

DESK GUIDE ON TRAUMA-INFORMED CHILD WELFARE FOR CHILD MENTAL HEALTH PRACTITIONERS



The Child Welfare System: A Day in the Life of a Child Welfare Worker

On my way into the office, I stop to check in with one of the mothers on my caseload. I need to see her for our monthly contact visit. I want to see her away from her children so we can talk about how her sobriety has been going since she was discharged from her drug treatment program. Hopefully, she'll be home this time. I reluctantly knock on the door, not knowing if she's there, but I have a sense someone is in the house. The yard is full of garbage and random furniture and there is a strong odor coming from somewhere. I seriously can't wait to leave. A man answers the door and tells me she's not home. He says he's a friend of hers and she went to the store. He doesn't know when she will be back. He tells me the children are at school. I think he's under the influence of something, but I don't want to get into it with this man who I don't know. I leave my card and ask that he have the mother call me.

I get into the office and I have to finish a court report for one of my cases. It's due today and I have written less than half of the approximately 20-page long report. Of course, I have voicemail messages. I check and there are 14! How can this be? I just checked them yesterday afternoon! Four messages are from the same frantic client demanding a visit with her children and wanting to know where her bus card is, one is from an angry foster parent, 2 are from a child's attorney, and 1 is my new client calling from jail wanting to know when he will see his child, then there are messages from therapists, and the second to last message is from a relative caregiver who is at the hospital with her 3-year old niece that she is providing care for. The child has a broken arm and the relative doesn't sound okay. Then the last message is from the hotline, saying there is an immediate response referral on one of my cases, the 3-year old. The hospital suspects abuse due to the nature of her injury. My supervisor appears and tells me I have to get to the hospital right away to investigate this referral, because the medical team suspects this is a non-accidental trauma. I remind him I have a court report to write. He tells me it will have to wait. Apparently, the rest of my messages will also have to wait. I head to the hospital and bring my laptop in hopes that I will somehow finish this court report so the judge doesn't yell at me again.

~ Written by a social worker with 6 years of experience as a child welfare frontline worker

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. The guide touches upon many subjects related to child welfare systems and trauma. There are also resource, glossary, and reference sections located at the end of this guide. In addition, there are two inserts that can be pulled out and displayed or placed in an area where they can be referred to on a regular basis. For more information about the topics covered in this guide, please visit www.ctisp.org to access the complete *Trauma-Informed Child Welfare Practice Toolkit*.



The Child Welfare System: The Structure of the Child Welfare System

The structure and terminology of child welfare varies dramatically across the United States. All states operate under a broad federal legal framework set out by Congress. Many systems are administered directly by the state and state employees are responsible for performing child protection, foster care, adoption, and various case management duties of child welfare workers. In other states, the systems are administered by the counties, under state supervision, and the staff are employed by the county. Still other jurisdictions are experimenting with privatization and relying on nonprofit contractors to perform some parts of the child welfare job like adoption or foster care, while a few have sought to privatize almost all direct services. Child welfare on tribal lands may include the Bureau of Indian Affairs. The lexicon of child welfare also varies from state to state and even community to community based on

state or local law and policy, court rules, and local initiatives.

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That said, there are some key common elements mental health professionals need to understand regardless of where they practice. All child welfare systems have three key federal goals they must strive to obtain for each child: **safety, permanency, and well-being**. The first, **safety**, has traditionally focused on physical safety and preventing further abuse or neglect of the child. Often, the first act of child protection is to investigate allegations, frequently in partnership with law enforcement, and to determine if there is enough evidence to conclude abuse or neglect has occurred or is at imminent risk of occurring. This decision is often called “substantiation” or “validation” (although the terms vary around the country). In making this decision, policy and law require the worker to document legal evidence

Adoption and Safe Families Act (ASFA)

On November 19, 1997, President Clinton signed into law (P.L. 105-89) the Adoption and Safe Families Act of 1997 (ASFA), to improve the safety of children, to promote adoption and other permanent homes for children who need them, and to support families. This law made changes and clarifications in a wide range of policies established under the Adoption Assistance and Child Welfare Act (P.L. 96-272), the major federal law enacted in 1980 to assist the states in protecting and caring for abused and neglected children. There are a number of major provisions of the ASFA that impact mental health services for children in child welfare:

- Accelerated permanent placement by requiring states to initiate court proceedings to free a child for adoption once that child had been waiting in foster care for at least 15 of the most recent 22 months, unless there are extenuating circumstances. It also allowed children to be freed for adoption more quickly in extreme cases.
- Required shorter time limits for making decisions about permanent placements which impacts the speed and types of information that child welfare workers need to gather from mental health providers in order to make their placement decisions:
 - ⇒ Required permanency hearings to be held no later than 12 months after entering foster care.
 - ⇒ Required states to initiate termination of parental rights proceedings after the child has been in foster care 15 of the previous 22 months, except if not in the best interest of the child, or if the child is in the care of a relative.
- Increased accountability by requiring Health and Human Services to establish new outcome measures to monitor and improve State performance.

of maltreatment. Simple gut feelings or unproven belief a child has been abused is not enough. Even if no court action is taken, child protection must collect and assess the evidence. Typically the standard required of child welfare is a “preponderance of evidence,” meaning the total weight of the evidence must exceed 50% to consider a case substantiated. This, of course, is below the “beyond reasonable doubt” standard required for criminal prosecution. For many children, when they come into contact with the child welfare system, safety is the only goal child protection addresses. In fact, the investigations of most allegations fail to achieve the threshold of evidence needed to conclude abuse occurred. Nationally, 80% of all allegations across the nation are not substantiated (U.S. Department of Health and Human Services [DHHS], 2012). In some cases, the allegations are substantiated, but the family is acting proactively and taking steps to make the child safe in their own home with little or no oversight from child protection.

The second goal, **permanency**, emerged strongly in the 1970s and 1980s in response to the increasing number of children placed in foster care. With this goal, the agency is mandated to make reasonable efforts to protect a child without placing the child out of his/her home. When placement outside the child’s home (with relatives, in foster care, or a group care agency) is necessary, the agency must move the child as expeditiously as possible from temporary foster care back home or to an alternative permanent home, such as adoption. Many state laws or agency policy assert a strong preference for keeping the child with his/her birth family or returning him/her as quickly as possible. This practice is often known as family preservation. The decision to return the child to a home or conversely keep a child in foster care often requires input from mental health providers working with the family. This is needed so the worker can inform the court, who makes the final decision about placement and reunification, about the issues facing the child and family and their progress or lack thereof. In reality, the number of children entering and remaining in foster care across the nation has been falling for a decade and is now 25% below what it was 10 years ago (U.S. DHHS 2006; U.S. DHHS, 2012a). Today, the threshold for entering care is higher and the threshold for returning home lower than it was 10-20 years ago.

The last goal, **well-being**, was only added to federal

law in the 1990s and until 2012 was never well-defined by the federal government. That has now changed. The federal government is seeking to connect traditional child welfare practice with emerging brain science and the relationship with trauma. This includes the increasing availability of evidence-based practices along with an understanding of adolescent health, the adverse childhood experiences research, and resilience. Child welfare will need to work closely with mental health to help children better manage their emotions, build and sustain meaningful relationships, improve their sense of self-worth, improve their communication skills, and learn to trust others; all of which may have been shattered by complex trauma experiences and the uncertainties of foster care. There is a strong interest in screening all children entering child welfare for mental health needs including the impact of trauma, along with providing evidence-informed assessment and connecting the child to the right evidence-based or informed treatment, when indicated, and with the right support services. Please see the Trauma and the Child Welfare System section on page 6 for more information. Other factors in well-being include physical health, educational opportuni-

Indian Child Welfare Act (ICWA)

This is a federal law passed in 1978 to “protect the best interests of Indian children and to promote the stability and security of Indian tribes and families” (25 U.S.C. § 1902). ICWA:

- ☑ Provides minimum federal standards for the removal and placement of American Indian children.
- ☑ Regulates states regarding the handling of child abuse and neglect, as well as adoption cases involving American Indian children.
- ☑ Affirms and supports tribal jurisdiction in child welfare proceedings.
- ☑ Foster placement preferences, including:
 - Member of the child’s extended family
 - Foster home licensed or approved by the child’s tribe
 - Indian foster home licensed or approved by the state department of social services
 - Institution approved by Indian tribe
 - Tribe may have a different order of preference
- ☑ Adoptive preference placements (when parental rights have been terminated or relinquished)

ties, and support. Bottom line, it is no longer good enough to place the child in a physically safe location or even in a permanent home where they will not be abused or neglect. Child welfare must go further. This is a big change and, not surprisingly, the rate in which these concepts are being embraced and adopted across the nation varies significantly with some early adopter departments forging new territory while some others are lagging behind.

Child welfare laws vary from state to state. To find more state-specific information about schedules of

court hearings, who may be present at hearings, determinations made at hearings, and permanency options, read Child Welfare Information Gateway's Court Hearings for the Permanent Placement of Children, which includes a summary of each state's statutes on these topics: www.childwelfare.gov/systemwide/laws_policies/statutes/planning.cfm. There is also a database available on child welfare-related legislation that is searchable by state, topic, status, year, keyword, etc.; here is the link: <http://www.ncsl.org/issues-research/human-services/2012-child-welfare-enacted-legislation-database.aspx>.

The Child Welfare System: Understanding the Culture of the Child Welfare System

There is great variability in how child welfare departments are organized and the diversity of legal frameworks within which they must operate. Further, every case is different and the contact between the worker and the family can vary greatly from case to case. However, despite these variations, there is a remarkable consistency in the culture of child welfare agencies. In virtually every case, someone—a

parent, the person making a referral, the child, the doctor, the child's attorney, the police, the parent's attorney—is criticizing child welfare. Workers must operate in a complex professional environment in which there are no shortage of

people who want to tell them what they should do or want them to magically make a parent or child "act right." They typically manage a caseload that does not allow enough time for each case and labor in an environment where they know a misstep can cost a child his or her life or conversely harm a child by keeping them out of a home now capable of safely caring for them. The judge, the attorney, the court-appointed special advocate (CASA), the therapist, and the teacher all think they know what the worker and agency should do for each child. Heaped on top of this is an unhealthy dose of secondary traumatic stress from the constant exposure to the violence the children on their caseload experienced. Some handle

this pressure better than others. A wise mental health professional will recognize the signs of stress and respond collegially in helpful ways rather than adding to the chorus of criticism.

Sometimes, however, the actions of a caseworker and what the mental health professional believes to be in the interest of the child may conflict. If agreement cannot be reached and the stakes are high for the child, it is important to understand that the child welfare caseworker works in an organizational setting and as such has a supervisory chain of command. If a serious difference of opinion (Leslie, 2013) exists, the therapist can

reach out to the supervisor and explore the issues. Many systems have a formal ombudsman who is tasked with objectively listening to those who disagree with child welfare actions.

In the end, the vast majority of child welfare workers care passionately about the children and families in their caseloads and child welfare administrators want to have the most effective system they can achieve. They pour a great deal of energy into that effort and mental health professionals can emerge as key allies in protecting children, helping them achieve permanence, and repairing or establishing protective, supportive, and emotionally responsive adult



relationships that are necessary for long-term well-being (Samuels, 2011).

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

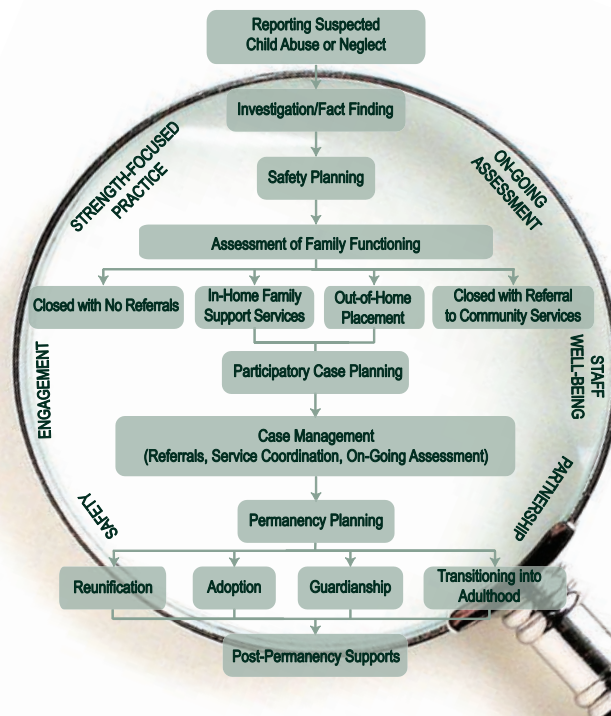
which provides guidance to child welfare agencies looking to expand their capacity to make meaningful and measurable changes in social and emotional well-being for children who have experienced maltreatment, trauma, and/or exposure to violence. This can be accessed at http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/2012/im1204.pdf.

The Child Welfare System: Child Welfare Practice

As is the case with many social service agencies, child welfare workers and supervisors have large caseloads and competing priorities. For each family a caseworker has on his or her caseload, there are numerous meetings, reports, and visits that need to be conducted. As with therapy, some cases may be highly labor intensive while others may only require ongoing monitoring. For many child welfare jurisdictions, practice is guided by a casework practice model. An effective practice model serves to engage youth, families, and the community in developing and delivering an array of services that meets the unique needs of the families served and helps the agency achieve its desired outcomes (American Public Human Services Association, 2011). 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 [NCWRCOI], 2008). It is the “clear, written explanation of how the agency successfully functions” (NCWRCOI, 2008, p. 1). The diagram below provides a visual depiction of the key points within a child welfare practice model, though all child welfare systems may not work exactly as it is depicted. Mental health traditionally becomes involved during the case planning process when children are referred for therapy. As you can see from the diagram, the child and family have already had multiple interactions

APPLYING A TRAUMA LENS TO A CHILD WELFARE PRACTICE MODEL



Responsibilities to Mitigate the Impact of Trauma

- Agency**
 - Mission, vision, and core values
 - Underlying theoretical framework/ rationale for the practice model
 - Policy
 - Practice principles
 - Standards of professional practice
 - Staff development and retention
 - Evaluation of desired outcomes
 - Evaluation of practice model impact on outcomes
- Supervision**
 - Coaching staff and case consultation
 - Monitoring staff performance and activities
 - Monitoring and supporting staff safety and well-being
 - Addressing secondary traumatic stress
 - Monitoring worker fidelity to practice model
 - Documentation

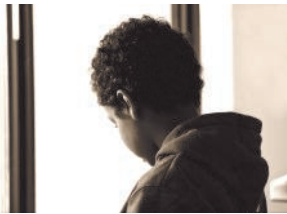


with the system prior to the referral for mental health services. In some jurisdictions, however, mental health may be involved during the investigation and removal process and can also inform the initial assessment process. For more information on child welfare

casework practice models and efforts to make them more trauma-informed, refer to *Guidelines for Applying a Trauma-Informed Lens to a Child Welfare Practice Model* (available Spring 2013 as part of the *Trauma-Informed Child Welfare Practice Toolkit*).

Trauma and the Child Welfare System

Mental health providers who work with children who have experienced trauma often interface with the child welfare system. Children involved in the child welfare system are particularly vulnerable to potentially traumatic events, including the events that brought them into the system, the process of removal by child protective services and/or law enforcement, and placement with substitute caregivers. Such events can cause child traumatic stress, which is defined as the physical and emotional responses of a child to



events that threaten the life or physical integrity of the child or someone critically important to the child (e.g., a parent or sibling).

Exposure to a single traumatic event that is limited in time (e.g., an auto accident, a gang shooting, or a natural disaster) is called an acute trauma. Chronic trauma refers to repeated assaults on the child's body and mind (e.g., chronic sexual or physical abuse, exposure to ongoing domestic violence, emotional or physical neglect). Finally, complex trauma is a term used by some trauma experts to describe both exposure to chronic trauma, often inflicted by parents or others who are supposed to care for and protect the child, and the immediate and long-term impact of such exposure on the child (Cook et al., 2005).

Traumatic events may overwhelm a child's capacity to cope and elicit intense emotional and physical reactions. These effects can be as threatening to the child's physical and psychological sense of safety as the event itself. While the effects of trauma are

prevalent and far-reaching among children in the child welfare system, the relationship between the child welfare and mental health systems is often wrought with tension due to conflicting goals, timelines, and tasks that need to be completed. However, recently 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.

Adopting a trauma-informed approach to child-serving systems provides benefits on multiple levels. It provides a common goal and language for both child welfare and mental health, and a framework for educating the workforce and affiliated stakeholders on the impact of trauma. When mental health providers have a better understanding of the goals and requirements of child welfare, it assists both systems in working more collaboratively with one another to ensure that each child and his or her family receives the services they need and in creating a more trauma-informed child-serving system. For more information on trauma and trauma-informed child welfare systems, please see *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org.

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Investigation

When a report of possible child abuse or neglect is received, the initial response often involves an investigation. Investigations may be conducted by child protective services staff, the police, or a

multidisciplinary team. The purpose of the investigation is to determine if a child has been harmed or is at risk of harm (a disposition), reduce the risk and increase the safety of the child, and determine

the need for services to support the family.

The foundation upon which the child welfare caseworker builds his/her decisions about safety, permanency, and well-being is often formed in the

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.

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, risk, and the underlying causes of

maltreatment, and begins a relationship with the child and family. Safety is focused on the immediate determination of maltreatment while risk is focused on the likelihood of future maltreatment.

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 welfare 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.



A thorough and 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. Ideally, this approach would do so in a way that not only avoids adding avoidable secondary adversities, but may actually help engage the child and family in a positive change process. Some of these actions are actually already commonplace in many communities while others still need to be developed. The investigative process is often an unavoidably stressful period for the child and family. This stress 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, and may bring that experience into the therapy setting.

For more information on investigation, please see *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org.

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

In 2011, the Child and Family Services Improvement and Innovation Act which provided the reauthorization of Promoting Safe and Stable Families (PSSF) included new language addressing trauma and vulnerable populations. It specified that state plans shall include an outline of “how health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child’s maltreatment and removal from home” (Child and Family Services Improvement and Innovation Act, Sec. 422, [b], [15A], [ii]). With this



legislation, the importance of screening for emotional trauma within child welfare populations became clear.

For many jurisdictions, this constitutes a new practice and they are trying to figure out how to institute a screening process for trauma within their policies and procedures. The goal within a trauma-informed child welfare system is that all children are screened for trauma and this information is used to inform whether a child is referred for a more comprehensive trauma-informed mental health assessment.

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. Trauma screenings assist caseworkers in gaining 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 remind the child of the trauma. Trauma screening information could also be informative to resource parents and, along with special training, it might reduce the likelihood of a placement change request by helping foster parents manage the difficult behaviors. Finally, a trauma screening plays a critical role in determining whether or not a child should be referred for general mental health treatment or trauma-focused treatment, or does not need treatment services at this time.

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There are a number of commonly used trauma screening tools that are available for use by child welfare workers for children across the developmental spectrum. With any tool that is used, it is important that the individual completing the tool receives 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. Some of these tools include the *Child Welfare Trauma Referral Tool* (CWT; Taylor, Steinberg, & Wilson, 2006), *Child and Adolescent Needs and Strengths* (CANS; Kisiel, Blaustein, Fogler, Ellis, & Saxe, 2009b), and the *Traumatic Events Screening Inventory – Parent Report* (TESI-PRF-R; Ghosh Ippen, 2002). For more information on screening, please see *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org.

Coordinating Services with Other Agencies

Children and families involved in the child welfare system are more likely than not to be involved with and receiving services from multiple individuals and agencies that may or may not be working in collaboration. In addition to public child welfare agencies, these may include mental health agencies, private non-profit child welfare and social service agencies, substance abuse and domestic violence programs, the courts, resource and adoptive parents, child advocacy centers, schools, and public health, among many others. Effective collaboration occurs on both the community and individual 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.

Individual coordination between the birth parent, child welfare caseworker, the mental health therapist, and the resource parent is critical



in assisting the child and his/her family along a more positive trajectory. In cases where the birth parent has unsupervised visitation, it is incredibly helpful to integrate him/her into the therapy process to provide him/her with the tools and skills needed to manage some of the child's challenging behaviors. For example, if the child and his/her resource parent are receiving mental health services such as Parent-Child Interaction Therapy (PCIT; Eyberg, 1988) to assist the resource 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 more information on coordinating services with other agencies, please see *Creating Trauma-*

Informed Child Welfare Systems: A Guide for Administrators in the toolkit or at www.ctisp.org.

Trauma and Psychotropic Medication Among Children in Child Welfare

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

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

- Irritable or angry mood

- Sleep problems
- Aggression
- Fear and anxiety
- Depression and sadness



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

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

Working with Birth Parents

Over the past several years, there has been a growing recognition that many parents who are involved in the child welfare system have their own histories of trauma. 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. 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.

Child welfare system interventions, such as removal of children from their parents, can be highly distressing for parents and can serve as reminders of parents' past traumatic memories and further impede parent functioning. Across multiple studies (Linares et al., 2001; Lieberman, Van Horn, & Ozer, 2005), caregiver

functioning has been found to be a major predictor of child functioning following the child's exposure to traumatic experiences. Thus, a trauma-informed child welfare system needs to support the caregivers and provide intervention for the caregivers' symptoms if it hopes to improve child outcomes. Failure to understand and address parent trauma can lead to:

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

(Oben, Finkelstein, & Brown, 2011)

While most child welfare jurisdictions do not have policies and procedures in place to screen parents for their own trauma history, it is a crucial next 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. Mental health plays a critical role in linking these parents to trauma-informed services to help them recognize the impact of trauma on their current parenting and to overcome past traumas. This ideally leads to an increased ability to protect their children, thereby enhancing child safety, permanency, and well-being. For more information on birth parents, please see *Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators* in the toolkit or at www.ctisp.org.

Working with Substitute Providers

Although the vast majority of children entering out-of-home care have trauma histories, most substitute care providers are not provided training on the impact of trauma or how to manage trauma reactions, nor are they given adequate support to help them cope with issues related to child traumatic stress. Substitute care providers include anyone who cares for a child in out-of-home care, including kin, resource parents, and group home workers among others. These care providers are often the ones who can have the biggest impact on a child's recovery from trauma, as they are usually the ones who are spending the most time with the child on a daily basis. They have a vital role in nurturing resiliency and healing in any child in their care who has experienced trauma. A child's trauma reactions can create serious challenges for caregivers, and if these reactions are not understood in the context of trauma, they can lead to placement disruptions. As placement instability impedes a child's chances of reunifying or being adopted (Fisher, Kim, & Pears, 2009), it is imperative that the child welfare system provide appropriate education and support to substitute care providers to reduce the number of placement disruptions.

A child who has experienced trauma often overreacts to environmental stimuli that remind him/her of the trauma called trauma triggers. This behavior can be confusing and frustrating for substitute care providers who do not understand the source of the distress.



Even when a child is placed in a safe environment, it may take a long time to regain a sense of psychological safety, or feeling safe. A child with a trauma history and related behavioral reactions is likely to exhibit a worsening of these reactions each time he/she has a disrupted placement (Newton, Litrownik, & Landsverk, 2000). A child with disrupted placements often blames himself/herself and comes to believe that he/she is unlovable and unwanted and that it is not safe to get close to substitute care providers for fear of further rejection or abandonment.

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

Resources

Documents:

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Online Database:

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

Online Resources:

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

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

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

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

Online Trainings:

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

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

Organizations:

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

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

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

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Glossary of Terms

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

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

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

Adoption and Safe Families Act - On November 19, 1997, the President signed into law (P.L. 105-89) the Adoption and Safe Families Act of 1997, to improve the safety of children, to promote adoption and other permanent homes for children who need them, and to support families. This new law makes changes and clarifications in a wide range of policies established under the Adoption Assistance and Child Welfare Act (P.L. 96-272), the major federal law enacted in 1980 to assist the states in protecting and caring for abused and neglected children.

Birth Parent - The biological parent of the child who is involved in the child welfare system.

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

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

Child and Family Service Reviews - The CFSRs, which are periodic reviews of state child welfare systems, enable the Children's Bureau to: (1) Ensure conformity with federal child welfare requirements; (2) Determine what is actually happening to children and families as they are engaged in child welfare services; and (3) Assist states in enhancing their capacity to help children and families achieve positive outcomes.

Child Protective Services (CPS) - Generally a division within the child welfare agency that administers a more narrow set of services, such as receiving and responding to child abuse and neglect allegations and providing initial services to stabilize a family.

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

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

Court-Appointed Special Advocate (CASA) - A CASA is a trained volunteer who represents the best interests of children as they are taken through the legal process. These trained volunteers investigate the case and inform the court, help identify resources to address a child's special needs, and recommend temporary and permanent plans for the child

Differential Response - Differential response is a CPS practice that allows for more than one method of initial response to reports of child abuse and neglect. Also called "dual track," "multiple track," or "alternative response," this approach recognizes variation in the nature of reports and the value of responding differently to different types of cases (Schene, 2001).

Foster Care - Full-time substitute care for children removed from their parents or guardians and for whom the state has responsibility. Foster care provides food and housing to meet the physical needs of children who are removed from their homes.

Guardian ad Litem (GAL) - A lawyer or lay person who represents a child in juvenile or family court. This person typically takes into account the best interest of the child and may perform a variety of roles, including those of independent investigator, advocate, advisor, and guardian for the child.

Juvenile and Family Courts - Courts with specific jurisdiction over child maltreatment and child protection cases, including foster care and adoption cases. In jurisdictions without a designated family court, general trial courts hear child welfare cases along with other civil and criminal matters.

Other Child Welfare Services - These services address the complex family problems associated with child abuse and neglect. They include family preservation, family reunification, adoption, guardianship, and independent living.

Permanency - In the child welfare context, permanency is one of the three goals of the Child and Family Services Reviews (CFSRs). Permanency refers to the child's stability in placements.

Permanency Hearing - Usually held 12 to 14 months after a child is removed from the home and every 12 months after that. At the permanency hearing, the judge makes decisions about where the child will live permanently.

Practice Model - A conceptual map or organizational ideology of how agency staff, families, and community stakeholders work together to promote child safety, permanency, and well-being.

Preliminary Protective Hearing - Also known as the initial hearing, shelter care hearing, detention hearing, emergency removal hearing, or temporary custody hearing. It occurs soon after the filing of the petition or the removal of the child from the home. The preliminary protective hearing is the most critical stage in the child abuse and neglect court process. Many important decisions are made and actions taken that chart the course for the remainder of the proceeding. At this hearing, the relationships between those involved in the process also are established, and the tone is set for their ongoing interactions.

Safety - In the child welfare context, safety is one of the three goals of the Child and Family Services Reviews (CFSRs). Safety refers to the child's ability to protect himself or herself from abuse or for the agency to do so. This can be interpreted as physical safety and psychological safety.

Substantiated Finding - A finding that has been "substantiated" typically means that an incident of child abuse or neglect, as defined by State law, is believed to have occurred.

Substitute Care Providers - Includes anyone who cares for a child in out-of-home care, including kin, foster parents, and group home workers among others.

Termination of Parental Rights (TPR) Hearing - The Adoption and Safe Families Act (ASFA) requires that filing for TPR must be instituted when: (1) A child of any age has been in foster care for 15 of the most recent 22 months, unless exceptions apply; (2) The child is an abandoned infant; (3) The parent has committed, aided, or attempted the murder or voluntary manslaughter of a sibling of the child; or, (4) The parent has committed a felony assault resulting in serious bodily injury to the child or a sibling of the child. Most TPR proceedings arising from child abuse and neglect are initiated by CPS, but in some states, the Guardian ad Litem (GAL) also can petition on the child's behalf for TPR.

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

Trauma 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 child welfare services. Trauma screening tools typically detect exposure to potentially traumatic events/experiences and/or endorsement of possible traumatic stress symptoms/reactions, they are not diagnostic. The format can be self-report or worker-administered. Information gathered from a trauma screening tool is used to determine if a child needs to be referred for a trauma assessment.

Unsubstantiated Finding - A finding that is "unsubstantiated" means there is insufficient evidence for the worker to conclude that a child was abused or neglected, or what happened does not meet the legal definition of child abuse or neglect.

Well-Being - In the child welfare context, well-being is one of the three goals of the Child and Family Services Reviews (CFSRs). Well-being refers to both the short- and long-term consequences for the child's mental health, physical health, and life trajectory.

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Definition of a Trauma-Informed Child Welfare System

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

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

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

Maximize Physical and Psychological Safety for Children and Families

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

Enhance Family Well-Being and Resilience

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

Partner with Youth and Families

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

Identify Trauma-Related Needs of Children and Families

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

Enhance Child Well-Being and Resilience

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

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

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

Partner with Agencies and Systems that Interact with Children and Families

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

Frequently Asked Questions by Child Mental Health Practitioners about Trauma-Informed Child Welfare



Question: The child's caseworker keeps asking me to make recommendations on placement when I have only seen the child for a couple of months. Why are they asking me that?

Answer: According to the Adoption and Safe Families Act, there is a push for children to move to permanency within 18 months of being in care, whether it is through the process of reunification or adoption. They have a legal mandate for this, so they are trying to seek your assistance and recommendation.

Question: I am confused about confidentiality. There are so many individuals on the child's team that I am not sure who I can share information about the child's therapy. Is there a general rule about this?

Answer: Unfortunately not. The rules and limits of confidentiality vary by state and county. It is recommended that you check with your local laws to determine the limits of confidentiality within your jurisdiction.

Question: Are child welfare workers actually doing the screenings that were described in the screening section?

Answer: While the federal government has mandated screening for emotional trauma within child welfare settings, there are no guidelines as to how they need to do this right now, so many are in the process of figuring it out. Therefore, this will vary across jurisdictions. It is recommended that you periodically check-in with your local child welfare system to assess how they are planning on meeting this requirement.

Question: The child is not living at home with his/her biological parent. Should I still involve the parent in therapy?

Answer: For many children involved in the child welfare system, reunification with the biological parent is the goal, so it is important to provide that caregiver with the skills and support needed to improve their parental protective capacity. Involvement of the biological parent will vary according to a number of factors related to the child's sense of safety with that parent. If possible, it is recommended to involve the parent unless there are direct safety reasons not to do so. Having a conversation with the caseworker about this particular case, and how birth parent involvement may be helpful, is useful in this type of situation.

Question: What about the foster parent? The child doesn't really know the parent. Should I involve the foster parent in treatment?

Answer: Much like the previous question, caregiver involvement in therapy is critical to providing the child with the support that he or she needs. Therapy is a great opportunity to provide the foster parent with psychoeducation on the child and his or her trauma triggers and provide him or her with skills on how to manage trauma triggers.

Suggested Questions that Mental Health Providers Can Ask Child Welfare Workers

- What are the reunification goals for this child? Where are we in that process?
- When are the court dates?
- What is the visitation schedule? Is it supervised or unsupervised?
- Are either of the parents involved in their own therapy?
- What are the safety issues that I need to be aware of as I consider involving the parent in therapy?
- Will the child be returning to a living situation with the offending parent?

