as sources of community support.
- Realize that research shows that success at school can serve as an important buffer in the lives of children exposed to a range of adverse childhood experiences** (Katz, 1997). Partnering with the educational system and educating school personnel about trauma and trauma reactions can help minimize school disruptions for a child in an out-of-home placement. Administrators may consider designating child welfare liaisons to community school districts to enhance communication and cross-system collaboration. Policies providing transportation support and higher education opportunities for youth in care also promote resilience.
- Link children who are suffering from the effects of trauma to appropriate trauma treatment since this enhances resilience by providing opportunities to learn coping skills and make meaning of the traumatic experience(s).** Training child welfare staff on trauma screening and the benefits of evidence-supported trauma treatment models is recommended.
- Give children who are suffering from the effects of traumatic stress exposure opportunities to master new skills and experience success to help develop or strengthen their internal locus of control and enhance their self-esteem and self-efficacy.** Child welfare staff can therefore promote resilience by linking a child to school, community, or extra-curricular activities.

- ☑ **Understand that multi-setting, multi-level interventions are recommended for optimizing child and family resilience.** Strengthening Families (www.strengtheningfamilies.net) focuses on a family's strengths and protective factors through a partnership with the family and community programs to promote better outcomes.



Resources

Documents:

Flynn, R. J., Dudding, P. M., & Barber, J. G. (Eds.). (2006). *Promoting resilience in child welfare*. Ottawa: University of Ottawa Press.

Metzger, J. (2008). Resiliency in children and youth in kinship care and family foster care. *Child Welfare, 87*(6), 115-140.

Werner, E. & Smith, R. (2001). *Journeys from childhood to midlife: Risk, resilience, and recovery*. Ithaca, NY: Cornell University.

Organizations:

Center for the Study of Social Policy - Strengthening Families Program website: <http://www.cssp.org/reform/strengthening-families>

ResilienceNet website: <http://resilnet.uiuc.edu/>



Section 2: Child Welfare Practice

Applying a Trauma Lens to Child Welfare Practice
Embedding Trauma-Informed Practice in the Broader
Child- and Family-Serving System
Trauma-Informed Investigation and Engagement
Screening for Child Trauma within Child Welfare
Jurisdictions

Chapter 6: Applying a Trauma Lens to Child Welfare Practice



Why is this Important to Child Welfare?

Child welfare administrators work and live in a world surrounded by trauma to children and the developmental challenges this trauma presents as the agency assumes its role as *parens patriae*¹.

“Symptoms due to traumatic stress may be misinterpreted, misdiagnosed, and go untreated...”

Applying a Trauma Lens to Child Welfare Practice is important to child welfare because a child’s trauma may come from both the abusive and neglectful acts of caregivers and the actions of the child welfare agency itself. The trauma of initial removal may be underestimated by many. This trauma may be further compounded by multiple moves, or even abuse, while in care. Symptoms due to traumatic stress may be misinterpreted, misdiagnosed, and go untreated, leading to poor school performance, impaired social relationships, and serious problems in later adult functioning. The agency’s failure to recognize and respond effectively to a child’s trauma experience(s) may enhance the likelihood of poor well-being outcomes and the phenomenon of intergenerational child maltreatment. Child welfare agencies have multiple opportunities and entry points when working with a

child and family to integrate trauma-informed practices into their daily work. It is important for agency administrators to recognize those multiple entry points and support their staff in embedding trauma-informed casework practice across many levels, as recommended in this chapter.

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¹ *Parens patriae*, Latin for "parent of the nation" refers to the legal public policy power of the government [i.e., state or county] to intervene against an abusive or negligent caretaker and act as the guardian of any child or individual who is in need of protection.



Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize Physical and Psychological Safety for Children and Families

Identify Trauma-Related Needs of Children and Families

Enhance Child Well-Being and Resilience

Enhance Family Well-Being and Resilience

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

Partner with Youth and Families

Partner with Agencies and Systems that Interact with Children and Families

Brief Summary

Although many jurisdictions across the country have begun developing child welfare casework practice models (Léveillé & Chamberland, 2010), there is not an existing model that has incorporated trauma as a major component of child welfare practice. There has been growing awareness that almost all children who are involved with the child welfare system have experienced traumatic events and that the impact of these traumatic events can lead to poor outcomes if not adequately addressed by the system. It has also been recognized that when the child welfare system does not intervene in a trauma-sensitive and trauma-responsive manner, the system can create secondary adversities (e.g., separation from siblings, multiple placements, and school disruptions) and new traumas that impede a child's recovery from the initial trauma that led to his/her involvement with the system. As the field is moving toward a trauma-informed approach to child welfare, guidelines are needed to help administrators and child welfare staff integrate trauma-responsive policies and practices into their agencies and services. These guidelines include applying a trauma lens to agency mission and values, standards of practice, staff development, evaluation, supervision, and casework practice in all situations from reporting of suspected child abuse to post-permanency services.

Background

Over the past several years, many states have been developing casework practice models in an effort to reform their child welfare systems. Some states' reform efforts have been driven by lawsuits (Child Welfare Policy and Practice Group [CWPPG], 2008), while others are motivated by the need to address problem areas and improve outcomes identified through the Child and Family Services Review (CSFR) process. A child welfare practice model can be defined as a conceptual map or organizational ideology of how agency staff, families, and community stakeholders work together to promote child safety, permanency, and well-being (National Child Welfare Resource Center for Organizational Improvement [NCWROI], 2008). It is the "clear, written explanation of how the agency successfully functions" (NCWRCOI, 2008, p. 1). The core elements of a child welfare practice model include:

- Agency mission, vision, and values
- Practice principles
- Standards of professional practice
- Strategies and tools for integrating values, practice principles, and standards of professional practice into daily practice
- Plan for assessing service needs and engaging families
- Clearly defined agency performance outcomes
- Strategies to achieve and measure family, agency, and worker outcomes
- Plan for supporting organizational and practice change

In 2008, the Child Welfare Committee of the National Child Traumatic Stress Network (NCTSN) developed the first edition of the *Child Welfare Trauma Training Toolkit* to educate and train child welfare professionals on the impact of trauma and how to address the needs of children and families affected by trauma in the child welfare system (Child Welfare Collaborative Group, NCTSN & The

California Social Work Education Center, 2008). In 2013, this training was updated to include more comprehensive information on birth parent trauma, secondary traumatic stress and includes a Participant Manual (Child Welfare Collaborative Group, NCTSN & The California Social Work Education Center, 2013). This training is being implemented in jurisdictions all over the country, but there has been no concerted effort to integrate trauma content from the toolkit into existing or developing casework practice models. In order for child welfare workers and supervisors to truly adopt, implement, and sustain trauma-informed practice, it is important to incorporate trauma into future and existing models.

A trauma-informed casework practice model recognizes the unique impact of trauma and the ways in which child welfare practice can be more effective when applied through a “trauma lens,” just as practice is more effective when applied through a cultural lens or with an understanding of child development. While trauma should not be the only or even the dominant consideration in the design of a practice model, the effects of trauma are far-reaching and impact casework practice at multiple levels.



Trauma and its widespread effects have traditionally been overlooked or not well-understood in day-to-day child welfare practice. Rather than being viewed as a new or competing initiative, trauma-informed child welfare is a lens which can be applied to current practice approaches and a fabric that is woven throughout agency practice. When child welfare staff have a solid understanding of trauma, how it impacts children and families, and how to intervene with trauma-responsive practices, they will be better equipped to engage families, link them to appropriate services, and help children achieve safety, permanency, and well-being.

Recommendations from the Field



- ☑ **Incorporate trauma knowledge into new casework practice models.** Child Welfare Administrators who are planning to develop a new practice model would be wise to incorporate trauma knowledge into the core aspects of the practice model.
- ☑ **Evaluate existing practice models.** Those jurisdictions with existing practice models can evaluate the model and its components to learn the extent to which they embody the Essential Elements of a Trauma-Informed Child Welfare System (see pages 12-14 of this guide).
- ☑ **Conduct a trauma-informed organizational assessment:** Administrators can utilize an organizational self-assessment (Fallot & Harris, 2002; Hendricks, Conradi, & Wilson, 2011) to evaluate the extent to which current agency policies and practices are trauma-informed. These assessments also help identify agency strengths and barriers in regard to trauma-informed services and areas in which greater attention is needed.
- ☑ **Utilize new resources to help guide the process:** The Chadwick Trauma-Informed Systems Project (CTISP) has developed a publication, *Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model*, to assist administrators with integrating trauma-informed policies, supervisory strategies, and practices into new and existing casework practice models. These guidelines are included in the *Trauma-Informed Child Welfare Practice Toolkit* along with the 16-page *Desk Guide on Trauma-Informed Child Welfare for Child Mental Health*, the 20-page *Desk Guide on Trauma-Informed Mental Health for Child Welfare*, the *Trauma System Readiness Tool*, and this guide for administrators. All of them are available on www.ctisp.org. The *Guidelines for*

Applying a Trauma Lens to a Child Welfare Practice Model will include specific strategies for incorporating trauma into an agency's:



- ⇒ Mission, vision, and core values
- ⇒ Policy
- ⇒ Practice principles
- ⇒ Standards of professional practice
- ⇒ Staff development and retention
- ⇒ Evaluation of desired outcomes and the practice model's impact on them
- ⇒ Staff safety and well-being
- ⇒ Supervisory practices
- ⇒ Casework practice

Suggestions and examples of trauma-informed policies and practices will be provided for each step of a sample casework practice. The steps of the practice are listed below.

Steps of a Casework Practice that can Become Trauma-Informed	
⇒ Reporting suspected child abuse or neglect	⇒ Visitation/parenting time
⇒ Investigation/fact finding	⇒ Participatory case planning
⇒ Safety planning	⇒ Case management
⇒ Assessment of family functioning	⇒ Permanency planning
⇒ In-home family support services	⇒ Reunification
⇒ Removal and initial placement	⇒ Adoption and Guardianship
⇒ Out-of-home placement	⇒ Post-permanency supports
	⇒ Transitioning into Adulthood

Facilitate culture change in the agency. The following steps are recommended for moving toward a trauma-informed culture:

- ⇒ Initial planning
 - ◆ Administrative commitment and support
 - ◆ Formation of a trauma workgroup or task force with full representation of each key stakeholder group
 - ◆ Identification of *trauma champions*
 - ◆ Programmatic awareness of the scope and timeline of the culture shift
- ⇒ A kickoff training event, including as many staff as possible and the following content:
 - ◆ Awareness of trauma-informed cultures
 - ◆ Importance of staff support and care
 - ◆ Importance of addressing trauma in child welfare
 - ◆ Implications for changes in staff's daily work with children and families

⇒ Short-term follow-up

- ◆ Development of an implementation plan by the trauma workgroup that is reviewed by staff, stakeholders, and consultants
- ◆ Training for all staff on understanding trauma
- ◆ Training on staff support and care



⇒ Longer-term follow-up

- ◆ Evaluation of progress by the trauma workgroup and consultants
- ◆ Planning for sustainability (Fallot & Harris, 2009)

Resources

Documents:

Chadwick Trauma-Informed Systems Project - *Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model*: <http://www.ctisp.org>

Conradi, L., Agosti, J., Tullberg, E., Richardson, L., Langan, H., Ko, S., & Wilson, C. (2011). Promising practices and strategies for using trauma-informed child welfare practice to improve foster care placement stability: A breakthrough series collaborative. *Child Welfare*, 90(6), 207-226.

National Child Traumatic Stress Network - *Child Welfare Trauma Training Toolkit*: <http://www.nctsnet.org/products/child-welfare-trauma-training-toolkit-2008>

Organization:

Child Welfare Policy and Practice Group website: <http://www.childwelfaregroup.org/>

Chapter 7: Embedding Trauma-Informed Practice in the Broader Child- and Family-Serving System



Why is this Important to Child Welfare?

Embedding Trauma-Informed Practice in the Broader Child- and Family-Serving System is important to child welfare since children who are involved in the child welfare system and have experienced traumatic events are likely to be involved in multiple child-serving systems. These events include both the trauma suffered by the child in his/her own home and the trauma created by the child-serving system itself (e.g., placement changes, separation from siblings). This trauma can continue until the time the child, or now adult, leaves the system. The effects of the trauma are shown in the statistics: 25% of children in the child welfare system will be incarcerated within the first two years after they age out of the system, more than 20% will become homeless, only 58% will have a high school diploma, and less than three percent will have a college education by the time they reach 25 years of age. Additionally, it is not uncommon for former dependent or delinquent youth to re-enter the child welfare system as parents. Given that the child welfare system often serves as the epicenter of services for these children, it is critical that the child welfare system is not only trauma-informed, but that it infuses this knowledge and practice into its partnership with other child-serving systems, including law enforcement, the courts, the attorneys, court-appointed special advocates (CASAs), and treatment providers.

“The trauma created by the child-serving system itself ... can continue until the time the child, or now adult, leaves the system.”

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Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize Physical and Psychological Safety for Children and Families

Identify Trauma-Related Needs of Children and Families

Enhance Child Well-Being and Resilience

Enhance Family Well-Being and Resilience

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

Partner with Youth and Families

Partner with Agencies and Systems that Interact with Children and Families

Brief Summary

Child welfare sits at the epicenter of a broader child-serving system, and therefore, a trauma-informed child welfare system cannot be created in isolation of related child- and family-serving systems that have contact with the families served by child welfare. In most cases, children served by the child welfare system, their siblings, and families are involved in many of these systems at the same time. Improvements in a child welfare agency, and even in its key support providers such as resource parents and community-based social service agencies, will fail to have the maximum impact if the courts, schools, law enforcement, juvenile justice system, domestic violence agencies, court-appointed special advocates (CASAs), substance abuse providers, mental health providers, and other providers the child welfare system relies upon are not trauma-informed or act in ways that are trauma-insensitive. The child welfare agency may find a synergy in their efforts if other systems, or a community of systems, embark upon the same journey toward trauma-informed practice along with child welfare, thereby providing consistent messages to their staff, the families who interact with the systems, and the community.

Background

No matter which part of the broader child welfare system an administrator focuses on, the Essential Elements of a Trauma-Informed Child Welfare System (see pages 12-14) can help guide assessment and joint planning. Some communities and entire states have found advantages in embedding efforts to move towards a trauma-informed environment in a more comprehensive multi-system initiative. Such an initiative would aim to shift major child- and family-serving systems to trauma-informed practice in an integrated manner. To succeed, those seeking to launch a multi-system initiative should recruit key stakeholders from the executive level of the targeted systems, such as a lead juvenile judge, head of the mental health department, district attorney, or superintendent of schools. The pace of progress can be accelerated through a shared vision among the leadership of all the organizations seeking to move toward a more trauma-informed child and family service system. Such multisystem initiatives are attractive, but may prove impractical for political or logistical reasons. The child welfare system in a community such as that should then explore partnerships with the system or systems where overlap and interactions are most common and coordination is critical. The purpose of this chapter is to highlight broader system-level coordination (for more information on individual and community-level collaboration, see Chapter 15: Collaborating with Other Agencies). Some of the most common child- and family-serving systems in which child welfare interacts are education, juvenile justice, and the mental health services system. Lessons learned from working with these three systems can be applied across various child and family-serving systems:

Education: Each child welfare system director must chart a unique course for approaching education. In some places, the state Department of Education or the local superintendent may be open to discussions about the value of trauma-informed practice, while in many more communities, child welfare administrators will need to reach out to school principals and counselors. As the child welfare agency gains an understanding of how to make children in its care feel more psychologically safe and how to manage triggers or traumatic reminders, it is important that the local schools are provided with similar trauma-related knowledge and skills. For example, school personnel need to be trained on childhood trauma and its impact as well as techniques designed to help the child



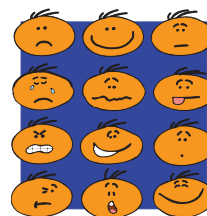
manage overwhelming trauma-related reactions, which will improve his/her ability to learn and prosper in a school setting.



Juvenile Justice: Children involved in the juvenile justice system present with high rates of trauma. In one study, 92.5% of participants active in juvenile justice had experienced one or more traumatic events in their lifetime and 11.2% of the sample had met criteria for posttraumatic stress disorder (PTSD) in the past year (Abram et al., 2004). Research suggests that some of the youths' delinquent behaviors occurred as a response to their traumatic stress history. A number of national organizations have

applied a trauma lens to their work with this population, including the National Commission on Correctional Healthcare, the National Council of Juvenile and Family Court Judges, the National Juvenile Defenders Center, and the National Center for Mental Health and Juvenile Justice (Ford, Chapman, Hawke, & Albert, 2007). State and county juvenile justice systems, departments of children and families, and children's advocates are sponsoring trauma initiatives across the country as well. Partnering with these and similar organizations, advocacy groups, and initiatives offers child welfare administrators many productive venues for public and professional education and development of collaborative models for evidence-based services for traumatized youths in the juvenile justice system.

Mental Health: Any child and his/her caregiver(s) involved in the child welfare system are likely to also interface with the mental health system either to address their own trauma history, or to address other general mental health concerns. Any child and/or adult recovering from traumatic stress should be referred for specialized mental health services designed to help the individual 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 interact with others, to attach with caregivers, learn in school, and manage his/her emotions in ways that are socially acceptable. General mental health concerns include behavioral problems (i.e., not resulting from trauma), depression, and anxiety, among others. For an adult 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 engaging in high-risk behaviors, such as smoking and substance abuse to cope with trauma triggers (Felitti et al., 1998). Few child welfare agencies are equipped to address the mental health needs within their agencies and most rely on other public and/or private mental health providers to deliver clinically indicated services to the child and family. It is vital that child welfare forge an alliance with those who provide clinical behavioral services to children and their caregivers referred by the agency. Failure to do so can lead to interagency conflict and more importantly missed opportunity to provide effective services and supports to the child and family.



Mental health providers serving child welfare children and families come in many forms from classic out-patient or in-home providers to substance abuse treatment agencies, treatment foster care, group homes, residential treatments, and psychiatric hospitals. Working with these providers is made more challenging as some work for public agencies while others work for non-profits or are private practitioners. Sometimes child welfare pays for the services and other times the providers depend on other sources of public or private reimbursement or philanthropy to support their work. Child welfare needs to establish a mutually respectful pathway of communication with its mental health partners. Child welfare must recognize mental health has related, but different goals when working with children

and families. It is important for mental health providers to hear what the child and family, as well as child welfare professionals, hope to accomplish with their referral for services, what goals child welfare has for the child and family, and what strategies child welfare believes should be considered in treatment planning.

Recommendations from the Field



- ☑ **Advocate among leadership in mental health, education, juvenile justice, and other systems to consider a trauma-informed approach to their work with families.** Some of the leaders in those systems may share an interest in working together on this effort. The systems most likely to be hearing similar messages about the value of trauma-informed care from their funding agencies and federal partners are those that mental health and substance abuse treatment.
- ☑ **Introduce other systems to the benefits of a trauma-informed approach and the importance of interagency collaboration.** By working together with the child welfare agency, systems such as juvenile justice, schools, courts, and others can better achieve their own goals and manage trauma-related behaviors in the home, community, and classroom. Many of the Essential Elements of a Trauma-Informed Child Welfare System, including Partner with Agencies and Systems that Interact with Children and Families, Enhance Child Well-Being and Resilience, Enhance Family Well-Being and Resilience, and Partner with Youth and Families, can be linked to the goals of the other systems in practical ways.
- ☑ **Advocate that those systems serving and interacting with adult caregivers who are involved in the child welfare system should seek to be trauma-informed.** Adult trauma history and symptoms play a central role in an individual's ability to parent and to protect his/her own child(ren). Trauma has been linked to substance abuse, the inability to regulate or manage emotions, and adverse influences on social interactions that extend well into adulthood and may impact child safety and well-being. These trauma symptoms further interfere with a parent's capacity to work effectively with the child welfare agency to address those factors that place a child at risk. Systems providing services to adult caregivers would benefit from applying a trauma-informed lens to their practices. Many of the Essential Elements of a Trauma-Informed Child Welfare System have direct application in working with traumatized adults such as Maximize Physical and Psychological Safety for Children and Families, Enhance Child Well-Being and Resilience, and Enhance Family Well-Being and Resilience. Working in synergy or collaboration with these systems can only improve outcomes for children and families.
- ☑ **Assume a leadership role in educating other systems about child and family trauma and its impact.** Working with mental health partners or independently, child welfare training departments can provide education and outreach to the:
 - ◆ Schools using the NCTSN's *Child Trauma Toolkit for Educators*
 - ◆ Courts/juvenile justice system utilizing NCTSN and related resources that have been developed for this audience

Resources

Documents:

Cooper, J. L., Masi, R., Dababnah, S., Aratani, Y., & Knitzer, J. (2007). *Strengthening policies to support children, youth, and families who experience trauma. Unclaimed Children Revisited, Working Paper No. 2.* Retrieved from the National Center for Children in Poverty website: http://www.nccp.org/publications/pub_737.html

Harris, M., & Fallot, R. (2001). *Using trauma theory to design service systems.* San Francisco: Jossey-Bass.

Henry, J., Richardson, M., Black-Pond, C., Sloane, M., Atchison, B., & Hyter, Y. (2011). A grassroots prototype for trauma-informed child welfare systems change. *Child Welfare, 90*(6), 169-186.

Hodas, G. (2006). *Responding to childhood trauma: The promise and practice of trauma-informed care.* Retrieved from the Pennsylvania Office of Mental Health and Substance Abuse Services website: http://www.nasmhpd.org/general_files/publications/ntac_pubs/Responding%20to%20Childhood%20Trauma%20-%20Hodas.pdf

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., ... Layne, C. M. (2008). Creating trauma-Informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice, 39*, 396-404.

National Child Traumatic Stress Network (NCTSN) - *Child Trauma Toolkit for Educators:* <http://www.nctsn.org/resources/audiences/school-personnel/trauma-toolkit>.

National Council for Community Behavioral Healthcare. (2011). *Trauma-informed behavioral healthcare. Issue 2.* Retrieved from http://www.thenationalcouncil.org/cs/about_us/national_council_magazine

Organizations:

NCTSN website - Resources for Juvenile Justice Professionals: <http://www.nctsn.org/resources/topics/juvenile-justice-system>

National Center for Mental Health and Juvenile Justice website: <http://www.ncmhji.com/>

National Center for Trauma-Informed Care website: <http://www.samhsa.gov/nctic>

National Center for PTSD website: <http://www.ptsd.va.gov>

Chapter 8: Trauma-Informed Investigation and Engagement



Why is this Important to Child Welfare?

“Addressing the issue of trauma is particularly critical during the investigation process, as it sets the stage for the family’s future interactions with the child welfare system.”

The public child welfare system initiated from an effort to address child safety as related to maltreatment from the child's caretaker. The evolution of the standards and means by which public child welfare agencies would interact with families lead to the emphasis on the requirement to provide services to either prevent removal, or to secure permanency when removal was warranted. Trauma-Informed Investigation and Engagement is important to child welfare because the child protective services investigation is one of the first entry points by which a child and family may become involved with the child welfare system and how the investigation is conducted sets the stage for the family's future interactions with the system. If an investigation is conducted in an accusatory and blaming manner, it creates an atmosphere where the child and family will not feel safe, regardless of which positive interventions are subsequently provided to the family. However, if the investigation is conducted in a manner supporting the child's and family's well-being, it sets the stage for a more positive interaction between child welfare workers and the children and families. Therefore, conducting a trauma-informed investigation is critical in efforts to create a more trauma-informed child welfare system.

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Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize
Physical and
Psychological
Safety for
Children and
Families

Identify
Trauma-
Related
Needs of
Children and
Families

Enhance
Child
Well-Being
and
Resilience

Enhance
Family
Well-Being
and
Resilience

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

Partner
with
Youth and
Families

Partner
with Agencies
and Systems
that Interact
with Children
and Families

Brief Summary

The foundation upon which the child welfare caseworker builds his/her decisions about safety, permanency, and well-being are often formed in the earliest days of a case. At this time, the child welfare caseworker, perhaps with the assistance of other disciplines and agencies (e.g., law enforcement), gathers facts, forms initial opinions about safety and risk and about the underlying causes of maltreatment, and begins a relationship with the child and family. This process is most often referred to as the investigation or assessment process. Essentially during this process, the child welfare caseworker determines if there is reason to believe a child has been abused or neglected and/or is at risk of abuse and neglect in the immediate future. The stakes are enormous in this process. Failure to understand the facts and risks can, and has, resulted in disastrous misjudgments that ended in the death of a child. On the other hand, incorrect or incomplete information can lead the child welfare professional to believe a child to be at risk when he/she is not and unnecessarily expose the child and family to the sometimes toxic effects of the child protection system. Even if the child welfare caseworker is successful in accurately gathering the facts and reaching correct safety decisions, the process may leave the child with new traumas and the family estranged and locked in an adversarial relationship with the child welfare professional who is seeking to protect the child and help the family.

Background

A trauma-informed approach to the investigative phase of the case may offer an opportunity to gain more accurate and complete information about what, if anything, happened and about any risks that lie under the surface. This approach would also do so in a way that not only avoids adding avoidable secondary trauma, but may actually help engage the child and family in a positive change process.

The investigative process is often an unavoidably stressful period for the child and family. This stress and how the child welfare worker approaches fact finding can cause memories of past trauma to surface and physiological reactions based on that past trauma to occur. A child who feels psychologically or emotionally unsafe during the investigation can experience the actions of the child welfare investigator as traumatic. The ability and willingness of the child and caregiver(s) to accurately describe their experience and to be reliable informants can be impaired further by an investigator's approach that is perceived as insensitive or overly authoritative. Using a trauma-informed approach, child welfare and other investigators can minimize the potentially adverse impact of the investigation process and improve the accuracy of the information they secure while enhancing engagement of all parties. Actions that seek to make both the child and adult caregiver(s), who may also be a trauma survivor himself/herself, feel as psychologically safe as possible under the circumstances can improve fact finding and enhance engagement while limiting the addition of new system-oriented traumas.

A trauma-informed investigation has several components and better informs the assessment of underlying risks and needs of the child and family. This type of investigation includes trauma-informed actions at both the system-level as well as the caseworker level. Some of these actions are actually already commonplace in many communities while others still need to be developed. Examples of three key places in investigations where the process can easily create more trauma for the child and

family, along with strategies that may make the process more trauma-informed and less stressful for the child and family, are listed below:

- **Multiple Agency Involvement:** Child welfare is not the only agency seeking information about allegations of abuse. If investigative agencies do not act in concert as a team, a child and his/her family members must provide the same information over and over to different parties who are not sharing with each other. This can be especially damaging when all investigators must ask about the details of traumatic events such as sexual abuse or violent death. To make this more trauma-informed, efforts should be undertaken to reduce the need for redundant interviews of any child or traumatized adult(s) through teamwork and coordination. This goal is a key principal of the child advocacy center movement across the nation. Many communities have established multidisciplinary investigative teams and child advocacy centers to facilitate this type of coordination. (See www.nca-online.org for information on teams around the nation).



- **Interviewing a Child:** It is often necessary during the investigation to ask a child directly about highly traumatic events such as abuse or violence in the home. Seeking intimate details of traumatic events, such as sexual abuse, in the midst of the initial investigation and without first building a trusting relationship or giving the child the skills needed to manage the stress, can actually add trauma and make it worse. Unfortunately, this information is often necessary for safety and case-planning purposes. A trauma-informed child welfare system seeks to gather this information in the least harmful way possible. Numerous protocols exist to guide forensic interviews that include adequate rapport building and use of open-ended questions inviting the child to offer the narrative rather than feeling interrogated. Even where the interview occurs can be important. Most initial interviews occur in the home or at school and the interviewer should select a quiet private neutral location. When possible, the child should not be interviewed in visual or hearing range of parents or others who may deliberately or unintentionally exert pressure on the child or invoke a fear response. The ideal place for the interview is in a structured child-friendly and neutral environment, such as found in a child advocacy center where the team can also reduce how many times the child must be interviewed by recording the interview so others can watch it later.

- **High Tension Law Enforcement Raids:** One challenging situation that requires special coordination to create a trauma-informed approach is working with law enforcement carrying out a drug raid, or other high tension type raid. It is not uncommon for law enforcement officers making arrests for manufacture or distribution of drugs to encounter a small child in the home under investigation. Many communities now assign child protective service workers to be present at the raid. From a trauma-informed perspective, it is important to recognize that the sudden and aggressive nature of law enforcement entry into the home can be traumatic in and of itself. The safety of all involved requires law enforcement to move swiftly and with overwhelming force often wearing menacing looking protective gear. The role of the child welfare worker should be to quickly secure the child and move him/her to a place of relative physical security and immediately help the child feel as psychologically safe as possible. Teams should be trained on strategies for de-escalating the child's stress during a drug raid. Caseworkers should avoid dressing in raid gear worn by law enforcement and seek to appear as nonthreatening as possible. As the child's own possessions may be contaminated with toxic residue, teams should come to the scene with basic essentials needed to care for the child and to serve as calming transitional objects such as stuffed animals from which the child can choose.



Recommendations from the Field



Trauma-informed actions that individual investigators can take to make the process more trauma-informed and **less stressful for a child** are to:

- ☑ **Do all one can to keep the scene calm and divert an angry and out-of-control parent or caregiver out of the child's presence, when possible.**
- ☑ **Seek to talk with the child in a safe and secure setting, even if within a home under investigation.** Avoid locations within the home where abuse is more likely to have occurred and where the memories (i.e., traumatic reminders) of any abuse would be the strongest, such as the bedroom in a sexual abuse case. Postpone detailed questions until the child can be interviewed in a neutral, child-friendly setting.
- ☑ **Explain in age-appropriate ways what is going on, answer the child's questions, ask what he/she is concerned about, and ask the child what would make him/her feel safe.** Try to follow through as best as practical.
- ☑ **Shield the child immediately from any crime scene where a body, seriously injured person or pet, or overt signs of violent death or injury are present.**
- ☑ **Focus the child on the familiar: school, pets, friends, safe relatives, etc.**
- ☑ **Ask the parent or caregiver to reassure the child that he/she is safe and the investigators are here to help the child.**

Trauma-informed actions that individual investigators can take to make the process more trauma-informed, **less stressful for adult caregivers, and more likely that the adult caregivers will engage** with child welfare are to:

- ☑ **Treat the parent or caregiver with respect and use a calm tone of communication even when confronted with aggression and hostility.** Trauma victims are often accustomed to losing power during traumatic events (e.g., child abuse, domestic violence, community violence) and may meet that loss of power with aggression or, alternatively, superficial compliance. Stress may cause a traumatic response and highly emotional, and less than rational, thoughts and actions. Workers should give the parent as much control over the environment as practical during the investigation to defuse some of the trauma-driven patterns. Seek opportunities to give the parent or caregiver a choice in how to proceed *within the limits of good investigation*.
- ☑ **Incorporate the use of peer mentors, recovery coaches, and model supports in child welfare offices and dependency courts to engage parents during the investigative and engagement process** (Center for Substance Abuse Treatment, 2010). Peer supports understand trauma-informed services, substance abuse, and the recovery process because of their own life experience, and can therefore assist with parent engagement and retention in services. Life-experienced workers are able to build stronger ties with parents, based on their own experiences in the system, thus building empathy and connection with the client (Gardner & Nava, 2007).
- ☑ **Avoid threatening an adult domestic violence victim with removal in an effort to force protective action.** Such actions may trigger or cause a trauma response that is unhelpful. Focus more on determining what protective actions have worked in the past and how those strategies can be strengthened with agency support. If removal is necessary, seek to redirect the stress as outlined on the next page.

Trauma-informed removals: It sometimes becomes necessary to remove the child from the home. While removals may be necessary to secure physical safety, they often leave the child feeling psychologically unsafe and can be perceived as highly traumatic thus potentially deepening the emotional scars a child may already have due to abuse or neglect. Here are some techniques to make a removal more trauma-informed:



- ☑ **Enlist the parent as part of the solution which can help the child and the parent who may both be trauma victims.** Explain to the parent that he/she is the expert on his/her child and ask the parent to give as much information as possible about how to make the child feel safe and comfortable in the foster care setting, even if it just for a short period. This includes everything from bedtime and morning routines; food likes, dislikes, and allergies; nicknames; favorite TV programs or other routines; lessons on how to help the child cope with stress; and related items. Collecting this information helps equip the substitute care provider with knowledge he/she can use to make his/her home feel somewhat familiar to the child. Some birth parents also report feeling respected by this approach and are more willing to engage with the worker. Some communities have developed simple forms that the parent can complete to be passed onto the foster parent.
- ☑ **Ask the parent or caregiver for copies of some family photos the child can take with them.**
- ☑ **Explain to the child what is happening in age-appropriate language.** Explain that it is normal to feel scared and confused and know the types of things kids his/her age worry about. Explain how he/she will be safe. Give the child as much information as possible about where he/she is going, who he/she will be staying with, what the placement or home is like (i.e., some workers show the child and/or the birth parents photos of the foster family or placement to reduce the fear of the unknown), explain how school will be handled tomorrow, and what is happening with siblings, parents, pets, and close relatives, as applicable.
- ☑ **Repeat information for the child, as needed, and give them written information and/or a phone number for someone they can call for more information, whenever possible.**
- ☑ **Minimize the number of "hand-offs" a child has to experience during the removal and placement process.** Ideally, the child would be able to be with the same person during the whole process.
- ☑ **Give the child some control and choice.** Ask the child what will help him/her feel safe or sleep better and what he/she really want to take with him/her (e.g., transitional objects such as a stuffed animal or his/her favorite pajamas). Some answers will not be practical such as taking a pet or a parent, but at least the worker can explain the practical limits of what can be arranged. Walk the child around his/her room and ask the child if he/she wants to take anything with him/her.

Note: It is important that controls are in place in the foster care system not to misplace these important objects and favorite clothing once in placement or the worker betrays the trust and deepens the trauma.
- ☑ **Provide the parent with written information on the process and how he/she can help ease the child's transition into foster placement even if he/she is planning to contest the placement in court.**

Resources

Document:

Pence, D. M. (2011). Trauma-informed forensic child maltreatment investigations. *Child Welfare*, 90(6), 49-68.

Organizations:

National Alliance for Drug Endangered Children website: <http://www.nationaldec.org/>

National Children's Alliance website: www.nca-online.org

Chapter 9: Screening for Child Trauma within Child Welfare Jurisdictions



Why is this Important to Child Welfare?

“...all children who have been exposed to traumatic events should be properly screened to determine their level and type of trauma exposure and symptoms...”

Screening for Child Trauma within Child Welfare Jurisdictions is important to child welfare because the short- and long-term effects of traumatic stress exposure on children in the child welfare system can be quite significant. Fortunately, there are numerous trauma-focused treatment practices that currently exist which have evidence to support their utility in helping children heal from traumatic stress symptoms (e.g., Trauma-Focused Cognitive-Behavioral Therapy [TF-CBT], Child-Parent Psychotherapy [CPP], etc.). However, in order to receive these practices, all children who have been exposed to traumatic events need to be properly screened to determine their level and type of trauma exposure and symptoms, and then referred for a more comprehensive trauma-focused assessment that directs them to the most appropriate treatment.

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Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize Physical and Psychological Safety for Children and Families

Identify Trauma-Related Needs of Children and Families

Enhance Child Well-Being and Resilience

Enhance Family Well-Being and Resilience

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

Partner with Youth and Families

Partner with Agencies and Systems that Interact with Children and Families

Brief Summary

Many child welfare jurisdictions are attempting to integrate trauma-focused screening questions or assessment tools into their casework practice. Trauma screening refers to a brief measure, test, instrument, or tool that is universally administered to children by child welfare workers, ideally during their initial contact with the child welfare system. Trauma screening tools typically detect exposure to potentially traumatic events/experiences and/or endorsement of possible traumatic stress symptoms/reactions. However, the tools are not to be used to diagnose what causes the symptoms, just state that they are present. 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. This chapter will highlight how the use of trauma-informed screening practices can aid the child welfare caseworker in better understanding the child in his/her care and facilitate referrals to the appropriate trauma-focused mental health professional for assessment and treatment. Much of the information gathered for this chapter was adapted from Conradi, Wherry, and Kisiel (2011).

Background

A trauma screening tool is designed to be universal; that is, it should 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. Common types of traumatic events screened for include:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Neglect (physical and emotional)
- Exposure to domestic violence
- War trauma
- Community violence
- Natural/manmade disasters

Types of traumatic symptoms may include:

- Posttraumatic stress disorder (PTSD; with symptoms such as hyperarousal, re-experiencing of the trauma, and avoidance of reminders/triggers of the trauma)
- Hypervigilance (i.e., being very alert)
- Dissociation (i.e., being very distracted or distant)
- Difficulties managing emotions or behaviors
- Difficulty sleeping
- Difficulty eating
- Difficulty concentrating

It is critical to screen for both trauma experiences and reactions these since *not all children who have experienced traumatic events will experience traumatic stress symptoms or trauma responses* (Kolko et al., 2010).



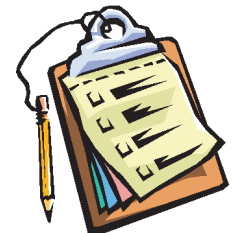
Each child is unique and the use of a trauma screening is critical to help determine the specific experiences of each child. However, there are a number of barriers that exist that prevent child welfare workers from conducting the screening. These include:

- Allocating time to receive training on how to effectively conduct the screening
- Finding time to conduct the screening
- Determining the best ways in which to utilize the information gathered during the screening and how to use it for referral purposes
- Managing the effects of secondary/vicarious trauma that may emerge when asking a child about the potentially numerous traumatic experiences they have had in their lives.

While there are barriers to conducting a trauma screening, there are also a number of benefits (see Conradi et al. [2011] for more information about the benefits of trauma screening in the child welfare system). In many ways, child welfare workers are already conducting trauma screenings, although they have not identified them as such. Integrating some questions about specific trauma experiences and symptoms can readily be woven into existing practices and tools. Further, once a caseworker has conducted a trauma screening, they will have a greater understanding of the types of traumatic events this child has experienced during his/her lifetime and to identify the types of events that may potentially trigger symptoms for the child (i.e., cause them to appear again). This information can be conveyed to the foster parent, along with offering education and skill-building on managing difficult behaviors and trauma triggers. This can ultimately help the foster parent manage the difficult behaviors and be less likely to request a placement change. Finally, a trauma screening plays a critical role in determining whether or not a child should be referred for general mental health treatment, trauma-focused treatment, or does not need treatment services at this time.

Administration of Trauma Screening Tools

There are a number of administration methods for trauma screening tools which may vary considerably based on 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. In general, there are three formats for trauma screening tools:



Child-completed tool (self-report): If a child is able to read, understand, and **complete** a screening tool (usually ages 8 and above, but will vary significantly across children), then it may be appropriate for the child welfare worker to allow the child to respond to the questions/items in writing or verbally ask the child to respond to the question/items using an interview-style format. A benefit to this strategy includes providing the child with an opportunity to verbalize his/her responses aloud. Research suggests that children often are more accurate reporters of internalizing symptoms (e.g., anxiety, depression, and some symptoms of trauma) in contrast to parents (Yule & Williams, 1990). However, a child welfare worker should take great care in asking highly personal and sensitive questions and be aware that a child may be sharing his/her experiences for the first time or be hesitant to share them at all. It may be difficult for both the child to share his/her experiences and for the caseworker to hear. Therefore, training on how to ask these questions in a sensitive manner is critical, and support in handling the responses is crucial for the caseworker and the child.

Caregiver-completed tool: For infants, toddlers, and young children (ages 0-8) or older children with developmental delays, it may be more appropriate to have a caregiver complete a trauma screening tool either by providing written responses to the questions/items or through an interview by the child welfare worker. This strategy is particularly helpful for detecting exposure to trauma for young

children who cannot verbalize information themselves. Studies using parents or teachers to identify traumatic stress responses in children have found that adults may be preoccupied with their own challenges, and may deny or minimize the full extent of psychological problems exhibited by children (Yule & Williams, 1990). If the caregiver is a foster parent, he or she may not know the child's trauma history and may over or under report trauma symptoms based on his/her experiences fostering other children in his/her care (Tarren-Sweeney, Hazell, & Carr, 2004).

Provider-completed tool: An information integration tool or measure is completed by the caseworker as he/she reviews and integrates all available information on a child, including court reports, interviews with his/her caregiver(s) and teacher(s), and behavioral observations. This integration strategy is particularly helpful in allowing the caseworker to make sense of a wealth of information that is available and can be used to screen infants and toddlers. However, if the caseworker has not asked the child or caregiver specific questions, he/she may not have the complete picture of the child's unique experiences.

Commonly Used Screening Tools

The following descriptions highlight some of the commonly used trauma screening tools that are available for use by child welfare workers for children across the developmental spectrum. Since many Master's level workers are typically not trained in psychological assessment, it is critical that these tools are completed by individuals with proper training and supervision in administration, scoring, and interpretation of the tools. Once a child welfare 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.*

Child Welfare Trauma Referral Tool (CWT; Taylor, Steinberg, & Wilson, 2006). In the CWT, questions about the child's history and presenting problems guide the caseworker in identifying whether the behaviors displayed are directly related to the child's traumatic experiences, or existed before the traumatic event. Based upon the answers, the caseworker determines whether to make a referral for general mental health treatment, for a specialized program such as a hospital or substance abuse program, for trauma-specific mental health (i.e., trauma assessment), or for no additional behavioral or mental health services. It is recommended that caseworkers receive training on specific trauma types and traumatic stress reactions prior to completing the tool.

Child and Adolescent Needs and Strengths (CANS; Kisiel, Blaustein, Fogler, Ellis, & Saxe, 2009b). The CANS is a multi-purpose tool that can serve both as a screening and an assessment tool. At the most basic level, a shorter version of the CANS can be incorporated as a screening tool that can gather basic information on whether any trauma experiences have occurred and whether problems with adjustment to this trauma are impacting a child's current functioning. As an information integration tool, ideally this information is collected from a range of different sources (e.g., interview of child and caregiver[s]; child self-report, caregiver and teacher report tools; observation of child and family; review of case records) and integrated into a single measure to better identify and plan for the service needs of children exposed to trauma (Kisiel, Blaustein, Fogler, Ellis, & Saxe, 2009a).

* There are measures/tools that are trauma-specific used in both screening and assessment (e.g., *Trauma Symptom Checklist for Children [TSCC]*, *Trauma Symptom Checklist for Young Children [TSCYC]*, and the *UCLA PTSD Reaction Index for DSM-IV [UPID]*). These are described in the Chapter 10: Comprehensive Trauma-Focused Mental Health Assessment.

Traumatic Events Screening Inventory – Parent Report (TESI-PRF-R; Ghosh Ippen, 2002). The *TESI-PRF-R* is a 24-item parent-administered interview that assesses a child’s experience of a variety of potential traumatic events including current and previous injuries, hospitalizations, domestic violence, community violence, disasters, accidents, physical abuse, and sexual abuse. Additional questions assess exposure to traumatic events and other additional information about the specifics of any traumatic events.

Recommendations from the Field



- ☑ **Provide broad training on child traumatic stress to the entire child welfare workforce before implementing any screening tool or process.** This includes training on different trauma types (e.g., sexual abuse, physical abuse, neglect, exposure to domestic violence, emotional abuse, etc.) and various traumatic stress reactions that children may exhibit, including internalizing and externalizing behavior problems. There are a number of resources that exist to assist child welfare systems in training on these topics, including the *Child Welfare Trauma Training Toolkit* (Child Welfare Committee, National Child Traumatic Stress Network, 2013).
- ☑ **Embed trauma screening practices into the already existing system.** Many child welfare workers are already conducting screenings very similar to trauma screenings, but they are not labeling them as such. For example, many risk assessment practices, decision/triage trees for mental health treatment, and practice models include questions regarding a child’s history and his/her behavioral responses. Trauma questions can readily be embedded into this structure.
- ☑ **Provide a forum in which caseworkers can discuss their experiences of conducting the trauma screening and any effects of secondary traumatic stress they may experience as a result of conducting the screening.** This is especially relevant for many caseworkers completing a trauma screening for the first time, since this may be the first time they are asking such specific questions regarding a child’s trauma history, which can be difficult to hear.
- ☑ **Ensure children who screen 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 PTSD** (Kisiel, Fehrenbach, Small, & Lyons, 2009). This should include a developmental assessment to see if they are lagging in any key areas.

Resources

Documents:

Griffin, G., McClelland, G., Holtzberg, M., Stolbach, B., Maj, N., & Kisiel, C. (2011). Addressing the impact of trauma before diagnosing mental health in child welfare. *Child Welfare*, 90(6), 69-90.

Strand, V. C., Sarmiento, T. L., & Pasquale, L. E. (2005). Assessment and screening tools for trauma in children and adolescents: A review. *Trauma, Violence, & Abuse*, 6(1), 55-78.

Online Database:

National Child Traumatic Stress Network Measure Review database: <http://www.nctsn.org/resources/online-research/measure-review>



Section 3: Mental Health Practice

Comprehensive Trauma-Focused Mental Health
Assessment

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

Psychotropic Medication Use Among Children Exposed
to Trauma

Chapter 10: Comprehensive Trauma-Focused Mental Health Assessment



Why is this Important to Child Welfare?

Comprehensive Trauma-Focused Mental Health Assessment is important to child welfare since it is a critical process by which a mental health professional can assist the child welfare practitioner in understanding the child’s background and current mental state and therefore facilitate case planning. It is essential that the child welfare professional obtains a rich understanding of a child’s history, specific to trauma, as he/she recommends services and supports that will ensure positive permanency, safety, and well-being outcomes. Mental health professionals have the good fortune of having well-established, valid, and standardized measures that are trauma-specific available to them as children enter the system. A comprehensive trauma assessment conducted by a qualified mental health professional is a valuable tool in both determining the level of care needed by a child and in determining the focus of treatment planning for the child, his/her family, and his/her caregiver. It is also valuable in assisting the placement provider with an understanding of the child’s needs and behaviors and intervention strategies that will lead to increased placement stability. This chapter gives a brief description of a number of trauma-focused assessment tools and practical ways of adding a trauma assessment to a child welfare system.

“...understanding of the child’s needs and behaviors and intervention strategies that will lead to increased placement stability...”

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Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize Physical and Psychological Safety for Children and Families

Identify Trauma-Related Needs of Children and Families

Enhance Child Well-Being and Resilience

Enhance Family Well-Being and Resilience

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

Partner with Youth and Families

Partner with Agencies and Systems that Interact with Children and Families

Brief Summary

Trauma assessment refers to a diagnostic process 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 utilize information collected during the trauma screening process (see Chapter 9: Screening for Child Trauma within Child Welfare Jurisdictions) and may include some of the same tools, it is more detailed and comprehensive. The assessment 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 measures, and behavioral observations. There is a great deal of evidence to suggest that appropriate determination of service and placement needs within child mental health and child welfare is contingent on the assessment of how both the child and caregiving systems function including needs and strengths (Kisiel, Blaustein, Fogler, Ellis, & Saxe, 2009b; Lyons & Weiner, 2009).

Background

Assessment offers a structured framework for identifying and addressing the needs of traumatized children and families (Kisiel, Blaustein et al., 2009b). For purposes of this chapter, assessment refers to the process conducted by a mental health provider designed to obtain more comprehensive and specific information about a child's current symptoms and functioning, family and caregiver environment, and strengths. This can often prove to be a challenging task as it involves gathering and integrating multiple pieces of information from varied sources and perspectives (Kisiel et al., 2009b). Assessment of the child's current condition—including the type of trauma experienced, the impact of the trauma on the child, and the internal and external resources available to the child—is necessary to identify the mental health treatment needs of the child and family.

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., each child abuse incident, any automobile 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). Some standardized clinical measures are specific to trauma, such as assessing for posttraumatic stress disorder (PTSD) symptoms and other common trauma reactions, these include:

- *The UCLA PTSD Reaction Index for DSM-IV (parent, child, and adolescent versions)* (UPID; Steinberg, Brymer, Decker, & Pynoos, 2004) The UPID is a revision of the Child PTSD Reaction Index: CPTS-RI (Pynoos, et al., 1998). It is a 48-item semi-structured interview that assesses a child's exposure to 26 types of traumatic events and assesses PTSD. It includes 19 items to assess the 17 symptoms of PTSD as well as 2 associated symptoms, guilt and fear of events recurring. This tool may be used as a screening tool on its own, or part of a larger trauma-informed assessment or psychological evaluation.
- *The Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001)* The CPSS is a child version of the Foa et al. (1997) Posttraumatic Diagnostic Scale (PTDS) for adults. This child-report tool assesses the frequency of all PTSD symptoms and was also designed to assess PTSD diagnosis. The first 17 items measure PTSD symptoms and yield a total Symptom Severity score. Seven additional items assess daily functioning and any functional impairment.
- *Trauma Symptom Checklist for Children (TSCC; Briere, 1996)* The TSCC, the child version of the adult *Trauma Symptom Inventory* (Briere, 1996), evaluates whether a child is experiencing symptoms related to acute and chronic trauma (see page 6) and posttraumatic stress. The tool's scoring system is conceptually based on theories of development and child trauma. This tool may be used as a screening tool on its own, or part of a larger trauma-informed assessment or psychological evaluation.
- *Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005)* The TSCYC is a 90-item caregiver-report instrument developed for the assessment of trauma-related symptoms in children ages 3-12. The scoring gives a detailed evaluation of posttraumatic stress symptoms and a tentative PTSD diagnosis. It also provides information on other symptoms such as anxiety, depression, anger, and abnormal sexual behavior. This tool may be used as a screening tool on its own, or part of a larger trauma-informed assessment or psychological evaluation.
- *Child Sexual Behavior Inventory (CSBI; Friedrich, 1997)* The CSBI is a 38-item caregiver-completed tool and was developed to assess children who have been sexually abused or are suspected of having been sexually abused. The scoring gives a total score, a Developmentally Related Sexual Behavior Score, and a Sexual Abuse Specific Items Score. It also gives scores on 9 domains: 1) Boundary Problems, 2) Exhibitionism, 3) Gender Role Behavior, 4) Self-Stimulation, 5) Sexual Anxiety, 6) Sexual Interest, 7) Sexual Intrusiveness, 8) Sexual Knowledge, and 9) Voyeuristic Behavior.

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. Comprehensive trauma assessments also focus on general symptoms such as depression, anger, and anxiety, which are often seen in children who have experienced trauma. In addition, strong programs gather information about how well the family is functioning and about the child's developmental level so that treatment can be developmentally and systemically appropriate. Because caregivers and children often do not agree on the problems that the child and family are experiencing, it is wise to ask additional informants (e.g., teachers, clergy, reliable community members), to provide information.

While this process of gathering specific information through screening and/or assessment approaches and using this to guide effective planning and service delivery seems straightforward and critical to good practice, linking these strategies together in a streamlined manner are less well-understood and exceedingly more challenging when working with traumatized children and their caregiving systems (Kisiel, Blaustein, et al., 2009b). A few established tools and techniques have been designed with these multiple purposes in mind and utilized effectively within child welfare settings (Chadwick Center for Children and Families, 2009; Kisiel, Fehrenbach, Small, & Lyons, 2009; Lyons & Rogers, 2004; Spaccarelli, 1994). Using information from the trauma assessment, therapists can develop treatment goals with measurable objectives designed to reduce risk and the negative effects of trauma.

Assessments help the mental health clinician gain a comprehensive understanding of the child as an individual with a unique history, family system, and levels of developmental, cognitive, and emotional functioning. From all of this, a unique client picture of the child is developed (Chadwick Center for Children and Families, 2009). A child who can benefit from a specific evidence-based treatment can then be triaged to the most appropriate intervention. 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).

Recommendations from the Field



- ☑ **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. It has been the author's experience that many individuals located within mental health agencies conduct trauma-focused assessments, but private practitioners may not do so within their own practice. Child welfare staff plays a particularly critical role in creating a demand for such assessment practices. 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?).
- ☑ **Conduct a comprehensive assessment across domains of functioning (i.e., developmental, educational, family, etc.) for children exposed to trauma, given the broad range of reactions that traumatized children may exhibit (beyond PTSD)** (Kisiel, Fehrenbach, Small, & Lyons, 2009). However, understand that not all children who have experienced traumatic events suffer from trauma-related symptoms and even fewer meet the diagnostic criteria for posttraumatic stress disorder.
- ☑ **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.**
- ☑ **Assess the functioning of the child's caregiving system as well as that of the child.** By determining the needs of parent(s) and/or caregiver(s) and his/her capacity to support the child in his/her recovery from trauma, the mental health professional's assessment of the parent/caregiver can help the child welfare professional create realistic permanency goals of the youth in care. (See Chapter 13: Using Trauma-Informed Services to Increase Parental Protective Factors.)

Resources

Documents:

Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of posttraumatic states. *Journal of Traumatic Stress, 18*(5), 401-412.

Conradi, L., Wherry, J., & Kisiel, C. (2011). Linking child welfare and mental health using trauma-informed screening and assessment practices. *Child Welfare, 90*(6), 129-148.

Griffin, G., McClelland, G., Holtzberg, M., Stolbach, B., Maj, N., & Kisiel, C. (2011). Addressing the impact of trauma before diagnosing mental health in child welfare. *Child Welfare, 90*(6), 69-90.

Strand, V. C., Sarmiento, T. L., & Pasquale, L. E. (2005). Assessment and screening tools for trauma in children and adolescents. *Trauma, Violence & Abuse, 6*(1), 55-78.

Online Database:

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

Online Training:

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/>

Chapter 11: Role of Trauma-Focused, Evidence-Based Mental Health Treatment for Child Trauma



Why is this Important to Child Welfare?

“...consider the effects of trauma and incorporate necessary components to help a child ‘re-condition’ brain functioning.”

The Role of Trauma-Focused, Evidence-Based Mental Health Practices for Child Trauma is important to child welfare for a number of reasons. There are some trauma-focused treatments that are more effective specifically with children who have been abused or neglected. One reason these treatments are more effective is that they address how thoughts, emotions, and behaviors are changed by traumatic experiences. It is critical that the child welfare community gains a better understanding of how significant negative events, whether one-time or chronic, can impact brain functioning and behavior. This understanding helps therapists, caregivers, and social workers appreciate that a traumatized child may be in need of a more specific evidence-based therapeutic intervention. Research has helped clarify that traumatized children often cannot easily change or improve their attention, behavior, and social relationships through traditional mental health practices. Evidence-based mental health treatments for abused and neglected children consider the effects of trauma and incorporate necessary components to help a child *recondition* brain functioning. This, in turn, can assist with more positive treatment outcomes, placement stability, and overall improved well-being.

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Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize
Physical and
Psychological
Safety for
Children and
Families

Identify
Trauma-
Related
Needs of
Children and
Families

Enhance
Child
Well-Being
and
Resilience

Enhance
Family
Well-Being
and
Resilience

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

Partner
with
Youth and
Families

Partner
with Agencies
and Systems
that Interact
with Children
and Families

Brief Summary

Recovering from traumatic stress often requires access to specialized mental health services designed to help a child recover from his/her traumatic experiences and the associated cascade of impacts that follow. Posttraumatic symptoms rarely go away without clinical attention. In fact, in many cases, the child's symptoms worsen as they get complicated by comorbidity (i.e., the addition of other problems that already existed) and development of problematic behaviors to cope with trauma-related distress, such as self-harm and drug use. Therefore, accurate assessment and focused, goal-directed treatment are essential. There are a number of evidence-based practices that have emerged in recent years that are designed to address child trauma and the externalizing behavior problems that are common among children within the child welfare system. Few child welfare agencies are equipped to address children's mental health needs on their own and most rely on other public and/or private mental health providers to deliver clinically indicated services to the child and family. It is vital that child welfare agencies forge an alliance with those who provide behavioral mental health services to children and families in the child welfare system. Failure to do so can lead to interagency conflict and, more importantly, a missed opportunity to provide effective, integrated, and coordinated services and supports to the child and family.

Background

Once a child has screened positive for trauma exposure and/or traumatic stress symptoms (see Chapter 9: Screening for Child Trauma within the Child Welfare System) and has participated in a trauma-focused assessment (see Chapter 10: Comprehensive Trauma-Focused Mental Health Assessment), the next step is to refer the child for mental health services, as necessary. Mental health providers serving child welfare children and families are a diverse group including:

- Out-patient (e.g., agency, private practice) providers
- In-home providers
- Substance abuse treatment specialists
- Treatment foster care, group home, and residential treatments providers
- Psychiatric hospital staff.

Working with these providers is made more challenging by the fact that some work for public agencies while others work for non-profits or are private practitioners. Sometimes the child welfare agency pays for the services, often through contracts with mental health agencies, and other times the providers depend on other sources of public or private reimbursement or philanthropy to support their work.

A number of trauma-focused mental health treatments are available to children involved in the child welfare system. While not all children in the child welfare system need to receive mental health treatment, there are a number of behaviors and symptoms/reactions that should result in a referral for trauma-focused treatment. These behaviors and symptoms/reactions differ based on the age of the child, the ability of the parent to provide supportive caregiving and manage difficult behaviors, and external supports that exist for this child and family. For example:

- In early childhood, caregivers and children often develop relationship problems following trauma.

These problems frequently result from the trauma and are best addressed with a trauma-focused treatment. Some of the common trauma-related reactions among young children include aggression, increase in fears, separation anxiety, developmental regressions, developmental delays, inability to focus and concentrate, and relationship/attachment problems. Trauma-exposed infants may have feeding difficulties and may be difficult to soothe. If the caregiver is able to handle this and help the infant feel safe and learn how to self-soothe, the child/family may not need an intervention. However, if the caregiver becomes overwhelmed by the child's reactions/behaviors, it would be important to get help for the caregiver and child.

- Pre-school age children who have experienced a trauma often display oppositional behavior that can be very difficult for caregivers to manage. This may include kicking, biting, screaming, and fighting with peers. If the caregiver is able to effectively manage these behaviors, treatment may not be needed. However, if the caregiver is unable to effectively assist the child in managing his/her emotions, the caregiver and child may benefit from a behaviorally oriented intervention that provides the caregiver with the skills necessary to help the child manage his/her emotions, set limits as needed, and strengthen the his/her relationship with the child.
- School-age children who have experienced trauma often have difficulties in school and suffer from unhelpful thoughts, such as blaming themselves for the traumatic event. They may display externalizing behavior problems (e.g., fighting, bullying, or talking back) or internalizing behaviors (e.g., withdrawing from others, becoming anxious or fearful in the face of seemingly innocent or mundane events, or crying easily). These children would benefit from an intervention focusing on helping them and their caregivers to manage these trauma reactions and process through the traumatic experience(s).
- Adolescents who have experienced trauma often engage in high-risk behavior, such as substance abuse, cutting classes, or sexual promiscuity. Since connection with peers is particularly critical for adolescents, interventions in which they can share their experiences with like-minded peers, learn how to develop healthy relationships, and build trust and support are critical. Any teens with severe trauma-related distress can also benefit from individual treatment approaches that are designed to reduce his/her distress and help him/her make meaning of his/her traumatic experiences.

Some community providers are true trauma experts with extensive training in trauma assessment and evidence-based treatments. Others may lack any special training or expertise, but may still claim that their mental health license is adequate to equip them to work with even the most complex trauma cases. This diversity among providers requires child welfare agencies to be aware of the strengths and specialties of their providers and strategically refer to providers based on their ability to meet the specific needs of the child and family. It is also in the best interest of the child welfare agency and the families it serves to promote and support the expansion of the provider network of trauma treatment specialists.

Common goals of trauma-focused treatment include:

- Re-establishing a sense of physical and psychological safety (see page 13).
- Helping the child and family manage emotions, particularly in the presence of trauma reminders.
- Helping the child and family gain an understanding of the traumatic experience, while recognizing that different family members may have had different experiences and, therefore, may develop an understanding of the traumatic experience in different ways.

Good trauma treatment is developmentally and culturally sensitive. In early childhood, key treatment goals include helping the caregiver to recognize and respond to the child's, and his/her own, posttraumatic stress-related symptoms in ways that enhance family's ability to function well. Treatment should incorporate the family's cultural values, natural healing practices, and sources of spiritual and/or community support (see Chapter 2: Influence of Culture on Responses to Traumatic Events).

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.
- **Evidence-Informed:** Research exists to support the use of components or pieces of the intervention.

The core components described in the boxes below and on the next page serve as the building blocks of good practice and are present in evidence-based practices that have been developed in recent years to treat child trauma. Some resources, such as *Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP)* (Chadwick Center for Children and Families, 2009), provide more information and training on these core components.

Core Components Found in Effective Evidence-Based Trauma Treatment

The current research on treatment models for child traumatic stress suggests several common elements found in effective evidence-based trauma treatment. Child welfare staff should be able to identify these common elements in any proposed treatment plan for children presenting with primary trauma issues:

- **Parent support, conjoint therapy, or parent training:** This may include incorporating the birth parent(s) and/or resource parents in treatment as appropriate. While the final decision regarding inclusion of the caregiver in treatment should be made by a well-trained mental health professional, it is often advantageous to incorporate the birth parent actively in the treatment process, particularly if there is an active plan for reunification.
- **Building a strong therapeutic relationship:** The therapeutic relationship is considered to be core to any effective treatment modality. Research has shown that no matter which evidence-based practice a mental health provider is utilizing with a client, it will not be effective if there is no relationship established.
- **Providing psychoeducation (i.e., information on psychological principles that guide human behavior) to children and caregivers:** Depending on the type of trauma experienced, psychoeducation will focus on normal responses to trauma, information about the traumatic event, and information to help children differentiate healthy vs. unhealthy behaviors (e.g., *good touch, bad touch*).

(Continued on next page)

Core Components Found in Effective Evidence-Based Trauma Treatment (Cont.)

- **Emotional expression and regulation skills:** This may include helping children increase their ability to identify various feelings and develop coping mechanisms for managing difficult feelings such as anger, sadness, or anxiety.
- **Anxiety management and relaxation skills:** The therapist will often work with the child to help the child develop relaxation skills. This will include practices such as visualization, deep breathing exercises, progressive muscle relaxation, etc.
- **Cognitive processing or reframing:** Many children who have experienced a traumatic event will blame themselves. For example, a child who has been sexually abused may believe that he/she wore the wrong outfit that day. A child who has witnessed domestic violence may blame himself/herself for the offender's angry outburst. Effective treatment will help the child identify the connection between his/her thoughts, feelings, and behaviors (i.e., the *cognitive triangle*), and identify his/her inaccurate thoughts and replace them with more helpful and accurate thoughts.
- **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:** The primary goal of trauma treatment is to help the child integrate the trauma experience so that it is one of his/her many life experiences, not his/her defining life experience. In order to integrate the trauma experience into his/her life, the child will often complete a *trauma narrative* with his/her therapist that allows the child to tell the story repeatedly, in tolerable doses while utilizing his/her relaxation techniques, so that the event loses its power and ceases to raise his/her anxiety level. This may be done through a number of creative ways chosen by the child, including writing a story, writing a song, drawing pictures, etc. The child will then share this information with a supportive caregiver to help validate his or her experience and encourage open discussion of the trauma. For children who have experienced ongoing, complex trauma, a life narrative can be created.
- **Personal safety training and other important empowerment activities:** Building on the psychoeducation previously described, the therapist will work with the child to develop healthy boundaries and ways to enhance physical and psychological safety.
- **Resilience and closure:** At termination of treatment, the therapist will focus on helping the child to identify his/her strengths and areas of resilience that can be used to cope with future adversity. Treatment closure should also include helping the family prepare for and cope with reactions and trauma reminders that may occur on the anniversary of the traumatic event, since symptoms may return in the presence of these reminders.

The box on the following page lists trauma treatment programs for children and/or adolescents with well-supported, supported, or promising research evidence. It is important to note that many of these evidence-based treatments were developed and tested with specific populations. Children who received these treatments when they were being tested had specific diagnostic criteria or symptoms and received the treatment within a research setting where the therapist practiced the specified treatment model with high fidelity (i.e., followed the model the same way each time). There are some challenges associated with transporting evidence-based practices from the research setting to the community setting. In particular, children receiving treatment in community settings may present with more complex and complicated trauma symptoms than those in research settings. Further, it is more

Trauma Treatment Programs for Children and/or Adolescents Rated by the CEBC as Having *Well-Supported, Supported, or Promising Research Evidence*

The California Evidence-Based Clearinghouse for Child Welfare (CEBC, www.cebc4cw.org) reviews published, peer-reviewed research for programs related to child welfare. The following trauma treatment programs for children and adolescents have been rated by the CEBC into the following Scientific Rating categories; their target populations from the website are included below:

1 - *Well-Supported Research Evidence*

- **Eye Movement Desensitization and Reprocessing (EMDR)** - Target Population: Children and adults who have experienced trauma. Research has been conducted on posttraumatic stress disorder (PTSD), posttraumatic stress, phobias, and other mental health disorders.
- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** - Target Population: Children with a known trauma history who are experiencing significant PTSD symptoms, whether or not they meet full diagnostic criteria. In addition, children with depression, anxiety, and/or shame related to their traumatic exposure. Children experiencing childhood traumatic grief can also benefit from the treatment.

2 - *Supported Research Evidence*

- **Child-Parent Psychotherapy (CPP)** - Target Population: Children age 0-5, who have experienced a trauma, and their caregivers.
- **Prolonged Exposure Therapy for Adolescents (PE-A)** - Target Population: Adolescents who have experienced a trauma (e.g., sexual assault, car accident, violent crimes, etc.). The program has also been used with children 6 to 12 years of age and adults who have experienced a trauma.

3 - *Promising Research Evidence*

- **Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)** - Target Population: Caregivers who are aggressive and physically, emotionally, or verbally abuse their children **and** their children who experience behavioral dysfunction, especially aggression, as a result of the abuse, as well as high conflict families who are at-risk for physical abuse/aggression.
- **Child and Family Traumatic Stress Intervention (CFTSI)** - Target Population: Children ages 7-18 recently exposed to a potentially traumatic event, or having recently disclosed physical or sexual abuse, and endorsing at least one symptom of posttraumatic stress.
- **Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)** - Target Population: 3rd through 8th grade students who screened positive for exposure to a traumatic event and symptoms of post-traumatic stress disorder related to that event, largely focusing on community violence exposure. It has been used in high school settings as well.
- **Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT)** - Target Population: Children ages 3-17 and their parents (or caregivers) in families where parents engage in a continuum of coercive parenting strategies.
- **I Feel Better Now! Trauma Intervention Program** - Target Population: At-risk children ages 6-12 with a history of trauma or loss.
- **Sanctuary Model** - Target Population: This program is not a client-specific intervention, but a full-system approach that targets the entire organization. The focus is to create a trauma-informed and trauma-sensitive environment in which specific trauma-focused interventions can be effectively implemented.
- **Seeking Safety for Adolescents:** Target Population: Adolescents with a history of trauma and/or substance abuse.
- **SITCAP-ART** - Target Population: At-risk and adjudicated youth, ages 12-17, with a history of trauma and/or loss.
- **Trauma-Focused Coping (TFC)** - Target Population: Children and adolescents in schools who have suffered a traumatic exposure (e.g., disaster, violence, murder, suicide, fire, accidents).

difficult to monitor a therapist's fidelity to a specific practice without the rigorous support and supervision that is more likely to be available in research settings. Therefore, a child with complex trauma histories and symptoms may not receive the most benefit from an existing evidence-based practice. Rather, an individualized treatment plan with a skilled trauma treatment professional addressing complex trauma may be more appropriate.

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 family, but child welfare should not dictate the actual course of therapy or require a specific treatment model. That clinical decision should be based on a full trauma-informed assessment (see Chapter 10: Comprehensive Trauma-Focused Mental Health Assessment). See the box on the following page for a list of trauma treatment programs for children and adolescents with well-supported, supported, or promising research evidence. In some cases, there are multiple barriers that exist within mental health settings that make it difficult for children and families to receive the trauma services that they need. In these situations, school-based treatment such as CBITS, described in the box on the previous page, may be helpful. Many of the treatments described in the box can be provided in the home and/or in residential care settings.

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 exist within the child welfare jurisdiction that have been trained on specific evidence-based practices, 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 box below contains some questions a child welfare worker can ask to determine if a therapist is trauma-informed.

Questions to Ask to Determine if a Therapist is Trauma-Informed

When a child welfare worker is referring a child to a treatment provider, there are some questions that he/she may ask in order to determine if that therapist is trauma-informed:

- Does the therapist talk to the family about the child's and/or family's experience of potentially traumatic events?
- Does the therapist provide trauma-specific or trauma-informed therapy? If so, how does he/she determine if the child needs a trauma-specific therapy?
- How familiar is the therapist with evidence-based treatment models designed and tested for treatment of child trauma-related symptoms?
- How does the therapist approach therapy with a child who has experienced trauma and his/her family regardless of whether he/she indicates formal trauma-informed treatment? Can he/she describe a typical course of therapy? Can he/she describe the essential elements of his/her treatment approach?

Finding qualified mental health providers is just the first step in this area. Child welfare needs to establish a mutually respectful pathway of communication. Child welfare must recognize mental health has related, but different, goals. It is important for mental health providers to hear what child and family, as well as, child welfare professionals hope to accomplish with their referral for services, what goals child welfare has for the child and family, and what strategies child welfare believes should be considered in treatment planning.

Recommendations from the Field



- ☑ **Seek to build a continuum of mental health treatment within the community that includes trauma expertise.** Administrators can help promote and advocate for enhancements in the expertise of the current mental health providers they rely upon in both trauma assessment and therapy. In some settings, this will mean integrating elements of trauma-informed evidence-based practices into the treatment options available at a residential care facility or offering specialized trauma training to treatment foster care staff or arranging adjunct trauma outpatient treatment for children in placement. It may involve incentivizing the use and expansion of evidence-based trauma treatment or removing barriers to accessing the best trauma-trained therapists in the community. The mere act of consistently asking about the qualifications of those who provide trauma treatment may have a motivating influence that leads to improvement in skill level among clinicians.
- ☑ **Exercise caution in placing additional documentation requirements on the providers especially if it is not required for payment.** It is advisable that efforts be made to streamline paperwork processes and communication demands so child welfare secures the feedback and insights it needs from mental health in ways that minimize duplication and inefficiencies. In many cases, the child welfare case manager can assist the provider in some of these tasks.
- ☑ **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 is 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. Child welfare policy should include screening a child and family in a way that does a rough sort among providers (see Chapter 9: Screening for Child Trauma within the Child Welfare System). This way a child and/or family with trauma symptoms is referred to providers with specialized knowledge and skills in trauma assessment (see Chapter 10: Comprehensive Trauma-Focused Mental Health Assessment). Administrators can work with state and local mental health agencies to develop a mental health list of providers and their specialties. Alternatively, the child welfare agency could designate select providers as trauma assessment sites where the agency could send a child and family for a thorough trauma assessment. Then based on the child's and/or family's unique needs discovered during the trauma assessment, these sites would refer to other providers for the actual treatment.
- ☑ **Minimize administrative barriers to recruiting and working with mental health providers.** Child welfare cases are among the most clinically complex cases seen in mental health settings. Adding to the challenge of serving child welfare referrals is all the clinical case management the mental health provider must engage in with child welfare cases. In addition to the parents of the child, the therapist will often need to spend time communicating with the caseworker, the foster parents or kin provider, the attorneys, the courts, the guardian ad litem, and others. In effect, there are numerous disincentives and barriers to serving child welfare-involved families. In some communities, this may be offset by enhanced reimbursement strategies that compensate the provider for the added time commitment. But many, if not most, communities lack such supports and the provider must secure his/her own payment from Medicaid or other sources. In most environments, all the added case management and documentation time is unreimbursed.

- ☑ **Guide treatment selection by utilizing a complete assessment by a qualified mental health provider.** Treatment selection and/or conceptualization may vary depending on the child’s trauma history (e.g., trauma type, number of traumatic experiences), whether physical safety is established, and whether the child has multiple diagnoses as well as other demographic factors (e.g., child’s age, ethnicity).
- ☑ **Involve the caregivers in the evaluation and trauma-focused treatment whenever safe and possible.** This may include foster parents and/or birth parents, particularly if reunification is a possibility. A child’s safety is always the top priority, so the level and type of parent involvement should be determined by a qualified mental health provider.
- ☑ **Develop collaborative relationships with mental health leadership and encourage ongoing coordination between child welfare and mental health services.** Child welfare administrators can work toward forging effective partnerships with mental health administrators and can develop policies that promote frequent and efficient communication between the two systems.



Resources

Documents:

AACAP Official Action. (2010). Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(4), 414-430.

de Arellano, M. A., Ko, S. J., Danielson, C. K., & Sprague, C. M. (2008). *Trauma-informed interventions: Clinical and research evidence and culture-specific information project*. Los Angeles, CA & Durham, N.C.: National Center for Child Traumatic Stress.

Online Resources:

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

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

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/>

Organizations:

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

Chapter 12: Psychotropic Medication Use Among Children Exposed to Trauma



Why is this Important to Child Welfare?

The use of psychotropic medications for children in child welfare systems is complicated. There are two main areas that are cause for concern: “How can medications be used *correctly*?” and “How can medications be used *safely*?” Children in child welfare systems can have the same mental health problems of children in the general population (e.g., attention problems, depression, and anxiety). In addition, they can also have problems due to neglect, exposure to trauma, and reaction to loss of relationships with their family. This second group of problems is not well-described in *Diagnostic and Statistic Manual of Mental Health Disorders (DSM-IV or the upcoming version V)* and is not well-studied in terms of which medication treatments are most helpful. At issue is how to use psychotropic medications to minimize these problems so other treatments can be used effectively (e.g., trauma treatments, behavioral, relationship-based, etc.). In terms of safety, we know all medications have side effects. Some of these side effects can lead to real health problems like weight gain, diabetes mellitus, heart disease, and sedation. There is a great need for child welfare systems to develop methods of monitoring that can reliably notice when side effects occur and give guidance to how these side effects should be managed.

There are two main areas that are cause for concern: “How can medications be used correctly?” and “How can medications be used safely?”

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Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize Physical and Psychological Safety for Children and Families

Identify Trauma-Related Needs of Children and Families

Enhance Child Well-Being and Resilience

Enhance Family Well-Being and Resilience

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

Partner with Youth and Families

Partner with Agencies and Systems that Interact with Children and Families

Brief Summary

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. It is not uncommon for a child to have multiple signs and symptoms of these problems and require several different types of treatment, including psychotropic medication. 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.). Concerns about medication side effects, inadequate medical monitoring, excessive use of medications, and lack of expertise in prescribers add to the complexity.

Background

Children in the child welfare system with trauma histories often present with a number of symptoms and behaviors that can be incredibly difficult to manage and may lead to placement disruptions. These behaviors include extreme aggression, mood dysregulation, impulsivity, and emotion-altering behaviors. The use of psychosocial interventions (i.e., interventions that use therapy alone) is often the primary defense against these behaviors. However, the use of psychopharmacological interventions (i.e., interventions that combine therapy and psychotropic medications), can assist in decreasing behavior problems. A psychotropic medication is one prescribed to help people who are experiencing a mental health disorder, such as depression, anxiety, conduct disorder, or attention-deficit hyperactivity disorder, as described in the *Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV)*, American Psychiatric Association, 2000).

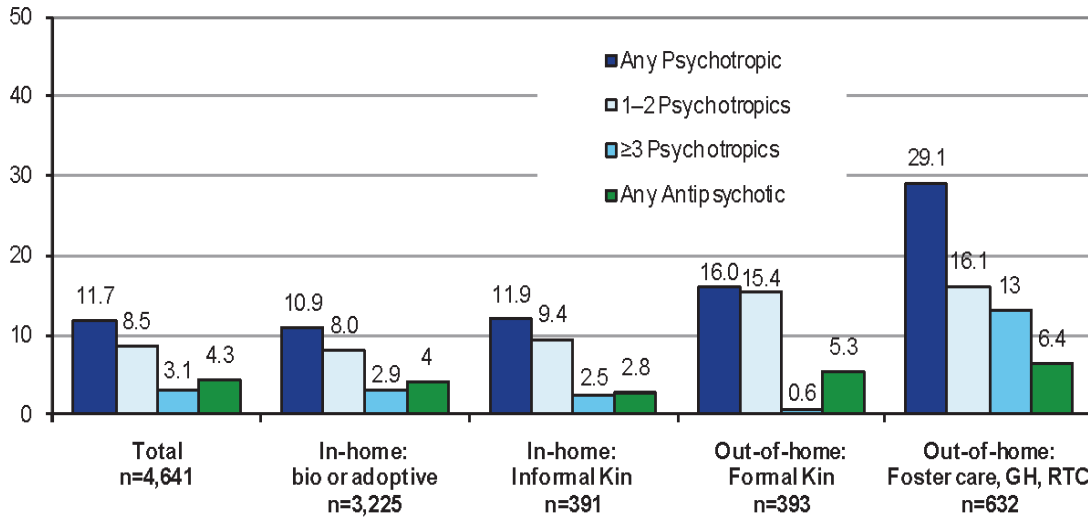
Psychotropic medication prescriptions for children and adolescents have risen two- to three-fold in the past decade. There are increased rates of psychotropic use with young children, especially those in foster care (U.S. Government Accountability Office, 2011). As 40% to 60% of children in the child welfare system are reported to meet criteria for at least one *DSM-IV* disorder, they are at higher risk for over prescription of psychotropic medications (Landsverk,



Garland, & Leslie, 2002). Rates of psychotropic medication use among children in the child welfare system are higher (14%) when compared to the general population (4%), especially among older children, boys, those with behavior problems, and children in group homes (Raghavan et al., 2005). Because of their complex symptom presentations, children in child welfare may be at greater risk of using multiple concurrent psychotropic medications with the potential for adverse effects (e.g., side effects, drug interactions, altering metabolism and nervous system development), despite lack of evidence that using multiple medications at the same time is effective (Raghavan & McMillen, 2008). 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>

The chart below shows the percentage of children in the National Survey of Children and Adolescent Well-Being II (NSCAW II) reported to be using one or more psychotropic medication by type or placement. As noted, rates of psychotropic use were substantially higher for children in group homes and residential treatment centers.

Figure 1. NSCAW II, Wave 2: percentage of children reported to be using one or more psychotropic medications, by type of placement^a



^a Rates of psychotropic use were substantially higher for children in group homes and residential treatment centers, compared with children in formal kin and foster care, which may have somewhat inflated mean levels of use in the out-of-home group.

(Stambaugh et al., 2012)

Although numerous studies have demonstrated that the rates of psychotropic medication prescriptions are high among children in foster care, these rates, at least in part, may reflect increased levels of emotional and behavioral distress. In some cases, psychotropic medication can provide benefit to many children and adolescents and should be used with children and adolescents for three reasons: 1) increase safety, 2) reduce suffering, and 3) improve functioning. If the medication works, the child or teen is better able to engage in other interventions. However, providers should try psychosocial interventions first before recommending the child be prescribed psychotropic medication. Then, if the child is prescribed a medication, the prescribers should be aware of the potential complications to medicating children and adolescents such as medication combinations, compliance from the child or adolescent on taking the medication, co-morbid conditions (e.g., having two diagnoses and trying to treat both), and potential for increased substance use.

There is no medication to treat post-traumatic stress. The U.S. Food and Drug Administration (FDA) has not approved any medication with the specific indication for treating PTSD in young children (Wilkinson & Carrion, 2012). Some medications can be used to reduce some trauma-related symptoms. Target trauma symptoms and examples of commonly prescribed medications are listed below.

- Affective arousal (e.g., irritable or angry mood): Prozac, Wellbutrin, Effexor, Imipramine, Lithium, Depakote
- Sleep problems: Benadryl, Ambien, Trazadone, Seroquel, Risperdal, Clonidine
- Fear and anxiety: Prozac, Valium, Xanax, Imipramine, BuSpar, Trazodone, Propranolol, Seroquel, Abilify, Prazosin (nightmares)

- Depression and sadness: Prozac, Zoloft, Paxil, Imipramine, Wellbutrin, Effexor
- Aggression: Risperdal, Seroquel, Prozac, Paxil, Lithium. Tegretol, Haldol, Propranolol
- Impulsivity and attention problems: Ritalin, Concerta, Strattera, Imipramine, Wellbutrin, Clonidine

Benzodiazepines are occasionally used right after a traumatic event to block the laying down of a new memory of the event.

There are trauma-related symptoms that are hard to treat with medications such as:

- Overeating
- Low patience
- Misinterpreting other people's behavior and intentions
- Thrill-seeking, risk-taking behaviors:
 - ◆ Substance abuse
 - ◆ Sexual behavior
 - ◆ Daring acts

These behaviors are best addressed using psychosocial interventions.

Therefore, while medication can be an important component of a comprehensive response to the complex mental health needs of children in child welfare, current use of psychotropic medications among children in foster care at times may exceed practice standards that are supported by empirical research. Strengthened oversight of psychotropic medication use is necessary in order to responsibly and effectively attend to the clinical needs of children who have experienced trauma. The processes and practices suggested by these guidelines provide increased opportunities for that oversight for children in foster care.

Recommendations from the Field



- ☑ The following two points are from guidelines provided by the American Academy of Child and Adolescent Psychiatry containing considerations regarding the consent, oversight, and policy issues related to psychotropic medication use for children in care. These include:

- A psychiatric evaluation is completed by a psychiatrist, if at all possible, before psychotropic medication is prescribed.
- A medical history is obtained, and a medical evaluation by a pediatrician is considered when appropriate.

(American Academy of Child and Adolescent Psychiatry, 2009)

- ☑ The following 9 guidelines for psychopharmacological interventions, documented in *Mental Health Practice: Guidelines for Child Welfare*, provide considerations regarding the consent, oversight, and policy issues related to psychotropic medication use for children in the child welfare system. These include:

- **Guideline 1- Informed Consent:** Informed consent is established when a clinician prescribes psychotropic medications. In establishing informed consent, information is given to the child, family (bio-parent, foster parent, or caregiver), and the caseworker/state-assigned decision maker about the treatment options (both medication and non-medication options), the risks/

side effects and benefits of the medication, the targeted symptoms, and the course of treatment.



- **Guideline 2 - Access to and Documentation of Psychotropic Medication:** Child welfare agencies ensure consistent access to prescribed psychotropic medications, and document the child's response to the medications, side effects, risks and benefits of the medications, and the timeframes for the expected response. This documentation follows the child throughout his or her stay in care.
- **Guideline 3 - Ongoing Communication with Child and Caregivers:** Prescribers have ongoing communication with the child and caregivers to monitor treatment response, side effects, and potential adverse reactions, such as change in weight or metabolic parameters, cardiovascular symptoms, suicidality, or other outcomes as appropriate to the medications prescribed. In addition, the prescriber discusses with the child and family medication adherence and any medication changes in the context of a collaborative relationship.
- **Guideline 4 - Reliable and Valid Rating Scales:** Reliable and valid clinical rating scales are used to quantify the response of the child's target symptoms to medication. During the initial three months on a particular medication(s), visits should take place at least monthly or more frequently if the child's condition is unstable. For children whose response to medication has stabilized, follow-up after the initial three months takes place on a quarterly basis, or more frequently if clinically required. If the youth's condition becomes unstable, the prescriber is contacted immediately.
- **Guideline 5 - Child Mental Health Training for Caseworkers:** Agencies ensure that caseworkers receive training in common child mental health disorders, effective treatment options, child and adolescent development, and neuro-developmental effects of prenatal substance exposure.
- **Guideline 6 - Information for Children and Families:** Children and families receive ongoing information on any diagnosed mental health problems, effective treatment options, and managing life with the condition.
- **Guideline 7 - Transition Planning:** In advance of youth leaving care, agencies ensure an adequate clinical transition plan, including the identification of future prescribers and sources of payment.
- **Guideline 8 - Support for Birth Families:** Child welfare agencies encourage, support, and monitor the mental health needs and access to psychotropic medications and other mental health services for birth families.
- **Guideline 9 - Periodic Reviews of Psychotropic Medication Use Patterns:** The agency periodically conducts reviews of patterns of psychotropic medication use within its caseload, on an aggregate- and provider-specific basis, and takes necessary action in response to findings of such reviews.

(The Reach Institute, Casey Family Programs, & The Annie E. Casey Foundation, 2009, pp. 12-15)

- When a child comes into the child welfare agency's care, try to have the caseworker obtain information about any medications the child is currently taking from the parents/caregivers.



- ☑ Support high levels of collaboration among child welfare agencies, professionals, organizations providing foster care and mental health services, children who are recipients of child welfare services, and their families.
- ☑ Administrators should apply a developmental approach to pharmacotherapy. While there may be some evidence or support for some medications in some groups, this may not apply to all ages.
- ☑ In certain situations, child welfare should consider referring children for a non-binding second opinion psychiatric evaluation. This may include:
 - When children and youth present with complicated, problematic, or unexpected responses to psychotropic medication
 - When they experience significant side effects, inadequate control of their mental health symptoms, or whose signs and symptoms of illness threaten their health and safety
 - Children who present with complex and atypical signs and symptoms, and
 - Children who present with severe risk to their safety and the safety of others despite intensive treatment.

Resources

Documents:

American Academy of Child and Adolescent Psychiatry, Committee on Community-Based Systems of Care. (2012). *A guide for community child serving agencies on psychotropic medications for children and adolescents*. Retrieved from http://gucchdtacenter.georgetown.edu/Activities/TrainingInstitutes/2012/Resources/Inst_20_R3_GuideForCommunityChildServingAgencies_on_PsychotropicMedications_for_children_and_adolescents_2012.pdf

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Leslie, L. K., Raghavan, R., Zhang, J., & Aarons, G. A. (2010). Rates of psychotropic medication use over time among youth in child welfare/child protective services. *Journal of Child and Adolescent Psychopharmacology*, 20(2), 135-143. doi:10.1089/cap.2009.0065

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U.S. Department of Health and Human Services (DHHS), Administration for Children Families, Administration on Children, Youth and Families, Children's Bureau. (2012). *Information memorandum* (Log No: ACYF-CB-IM-12-03). <http://www.acf.hhs.gov/programs/cb/resource/im1203>.

Organization:

Child Welfare Policy and Practice Group website: <http://www.childwelfaregroup.org/>



Section 4: Cross-System Partnering

Using Trauma-Informed Services to Increase Parental
Protective Factors

Trauma-Informed Caregiving: Working with Substitute
Care Providers

Collaborating with Other Agencies

Chapter 13: Using Trauma-Informed Services to Increase Parental Protective Factors



Why is this Important to Child Welfare?

“Untreated trauma affects the parenting abilities of all of the caregivers in the lives of these children; resulting in disrupted placements and client recidivism.”

While it is becoming more common to screen, assess, and treat children for trauma, the child welfare community has not widely focused on the birth parents and the events that they may have experienced, as children and as adults. Child welfare courts and counties regularly refer parents to treatment for substance abuse, domestic violence, and mental health issues. However, they often rely on their contracted therapists, counselors, and other mental health professionals who may have little training on therapeutic methods being used to address trauma. Using Trauma-Informed Services to Increase Parent Protective Factors is important to child welfare since research has shown that abuse and neglect are often intergenerational. This possible history of abuse and/or neglect may also affect the emotional safety and well-being of both the parents and the child when placing an at-risk child into the home of maternal or paternal grandparents where the parent’s abuse and/or neglect took place or when placing the child with parents’ siblings who may have been abused and/or neglected as well or witnessed it. Untreated trauma affects the parenting abilities of all of the caregivers in the lives of these children; resulting in disrupted placements and client recidivism. If strengthening the family is the priority, then being trauma-informed and utilizing trauma-focused screening, assessment, and treatment services for each member of the family, including birth parents, should be the first step as this chapter describes.

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Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize Physical and Psychological Safety for Children and Families

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Brief Summary

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. Whether parents have experienced 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. 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. Screening parents for trauma when they become involved with the child welfare system is a crucial step toward identifying those parents whose recent and past traumas continue to have a negative impact on their parenting and ability to protect their children from future harm. Linking these parents to trauma-informed services to help them recognize the impact of trauma on their current parenting and to overcome past traumas can increase their ability to protect their child, thereby enhancing child safety, permanency, and well-being.

Background

It is well-known and well-documented that childhood adversity (e.g., parental mental illness, exposure to domestic violence) can lead to unhelpful behaviors and a host of physical and psychosocial problems in adulthood (Felitti et al., 1998). More specifically, childhood maltreatment is a risk factor for substance abuse in adulthood (Miller, Downs, & Testa, 1993). The link between childhood trauma and substance abuse is especially high for women. Studies have shown childhood physical and sexual abuse rates of 55%-99% among women with substance abuse problems (Najavits, Weiss, & Shaw, 1997). Women who have been traumatized may use substances as an effort to self-medicate, to escape from their trauma-related distress (Covington, 2002). Parental substance abuse, particularly maternal substance abuse, is one of the most common reasons why families become involved in the child welfare system. There is also research linking a childhood history of neglect in women to a higher risk of neglecting one's own children (Dunn et al., 2002). In addition to childhood traumas, many parents who become involved with the child welfare system experience domestic violence and/or community violence as adults.

Numerous studies link caregiver trauma history, past and current, to child functioning (Scheeringa & Zeanah, 2001; van Ijzendoorn, 1995; Main & Hess, 1990). Pathways for intergenerational transmission of trauma effects include caregiver symptoms (e.g., depression and PTSD), impaired parenting practices, and problems in the caregiver-child relationship. Adults who were maltreated as children often lack positive role models for establishing and maintaining trusting relationships and, therefore, may engage in dysfunctional and even violent adult relationships. Unresolved childhood trauma can lead parents to re-enact the trauma with adult partners and/or displace trauma-related anger onto their children (Walker, 2007). Parents with unaddressed trauma histories are more likely to treat their own children the way that they were treated (Neborsky, 2003) and often have difficulty forming healthy attachments with their children (Main & Hesse, 1990). Therefore, parental trauma history can impede the protective factors of family



functioning, social support, and nurturing and attachment. Parents abused as children may also have learned inappropriate and harmful parenting styles, such as using threats and violence, from their own parents and may maintain the belief that this kind of parenting is normal and acceptable. Many adults who have an untreated history of sexual abuse tend to miss the “red flags” signaling unsafe situations for their own children, because of their own avoidance of any trauma reminders.

A parent’s trauma history may not only expose his or her child to higher risk for maltreatment, but also impacts 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 caregiver’s ability to respond to the 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.

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
- Retraumatization
- An increase in relapse
- Withdrawal from service relationship
- Poor treatment outcomes

(Oben, Finkelstein, & Brown, 2011)

Recommendations from the Field



- Adopt and implement child welfare policies and procedures related to screening for adult trauma.** There are numerous instruments for adult trauma screening that are available and appropriate for use by child welfare workers (Blake et al., 1995; Gentry, 1996). Trauma screening tools help clarify the kinds of experiences that parents have lived through and how these experiences impact their current functioning. Trauma-related questions can also be incorporated into existing child welfare assessment tools to avoid placing extra paperwork on caseworkers. Parents who report their own history of trauma and current trauma symptoms and/or substance abuse would benefit from a referral to a trauma specialist to assess and treat these issues so that they do not interfere with parenting and protective factors. Screening is crucial for making appropriate service referrals.
- Advocate for better-trained therapists** to work with parents to resolve issues, including trauma, that interfere with protective factors. Administrators can collaborate with mental health departments and community agencies to support trauma training initiatives for adult-serving providers. Policies that promote training in evidence-informed and integrated trauma treatment for community providers, and contracts favoring trauma-trained programs, help ensure that parents

are getting the treatment that they and their children deserve.



- ☑ **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>).

- ⇒ **Seeking Safety** (Najavits, 2002) is a group or individual treatment model that is supported by research, is present-focused, and teaches coping skills to help adults seek safety from trauma and/or substance abuse at the same time.
- ⇒ **The Trauma Recovery and Empowerment Model** (TREM: Harris & The Community Connections Trauma Work Group, 1998) is a group-based intervention for women with histories of sexual and physical abuse that facilitates trauma recovery through cognitive restructuring and skill-building to address consequences of the abuse, including post-traumatic stress disorder (PTSD), depression, and substance abuse. There is a similar group program for men (M-TREM).
- ⇒ **Trauma Affect Regulation: Guide for Education and Therapy** (TARGET: Ford & Russo, 2006) is a strengths-based model that teaches men and women skills to regulate emotion, manage intrusive trauma memories, promote self-efficacy, and achieve recovery from trauma.
- ⇒ **Helping Women Recover/Beyond Trauma/Helping Men Recover** (Covington, 2003; Covington, 2008; Covington, Griffin, & Dauer, 2011) are three gender-responsive group curricula (two for women and one for men) that integrate trauma and substance abuse treatment.

- ☑ **Promote awareness of parent trauma and its impact across the child welfare system,** including child welfare staff, the courts, and community partners. Parents can be more effectively engaged in the service delivery process if the underlying impediments to their ability to protect and support their children are understood and addressed by the system. Trauma-informed training for child welfare professionals would help them to:

- ⇒ Understand that parents' anger, fear, avoidance, and challenging behaviors may reflect reactions to their own past traumatic experiences, not to the child welfare worker himself/herself.
- ⇒ Remember that traumatized parents are not "bad" and that approaching them in a punitive way, blaming them, or judging them likely will worsen the situation rather than motivate a parent.
- ⇒ Build on parents' strengths and desire to be effective in keeping their children safe and reducing their children's challenging behaviors.
- ⇒ Help parents understand the impact of past trauma on current functioning and parenting, while still holding them accountable for the abuse and/or neglect that led to involvement in the system.
- ⇒ Pay attention to ways trauma can play out during court proceedings, case conferences, visits with children in foster care, etc. Help parents anticipate their possible reactions and develop coping skills to respond to stressors and trauma triggers.

(National Child Traumatic Stress Network, Child Welfare Committee, 2011)

Resources

Documents:

Chemtob, C. M., Griffing, S., Tullberg, E., Roberts, E., & Ellis, P. (2011). Screening for trauma exposure, and posttraumatic stress disorder and depression symptoms among mothers receiving child welfare preventive services. *Child Welfare, 90*(6), 109-128.

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National Child Traumatic Stress Network, Child Welfare Committee. (2012). *Birth parents with trauma histories and the child welfare system: A guide for resource parents*. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress. Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_resource_parent_final.pdf

Online Resources:

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

Chapter 14: Trauma-Informed Caregiving: Working with Substitute Care Providers



Why is this Important to Child Welfare?

Trauma-Informed Caregiving: Working with Substitute Care Providers is important to child welfare for two main reasons: 1) The substitute care providers play a crucial role in helping to address the issue of trauma for the child they care for, and 2) they are impacted by the traumatic experiences of the child. In their role with the child, it is important for them to be aligned with the caseworker in a trauma-informed way. These care providers play a critical role with the child and his/her family in helping to create a psychologically safe environment for the child that minimizes the impact of further traumatic stress, reduces the need for multiple placements, fosters and builds resilience, and strengthens the social emotional wellbeing of the child which will help them towards permanency.

“...helping to create a psychologically safe environment for the child that minimizes the impact of further traumatic stress...”

As with any professional who works with a child or adult that has had a traumatic experience(s), substitute care providers also require the supports necessary to minimize the secondary traumatic stress, be effective caregivers for the child in their care, and partner with the other professionals working with the child and his/her family (e.g., the child welfare worker, the school personnel, and the treatment provider(s)). This chapter describes

practical implications that a child welfare system can do to help substitute care providers better provide care for a foster child and take care of themselves in the process.

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Brief Summary

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 resilience 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.

Background of the Issue

Virtually all children entering out-of-home care have experienced significant trauma, and many children are further traumatized by removal from their parents and/or siblings. Once a child enters the foster care system, he/she is likely to be exposed to multiple losses (e.g., separation from family, peers, school, community, and culture), which can compound the effect of trauma and impede the child's ability to recover. While there are many reasons for placement instability, children's behavior problems and resource parents' lack of ability to manage these problems are frequently cited (Lindhiem & Dozier, 2007; Newton, Litrownik, & Landsverk, 2000; Chamberlain et al., 2006). Trauma reactions can include behavioral manifestations including aggression, anger/defiance, and self-harm. 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. Many times a child with disrupted placements ends up in higher levels of care, including group homes/residential treatment settings. These highly structured settings can cause negative reactions in a child who has experienced trauma, as he/she may feel powerless and resentful of authority figures and rigid rule systems. Practices such as restraint and seclusion can be particularly difficult for such a child.

Although foster and adoptive parents and residential providers are required to undergo specialized training, this training usually does not include much content related to trauma or how to provide

trauma-informed caregiving. Resource parents and group home staff are therefore ill-prepared to handle the trauma-related reactions and behaviors exhibited by a traumatized child who enters their home. Well-meaning resource parents often request placement change when they feel unable to give a traumatized child the care that he/she needs. Placement disruption is financially costly to the child welfare agency and takes an emotional toll on the child and the resource family. Child welfare systems are likely to continue to have substandard rates of placement stability and permanency if they fail to provide the proper education, training, and support to substitute care providers.



Recommendations from the Field



- ☑ **Work with the organizations that provide initial licensing training to resource parents and group home staff to ensure that initial training includes education on trauma and its impact as well as trauma-informed parenting skills.**
- ☑ **Work with training entities, state foster parent associations, and resource parent support groups to promote ongoing trauma training and skills building for substitute care providers.**
- ☑ **Consider contracting with agencies who will implement *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents*.** (A free training manual for this course is available through the NCTSN - see entry for it in the Resources section on the next page. It is listed under the first author's name: Grillo, C. A.).
- ☑ **Educate substitute care providers about trauma triggers and psychological safety.**
- ☑ **Institute policies that include substitute care providers as important members of the child's and family's support team and involve them in team decision-making meetings.**
- ☑ **Work to remove administrative barriers to communication and collaboration to ensure that all substitute care providers have the information they need to care for and meet the child's needs.**
- ☑ **Provide training to permanency/foster care/kinship/adoption staff on how to support resource parents on trauma issues and how to work with them on secondary traumatic stress reactions and self-care.**
- ☑ **Work to enhance family finding efforts, as kinship placements tend to be more stable than non-kinship placements** (Chamberlin et al., 2006).
- ☑ **Ensure adequate support** (financial, social, and emotional) **and services to kinship care givers.**
- ☑ **Promote and facilitate positive relationships between birth and resource parents to enhance placement stability;** and support the role of the resource parent as a mentor to the birth parent.
- ☑ **Ensure adequate and appropriate respite services** to give substitute care providers much-needed breaks.

- ☑ Enlist extended family members and family friends with whom the child is already familiar as respite providers.
- ☑ Identify and certify respite caregivers as soon as a child is placed.
- ☑ Encourage residential care agencies to train their staff in one of the trauma-informed care models, including the Sanctuary Model (Bloom, 2005).
- ☑ Work with residential providers to reduce or eliminate harsh practices such as seclusion and restraint and encourage them to train staff in trauma-informed alternative methods.
- ☑ Promote trauma-informed step-up, step-down, and wraparound services at all levels of intervention to ease transitions for youth in out-of-home care.



Resources

Documents:

Grillo, C. A., Lott, D. A., & Foster Care Subcommittee of the Child Welfare Committee, National Child Traumatic Stress Network. (2010). *Caring for children who have experienced trauma: A workshop for resource parents – Participant handbook*. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress. Retrieved from <http://nctsn.org/products/caring-for-children-who-have-experienced-trauma>

National Child Traumatic Stress Network, Child Welfare Committee. (2012). *Birth parents with trauma histories and the child welfare system: A guide for resource parents*. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress. Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_resource_parent_final.pdf

National Center on Child Abuse and Neglect (NCCAN) - Substitute Care Providers: Helping Abused and Neglected Children: <http://www.childwelfare.gov/pubs/usermanuals/subscare/index.cfm>

Online Training:

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

Chapter 15: Collaborating with Other Agencies



Why is this Important to Child Welfare?

“The trauma that abuse and neglect causes directly, and that the system often exacerbates, has profound and enduring effects on children.”

Collaborating with Other Agencies is important to child welfare because children and families in the child welfare system are likely to be involved with multiple agencies and collaboration among these agencies can help reduce further potential trauma. Child welfare administrators are in a unique position to provide leadership towards the implementation of a collaborative and coordinated trauma-informed system of services and supports. The trauma that abuse and neglect causes directly, and that the system often exacerbates, has profound and enduring effects on a child. This recognition provides an opportunity to engage staff, courts, service providers, and contractors in important conversations about mitigating such trauma. In addition to providing high quality care, a system that meet the needs of children and families through trauma-informed practice has the potential to positively impact state and federal child welfare outcomes. This chapter contains practical tips on how a child welfare system can avoid creating more trauma in a child’s life by coordinating certain services that a child in the system may need.

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Essential Elements of a Trauma-Informed Child Welfare System Addressed

Maximize
Physical and
Psychological
Safety for
Children and
Families

Identify
Trauma-
Related
Needs of
Children and
Families

Enhance
Child
Well-Being
and
Resilience

Enhance
Family
Well-Being
and
Resilience

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

Partner
with
Youth and
Families

Partner
with Agencies
and Systems
that Interact
with Children
and Families

Brief Summary

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 collaborative with one another. 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, foster and adoptive 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.

Background

The majority, if not all, children and families involved in the child welfare system are involved with multiple agencies and systems. These include the child who is receiving mental health treatment and is involved in the juvenile justice system, and the parent who is receiving both substance abuse and domestic violence services. Therefore, in order to provide the best services for children and families in its care, the child welfare agency must establish strong collaborative partnerships on the individual, agency, and system levels. According to the Center for Technology in Government (2003), the definition of collaboration is "A reciprocal and voluntary agreement between two or more distinct public sector agencies, or between public and private or non-profit entities, to deliver government services" (p. 4). Collaboration must include a minimum of two distinct organizations, a formal agreement about roles and responsibilities, a common objective aimed at the delivery of a public service, and the sharing or allocation of risks, benefits, and resources. In order for the child welfare system to become more trauma-informed, it must prioritize collaboration efforts on both the community level across multiple systems and on the individual level across individuals involved with a particular case.

The Center for Technology in Government (2003) outlines what it found to be the four critical success factors that were crucial in ensuring a smooth development and successful implementation of collaboration projects:

- Leadership - Successful collaboration is initiated by public sector leaders who share a vision of better government. "Commitment of top political leaders at all levels of government proved critical to sustain the initial effort and achieve a successful partnership and service delivery" (p. 9).
- Trust - There are two kinds of trust relationships. First, public trust is the degree to which citizens and other groups in society believe the project or service program can be trusted to treat them fairly. Second, professional trust is the degree to which people and organizations charged with developing and delivering a service believe they can rely on the motives and predict the performance of other participants. Trust can be obtained through institutions (laws, contracts, MOUs) or personal relationships (Dawes, 2003).

- Risk management - Collaboration naturally encounters risks, both internal and external. Internal risks stem from the nature of the project, the participants, and their relationships, while external risks are those encountered in relationship to other agencies and systems. Risks may be managed if they are identified and understood early on in the process (Préfontaine, 2003).
- Communication and coordination - This factor includes information sharing, good communication, and well-orchestrated coordination. Formal roles should be defined, widely understood, and allowed to evolve; and informal relationships need to be allowed to flourish, as well (Gant, 2003).

Community Collaboration

On a community level, it is vital that a trauma-informed child welfare system helps to coordinate their policies, practices, and resources with collaborating organizations in a trauma-informed environment with each supporting the other. Child welfare would be well-advised to use its leadership role to align the array of public and private resources it relies upon to build a coordinated continuum of trauma-informed care.



This can be facilitated by identifying key points of overlap where trauma-informed practice coordination is critical and building system communication pathways to minimize working at cross purposes. Administrators must consider that child welfare is typically a serial system where children come into contact with different people, one after another, as the case is handed off from one worker to another as the case moves through the system. It is imperative to remember a child (not just a record) is being moved from system to system and take steps to ensure these exchanges are designed not to add to the trauma, inadvertently undo the good work of others, or fail to pass critical information such as insights into trauma triggers (i.e., traumatic reminders) to the next person responsible for working with the child and family.

Individual Caseworker Collaboration

The caseworker can also be trained and coached to apply a trauma lens to his/her efforts to coordinate the investigation and service delivery processes in child welfare. To do this and have the maximum impact, a caseworker must first work to coordinate the mix of service providers he/she has aligned to work with the highly traumatized child and his/her family. In particular, individual coordination between the birth parent, child welfare caseworker, the mental health therapist, and the foster 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 et al., 2001) 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.

For information on broader collaboration across larger systems, please see Chapter 7: Embedding Trauma-Informed Practice in the Broader Child and Family-Serving System.

Recommendations from the Field



- ☑ **Establish a strong partnership and ensure ongoing collaboration with law enforcement and medical/forensic interviewing on the front end of the investigative process.** These systems are all actively involved with investigation or fact finding and all are interacting with the same children and families. The child advocacy center model offers a strong trauma-informed model to accomplish this type of collaboration. The National Children's Alliance has information on the child advocacy center model on its website: www.nationalchildrensalliance.org.
- ☑ **Encourage collaboration between the workers removing children, when necessary, and the agency or placement resources receiving the children for care.** For example, a trauma-informed caseworker may ask the child if he/she would like to take a transitional object (e.g., a stuffed animal, favorite toy, etc.) with him/her to feel safer. In a system that is not trauma-informed system, the shelter or foster parent may take the object away upon placement as "dirty." In a trauma-informed system, the shelter or foster parent would acknowledge how this transitional object is critical in ensuring the child's feeling of psychological safety.
- ☑ **Ensure collaboration between the caseworker, the foster parent, and schools.** For example, the caseworker and the foster parent may determine that the child experiences a trauma trigger when confronted by loud voices. The foster parent may learn to use calm tones to gain the child's attention, only to find the child's teacher raising his/her voice in demanding tones in an effort to gain the child's focus or compliance. In a trauma-informed system, this critical information would be shared with the school system to ensure that all critical adults in the child's life are using similar strategies to assist the child in coping with overwhelming emotions and to feel safe.
- ☑ **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.

Resources

Document:

Center for Technology in Government. (2003). *New models of collaboration: A guide for managers*. Albany, NY: Center for Technology in Government, University at Albany, SUNY. Retrieved from http://www.ctg.albany.edu/publications/online/new_models/

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Organization:

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



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