

Developing a Trauma-Informed Child Welfare System

The effects of child abuse and neglect are as varied as the children affected. Some children who have experienced trauma are resilient and show few, if any, lasting effects. Others experience intense trauma, which may affect many aspects of their lives and last well into adulthood. It is essential that child welfare professionals are prepared to provide appropriate support to all children and families who experience trauma as a result of child abuse, neglect, or other acts of violence.

This issue brief will discuss the steps that may be necessary to create a child welfare system that is more sensitive and responsive to trauma. Every child welfare system is different, and each State or county child welfare system will need to conduct its own systematic process of assessment and planning, in collaboration with key partners, to determine the best approach. After providing a brief overview of trauma and its effects, this issue brief discusses some of the primary areas of consideration in that process, including workforce development, screening and assessment, data systems, evidence-based and evidence-informed treatments, and funding.

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Acknowledgments

Although partnerships are emphasized throughout the document, we end with a more in-depth discussion of the importance of collaboration in creating a successful, trauma-informed child welfare system.

The field is still in the beginning stages of gathering evidence about what is required to implement a trauma-informed approach to child welfare, and what the outcomes of such an approach may be. For this reason, some of the content for this issue brief has been influenced by interviews with Children’s Bureau grantees and other thought leaders in the field who are among the first to implement and evaluate such an approach. This includes grantees funded through the Integrating Trauma-Informed and Trauma-Focused Practice in Child Protective Service Delivery (HHS-2011-ACF-ACYF-CO-0169; http://www.acf.hhs.gov/hhsgrantsforecast/index.cfm?switch=grant.view&gff_grants_forecastInfoID=29079), Initiative to Improve Access to Needs-Driven, Evidence-Based/Evidence-Informed Mental and Behavioral Health Services in Child Welfare (HHS-2012-ACF-ACYF-CO-0279; http://www.acf.hhs.gov/hhsgrantsforecast/index.cfm?switch=grant.view&gff_grants_forecastInfoID=40944), and Promoting Well-Being and Adoption After Trauma (HHS-2013-ACF-ACYF-CO-0637; http://www.acf.hhs.gov/hhsgrantsforecast/index.cfm?switch=grant.view&gff_grants_forecastInfoID=64839) grants.

Trauma and Its Effects

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (SAMHSA, 2014). If trauma follows a single event that is limited in time (such as a car accident, shooting, or earthquake), it is called *acute trauma*. When children are exposed to multiple traumatic events over time that are severe, pervasive,

and interpersonal in nature (such as repeated abuse and neglect), and they experience long-term consequences from these experiences, this is called *complex trauma* (National Child Traumatic Stress Network, 2014). Complex trauma may interfere with a child’s ability to form secure attachments to caregivers and many other aspects of healthy physical and mental development.

Historical trauma affects populations that have experienced cumulative and collective trauma over multiple generations. Affected groups in the United States include American Indians, African-Americans, immigrant groups, and families experiencing intergenerational poverty. Children within these families may exhibit signs and symptoms of trauma—such as depression, grief, guilt, and anxiety—even if they have not personally experienced traumatic events.

Traumatic experiences overwhelm children’s natural ability to cope. They cause a “fight, flight, or freeze” response that affects children’s bodies and brains. Chronic or repeated trauma may result in toxic stress that interferes with normal child development and cause long-term harm to children’s physical, social, emotional, or spiritual well-being. These adverse effects can include changes in a child’s emotional responses; ability to think, learn, and concentrate; impulse control; self-image; attachments to caregivers; and relationships with others. Across the life span, traumatic experiences have been linked to a wide range of problems, including addiction, depression and anxiety, and risk-taking behavior—these in turn can lead to a greater likelihood of chronic ill health: obesity, diabetes, heart disease, cancer, and even early death. For more information about the long-term effects of child abuse and neglect and other traumatic experiences, see the Adverse Childhood Experiences study (ACE Response, http://www.aceresponse.org/who_we_are/subpage.cfm?ID=43) and Longitudinal Studies of Child Abuse and Neglect (LONGSCAN, <http://www.unc.edu/depts/sph/longscan/>). Child Welfare Information Gateway also produced a factsheet

that explains the long-term physical, psychological, behavioral, and societal consequences of child abuse and neglect. Read *Long-Term Consequences of Child Abuse and Neglect* at <https://www.childwelfare.gov/pubs/factsheets/long-term-consequences>.

Not all children will experience all of these effects. Children's responses to traumatic events are unique and affected by many factors, including their age at the time of the event, the frequency and perceived severity of trauma, and the child's innate sensitivity, as well as protective factors such as the presence of positive relationships with healthy caregivers, physical health, and natural coping skills.

Trauma of all kinds is extremely common among children involved with child welfare. Studies show that as many as 9 out of 10 children in foster care have been exposed to some form of violence (Stein et al., 2001). Entry into the child welfare system causes additional trauma due to separation from family, school, neighborhood, and community, as well as fear and uncertainty about the future. In addition, children who enter the child welfare system are more likely than others to have experienced multiple traumatic events and to exhibit more complex symptoms (Chadwick Trauma-Informed Systems Project, 2013). For example, one study showed that nearly half of youth who were subjects of maltreatment reports had emotional or behavioral problems that were clinically significant (Burns et al., 2004).

Professionals who work within child-serving systems must be aware of a child's trauma history and its effects, or their actions and responses to the child may inadvertently trigger trauma memories, worsen symptoms, or further traumatize the child. When child welfare professionals are mindful of a child's history of trauma, they are better positioned to connect that child to appropriate, trauma-informed, evidence-based services for support. With awareness and knowledge of how to address and treat children's trauma histories, the child welfare system can become a place of healing.

Implementing Trauma-Informed Practice in Child Welfare Systems

The National Child Traumatic Stress Network (NCTSN, n.d.) adopted the following definition of a trauma-informed system:

A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.

In other words, trauma-informed child welfare practice is not a discrete task but rather involves the day-to-day work of the system as a whole. Child welfare systems that are trauma informed are better able to address children's safety, permanency, and well-being needs. Service improvements include more children receiving the trauma screening, assessment, and evidence-based treatment they need. These improvements, in turn, may produce better outcomes, including:

- Fewer children requiring crisis services, such as emergency department visits or residential treatment
- Decreased use of psychotropic medications
- Fewer foster home placements, placement disruptions, and reentries
- Reduced length of stay in foster care
- Improved child functioning and increased well-being (U.S. Department of Health and Human Services, 2013)

Use of Psychotropic Medications

Studies consistently show that children involved with child welfare are prescribed psychotropic medications at higher rates than the general population (Children’s Bureau, 2012).

Effective screening and assessment for trauma can help child welfare systems more effectively identify and treat psychological symptoms and behaviors resulting from trauma. Addressing trauma symptoms with appropriate, evidence-based psychosocial treatment may decrease the need for psychotropic medications.

See the following resources for more information:

- Use of Psychotropic Medications web section (resources for professionals, collected by Child Welfare Information Gateway): <https://www.childwelfare.gov/topics/systemwide/mentalhealth/effectiveness/psychotropic/>
- *Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care* (a guide for professionals to use when working with youth, produced by the Children’s Bureau): <https://www.childwelfare.gov/pubs/makinghealthychoices/>

Key elements of a transition to a trauma-informed child welfare system may include workforce development; routine screening and assessment for trauma history and related symptoms; changes to data systems; implementation of trauma-informed, measurement-driven case planning and referral to evidence-supported treatment; and new approaches to funding for services.

For more information and resources on implementation, see the Trauma-Informed Practice section of the Information Gateway website at <https://www.childwelfare.gov/topics/responding/trauma/>.

Workforce Development Considerations

The workforce is a critical element in the trauma-informed child welfare system. The workforce includes staff at all levels of the agency (receptionists, frontline staff, caseworkers, supervisors, managers, administrators, and other staff), as well as foster and adoptive parents.

Many consider development of a trauma-informed workforce to be a necessary step before other components of a trauma-informed system can be implemented effectively. In order to become more trauma informed, professionals and resource families may need to make significant shifts in thinking and behavior while performing jobs that are stressful already. It will be important to integrate a trauma perspective throughout the system’s day-to-day activities as much as possible so that staff view this as an essential element of their work, rather than as simply another new initiative that may fade quickly.

Shifts in Thinking

Moving from a traditional child welfare approach to one that is more trauma informed requires members of the workforce at all levels to make certain paradigm shifts. These may include the following:

- **A “trauma lens.”** In the past, trauma was thought to result from a single, catastrophic event. We now know that chronic neglect, abuse, or any incident of separation, loss, or grief—even a sudden move or placement change—can be traumatic for children. Developing a trauma lens includes reinterpreting behaviors that were previously seen as being caused by a mental illness or behaviors exhibited by a “bad kid” as the potentially reversible consequences of trauma.

In general, becoming a trauma-informed child welfare system involves a shift from asking, “What’s wrong with you?” to asking, “What happened to you?”

- **Shift in goals.** The focus of child welfare services is often on substantiating a defined occurrence of child maltreatment and ensuring children's physical safety. In a trauma-informed system, the focus broadens to include healing the impact of trauma and improving children's social and emotional well-being, along with the more traditional goals of safety and permanency.
- **Importance of collaboration.** To achieve the goal of enhancing well-being, many child welfare agencies find they must significantly deepen their collaboration with other service systems, including enhancing communication, planning and working toward joint goals, sharing robust data about the families they serve, and strategically blending or braiding funding streams.
- **Focus on early intervention.** A growing body of research demonstrates the long-term effects of trauma on children's physical, social, and emotional well-being. A trauma-informed child welfare system reflects the understanding that by focusing more resources on identification of trauma and early intervention services, we may prevent or mitigate some of those long-term effects.
- **Approach to families.** In making this shift, it is important to be clear with families about the boundary between their involuntary participation in the child welfare system (substantiation of maltreatment) and what may be their voluntary participation in services to promote healing from trauma.
- **Awareness of intergenerational trauma.** It also is important to understand that family members are likely to have experienced their own trauma. Like their children, caregivers' challenging behaviors may be most productively viewed as maladaptive responses to their own trauma.
- **Role of child welfare professionals.** With the shift in attention toward well-being and healing, the child welfare professional's role changes. Staff will spend more time screening for trauma, facilitating effective mental health treatment, and following up to ensure appropriate progress is being made toward those treatment goals, including monitoring the use of psychotropic medication.

- **Awareness of secondary traumatic stress.** Hearing about children's trauma histories may result in secondary traumatic stress among professionals and caregivers. Left untreated, this can decrease effectiveness and lead to excessive burnout or turnover. Being trauma informed requires attention to trauma's effects on all participants in the system, including children, caregivers, and service providers.

Staff Training

Trauma training should be introduced from the beginning of each staff member's employment at the agency. Topics may include:

- Trauma basics: What trauma is, its impact on the brain, and how it affects children (including the role of triggers/reminders)
- How to screen children for trauma
- Children's need for physical and psychological safety
- Resiliency case planning: Looking beyond risk to explore how services can build children's resilience and sense of competency
- When, how, and where to refer children for evidence-based trauma treatment
- How to work with parents who have been traumatized

The **National Child Traumatic Stress Network (NCTSN)** offers the *Child Welfare Trauma Training Toolkit*, which is available at <http://www.nctsnet.org/products/child-welfare-trauma-training-toolkit-2008>.

NCTSN also offers a guide for administrators on using a trauma-informed lens to transform child welfare systems. It is free and can be accessed after creating an account and logging in at <http://www.surveygizmo.com/s3/1769592/Access-to-Creating-TICW-Systems-A-Guide-for-Administrators-CTISP-DI>.

For more training resources, visit the NCTSN website at <http://www.nctsnet.org/resources/training-and-education>.

Effective training for trauma-informed child welfare practice will require more than a single workshop or class session. Staff need to be actively engaged in changes to the system; soliciting their input will be critical to creating buy-in and successful implementation. Adult learners also need to hear messages many times, and in a variety of ways, before they are likely to change their behavior. Training can be conducted separately for child welfare professionals, but it may have more impact if child welfare staff are cross-trained with other professionals in partner agencies and systems. After initial training, follow-up training and technical assistance can be provided in some or all of the following formats:

- Supervision, including case review, fidelity monitoring, and accountability
- Coaching and mentoring
- In-house “trauma consultants” or “trauma champions”
- Learning collaboratives
- Periodic “booster” trainings (face to face or via webinars)
- Newsletter tips and reminders about trauma symptoms, behaviors, and impact

Education and Support for Resource Families

In a trauma-informed child welfare system, information about child traumatic stress is a central part of the initial training required to become a foster or adoptive parent. Current resource parents can be trained separately or engaged in joint trainings with child welfare staff. This training also should be offered to kinship caregivers, as well as to birth parents who are reuniting with their children. It should include the basics of trauma and its impact on children, the significance of trauma triggers, how to recognize and respond appropriately to trauma-related behaviors, how foster and kinship caregivers can work effectively with birth parents, and the importance of self-care.

Education is an ongoing process. After initial training, a trauma-informed perspective can be infused in work with resource parents in additional ways, including the following:

- Regularly include tips or articles about child trauma in resource parent newsletters. (See the Information Gateway factsheet *Parenting a Child Who Has Experienced Trauma*, which can be found at <https://www.childwelfare.gov/pubs/factsheets/child-trauma>.)
- Connect foster parents or kinship caregivers with birth parents soon after placement, and collect information from birth parents to share with caregivers regarding the child’s trauma history, triggers, and behaviors.
- Conduct child-focused team meetings that engage birth parents and kinship caregivers or foster parents in collective planning and problem solving. Include a trauma consultant on these teams to provide early intervention to children who display troubling behavioral symptoms in placement.
- Implement placement disruption prevention meetings when needed.¹

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents, by the National Child Traumatic Stress Network, is a training resource that may be useful when working with resource parents, see <http://www.nctsn.org/products/caring-for-children-who-have-experienced-trauma>.

Secondary Traumatic Stress

Working with children and families who have experienced trauma is undeniably difficult. As professionals screen and assess children and families for trauma, and resource parents receive more information about children’s histories, they may be vulnerable to secondary traumatic stress (STS)—traumatic stress as a result of exposure to others’ experiences. (Secondary traumatic stress is sometimes referred to as *vicarious trauma* or *compassion fatigue*.) Left untreated, STS can lead to decreased effectiveness and morale and high rates of burnout and turnover.

¹ Some of the training suggestions for professionals and resource families are derived from the National Child Traumatic Stress Network (2013).

A trauma-informed child welfare agency recognizes the need to invest in the health, well-being, and resilience of its workforce. Some suggestions for helping to prevent and address STS (and attend to primary stress experienced on the job) include the following:

- Begin trauma trainings with a discussion of STS. This can help professionals make a personal connection to the topic and build buy-in for the training, while validating staff experience.
- Create peer-to-peer support groups to give staff and resource families opportunities to learn about STS, share their experiences, and discuss coping strategies.
- Build “resident expert teams” of 6 to 10 staff members charged with identifying and assessing STS and its effects and helping to build a system to better support affected staff.
- Offer health and wellness activities (e.g., mindfulness, yoga, dance, art) in the office and at foster parent trainings or gatherings to encourage resilience.
- Integrate resilience skill-building into training, staff meetings, and supervision.
- Offer Psychological First Aid to staff and resource families who work with a child or family involved in a tragic accident, incident of violence, or death.²
- Take time during supervision and/or case staffing to address how cases are impacting the child welfare professional personally and what support is needed from peers.

Find more information about STS on the Child Welfare Information Gateway website at <https://www.childwelfare.gov/topics/responding/trauma/secondary/>.

Screening and Assessment

A trauma-informed child welfare system relies heavily on initial and ongoing screening and assessment to identify children’s trauma-related needs and assess their progress (U.S. Department of Health and Human Services, 2013).

² Psychological First Aid is an evidence-informed approach for assisting children, adolescents, adults, and families in the aftermath of disasters, see <http://www.nctsn.org/content/psychological-first-aid>.

The goals of trauma screening and assessment include the following:

- **Trauma screening** to learn about a child’s trauma history, to identify current symptoms and functional delays, and to identify children who need further assessment and possible treatment. Screening should be brief and should be administered to all children entering child welfare, as part of or in addition to regular, comprehensive screenings already conducted by child welfare professionals, such as safety and risk assessment, family assessment, placement tools, and collection of prenatal and parents’ medical history. Screening should be repeated periodically thereafter, including after stressful events, such as a change in placement.
- **Mental health assessment** for children whose screen indicates a trauma history combined with psychological symptoms and/or functional delays. A positive screen warrants referral to a specialist. This more in-depth clinical evaluation by a mental health professional may include a diagnostic interview in addition to standardized mental and behavioral health assessment tools. The mental health assessment forms the basis for treatment planning.
- **Functional assessment** or periodic and holistic evaluation of a child’s social and emotional functioning. In the case of functional assessment, measurement tools are used not to reach a diagnosis but to gather data about individual children’s strengths and needs, measure improvement in skills and competencies, and inform ongoing case planning. Many evidence-based treatment models incorporate this within service delivery.
- **Outcome measurement.** At a child level, outcomes are measured to ensure that services are achieving desired effects and to inform changes to the treatment plan. At the system level, this process can help identify changes needed to improve the effectiveness of the service array as a whole.

These goals are not mutually exclusive—a single instrument, in the right context, may be used for multiple purposes. For example, functional assessment measures may be administered as part of the mental health assessment and may also serve the role of outcome measurement. (For a more detailed discussion, see Conradi, Landsverk, & Wotring, 2014.)

Selecting Screening and Assessment Measures

The following are some considerations that child welfare agencies and their partners might weigh when selecting trauma screening and assessment instruments:

Length. Keeping an initial screening as brief as possible is critical, in light of other activities that must be completed by child welfare professionals upon children’s entry to the system. Children whose initial trauma screens are positive should receive a more thorough follow-up assessment by a clinical mental health provider.

Content. Most screening tools seek to assist busy child welfare professionals in quickly identifying trauma exposure and/or symptoms. There tend to be different screening tools for older and younger children, and some tools employ language and cultural adaptations for different populations. A follow-up assessment should more fully explore the child’s trauma history and current symptoms. Symptoms may include internalizing and externalizing behaviors, as well as moods, cognitive issues, school difficulties, trauma triggers, and relational skills, among others.

Connections Between Trauma Exposure and Symptoms. Some tools have the potential to help professionals see important connections between a child’s exposure to traumatic events and his or her present functional difficulties. An instrument that makes these connections explicit may help prevent staff from misinterpreting behavior and may facilitate more appropriate referrals.

Cost. Costs to consider include the initial purchase of the instrument, training required to implement it, and expenses for data collection and/or analysis.

Ease of Administration and Data Sharing. Agencies and partners may need to ask the following questions: Is it a paper/pencil screening, or can it be administered via computer, with results linked automatically into the existing data system? Is the instrument self-scoring? Where will the necessary information come from (the parent/caregiver, the child, other sources such as case records and third-party reports)?

Psychometric Properties. How accurately does the tool measure what it purports to measure? How many false positives and/or negatives will it produce (e.g., sensitivity and specificity)?

For more potential screening and assessment tools, visit the following websites:

- National Child Traumatic Stress Network Measures Review Database: <http://www.nctsn.org/resources/online-research/measures-review>
- SAMHSA, Screening Tools for Trauma: <http://www.integration.samhsa.gov/clinical-practice/screening-tools#TRAUMA>

Data System Needs

Selecting appropriate screening and assessment tools is important, but it is equally important to consider how the data will be used—individually, on a systems level, and across systems. Currently, the research base does not exist to say what approaches to data collection and sharing are most effective. The field is just beginning to explore what data a trauma-informed child welfare agency needs to collect and how those data should be used.

The following are some questions for child welfare agencies to consider as they assess their own data systems' strengths, needs, and gaps, and develop processes for filling those gaps:

- **On a child level,** how might critical data (for example, screening and assessment results) be captured as a child moves throughout the system? Could these data be used to prompt a caseworker to follow up with further assessments or treatment, or could the data system help track an individual child's progress and drive case planning by comparing results over time?
- **On a systems level,** how can aggregated data be used to understand what is happening to children in the child welfare system? For example, what types of children are improving, based on functional assessment scores? What services are they using? Which children are not improving or are getting worse?
- **Across systems,** how could data be made accessible to all service providers who are involved with a child, including those working in systems such as mental health and Medicaid, while taking into consideration confidentiality concerns and privacy guidelines where applicable? Likewise, could the results of assessments completed by mental health professionals and Medicaid claims data (for example, data related to prescription and dosage of psychotropic medications) be accessible within the child welfare data system to inform case planning?

Evidence-Supported Practices for Trauma Treatment

To recover from trauma, children and families often require treatment delivered by skilled child welfare staff and mental health therapists. Children are well served when interventions are effective and appropriate for their needs, gaps and duplication are eliminated from the service array, and funders work together to coordinate services and reimburse providers for treatment.

Selecting Evidence-Based/Evidence-Informed Interventions

To ensure an appropriate array of evidence-based and evidence-informed services for children who have experienced trauma, child welfare systems must first assess the needs of their population and the services that currently exist within their communities.

Children and youth should be reevaluated periodically to identify any new symptoms that have emerged and to assess treatment progress. Data about children's improvement (or lack thereof) over time, gathered from functional assessments and outcomes measurement, can be used to continuously monitor individual children's progress and guide case planning.

Eventually, this data also may be aggregated to help agencies assess the appropriateness of the service array for all children and for particular subgroups. Using that information, the service array can be further reconfigured to best meet the measured needs of children, as part of the agency's continuous quality improvement (CQI) process. (For more information about CQI in child welfare, see the Children's Bureau Information Memorandum on Establishing and Maintaining Continuous Quality Improvement Systems in State Child Welfare Agencies, <http://www.acf.hhs.gov/sites/default/files/cb/im1207.pdf>, and the Information Gateway web section on Approaches to Quality Improvement at <https://www.childwelfare.gov/topics/management/practice-improvement/quality/approaches/>.)

Following are some evidence-based and evidence-informed programs that are being used to help children, youth, and families who have experienced trauma. The research base for these treatments varies; the inclusion of a program in this issue brief should not be viewed as an endorsement by the Children's Bureau.

For more information about evidence-based treatments, visit the following websites:

- California Evidence-Based Clearinghouse for Child Welfare, Trauma Treatment (Child & Adolescent): <http://www.cebc4cw.org/topic/trauma-treatment-for-children/>
- National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices: <http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices>
- SAMHSA's National Registry of Evidence-based Programs and Practices: <http://www.nrepp.samhsa.gov/>

Evidence-based treatments are those that are supported by scientific research as being effective in improving outcomes for children and families. They have strong research design, evidence of significant positive effects, sustained effects, and capacity for replication.

A strong evidence base supports the following practices, according to the California Evidence-Based Clearinghouse:

- **Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)** is one highly popular and well-researched intervention shown to help children and adolescents who have experienced trauma. It is designed to reduce negative emotional and behavioral responses by addressing distorted beliefs and attributions related to the trauma. For more information about TF-CBT, visit <http://tfcbt.musc.edu/> or read Information Gateway's *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma* at <https://www.childwelfare.gov/pubs/trauma/>.

- **Parent-Child Interaction Therapy (PCIT)** is a family-centered treatment approach proven effective for abused and at-risk children ages 2 to 8 and their caregivers. During PCIT, therapists coach parents while they interact with their children. For more information, visit <http://www.pcit.org/> or read Information Gateway's *Parent-Child Interaction Therapy With At-Risk Families* at https://www.childwelfare.gov/pubPDFs/f_interactbulletin.pdf.
- **Eye Movement Desensitization and Reprocessing (EMDR)** has been validated as an effective treatment for trauma victims. It integrates a number of different therapeutic approaches, including cognitive-behavioral therapy and the use of eye movements to decrease emotional distress related to traumatic memories. For more information about EMDR, visit <http://www.emdr.com/>.

Evidence-informed practices make use of the best available research and practice knowledge to guide program design and implementation within the context of the child, family, and community characteristics, culture, and preferences.

The following are some of the available trauma-focused treatment models supported by research or practice knowledge:

- **Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT):** <http://www.afcbt.org/>
- **Attachment and Biobehavioral Catch-up (ABC):** http://www.infantcaregiverproject.com/#!/about_us/cjg9
- **Attachment, Self-Regulation, and Competency (ARC):** <http://www.traumacenter.org/research/ascot.php>
- **Child and Family Traumatic Stress Intervention (CFTSI):** <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=305>
- **Child-Parent Psychotherapy (CPP):** <http://preview.childtrauma.ucsf.edu/resources-0>
- **Cognitive-Behavioral Therapy for Posttraumatic Stress Disorder (CBT for PTSD):** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3083990/>

- **Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems (MATCH-ADTC):** http://www.practicewise.com/portals/0/MATCH_public/index.html
 - **Prolonged Exposure Therapy for Adolescents:** <http://www.med.upenn.edu/ctsa/certification.html>
 - **Real Life Heroes:** <http://reallifeheroes.net/>
 - **The Sanctuary Model:** <http://sanctuaryweb.com/sanctuary-trauma.php>
 - **Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS):** <http://sparcstraining.com/>
 - **Trauma Affect Regulation: Guide for Education and Therapy (TARGET):** <http://www.advancedtrauma.com/Services.html>
 - **Trauma Systems Therapy (TST):** <http://www.aboutourkids.org/traumasystemstherapy/>
- What kind of **implementation support** is offered for the treatment model (including fidelity management)? Are there ongoing trainings and support, or is training delivered in a single session?
 - Can the model be delivered in an **outpatient setting**?
 - Does it include a **caregiver component**?
 - Who administers the therapy? What level of **education and training** is required?
 - How much will it **cost** to implement and sustain the practice?
 - Who **owns and supports** the treatment model?
 - How **readily available** is the model, and how accessible is training and support?
 - Is the model a **good fit with agency and partner needs, values, workforce capacity, and other resources**?
 - Can the model be **adapted** as needed while maintaining adequate **fidelity**?

Selecting Interventions

Before meaningful changes to the service array can be made, there must be buy-in at all levels of the child-serving system, as well as collaboration across systems, including Medicaid, mental health, juvenile justice, education, and health care. Administrators and decision-makers must fully understand the effects of trauma and embrace the need to develop and fund evidence-based treatments.

The following are some questions for agencies to consider to help assess the fit of a particular therapeutic model for a community's needs:

- What **level of evidence** is available to support claims of effectiveness?
- Is the practice effective with a **broad spectrum of children and families** (including various ages and cultural settings)?
- Has the practice been proven effective specifically with **children and families who have experienced trauma**?
- Is the practice a **good fit for the needs of the target population**?

Funding

The field has yet to reach consensus on whether developing a trauma-informed child welfare system will require additional funding and what a successful approach to funding this work will entail. (While it seems clear that implementing evidence-based practices will require significant investments to train staff and maintain fidelity, these costs may be offset by savings in other areas within a fully trauma-informed system.) Because every child welfare jurisdiction is different, States and counties will lead the way in developing what works best for them.

Agencies may wish to begin by exploring opportunities to leverage current, existing funding streams to support trauma-informed training, screening and assessment, interventions, and data systems. This will likely include working closely with systemic partners—for example, working with the State Medicaid system and managed care organizations to fund evidence-based, trauma-informed treatments for children. However, the available resources and policies guiding the use of these funding streams will vary by State.

The Information Gateway Funding for Program Areas web section lists resources for specific types of programs, including mental health. It can be found at <https://www.childwelfare.gov/topics/management/funding/program-areas/>.

For information and resources about Medicaid funding, see the web section on using Medicaid to fund prevention services at <https://www.childwelfare.gov/topics/management/funding/program-areas/prevention/federal/nondedicated/medicaid/>.

Agencies may also want to review the guidance provided in the following joint Center for Medicaid and CHIP Services (CMCS) and SAMHSA Informational Bulletin on coverage of behavioral health services for children, youth, and young adults with significant mental health conditions (a category that is likely to include many children who have experienced trauma) at <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf>.

Cross-System Collaboration

To serve traumatized children and families effectively, the entire child-serving system—at the agency, local, and State levels—needs to understand trauma and create policies and practices that support more effective treatment. In a trauma-informed system, child welfare, mental health, Medicaid, juvenile justice, the courts, health care providers, and schools work together with a common purpose of helping children and families heal.

Collaboration is not without challenges. Some of the difficulties experienced by Children’s Bureau grantees interviewed for this brief include the following:

- Different understandings of what trauma is and how it affects children and families
- Conflicting goals or priorities
- Funding constraints
- Policies and practices that limit the time available to help children and families heal from trauma

- Lack of a universal consent form or other confidentiality concerns

Despite these challenges, some strategies have shown promise in building collaboration across child-serving systems. Building relationships across systems as a matter of course and maintaining these relationships through regular contact have been found to be more effective than waiting for a crisis to force systems to work together. Some strategies for initiating stronger cross-disciplinary relationships include the following:

- **Cross-disciplinary trauma training.** When professionals from various child-serving disciplines attend trauma training together, they develop a shared vocabulary, commitment, and understanding of trauma and have the opportunity to develop norms, values, and procedures for how teams will work together to support children and families.
- **Collaborative system mapping.** In this process, representatives from multiple disciplines work together to create a flow chart for how children and families move through each system. This can help staff and administrators alike learn more about how other systems work. Identifying points of intersection between systems can lead to deeper discussions about infrastructure, case/treatment plans, referrals, data sharing, and communication (e.g., when there is court involvement or a threat of disruption).
- **Shared STS trainings.** All child-serving professionals have stressful jobs and experience the difficulties of working with children and families who have trauma histories. Sharing experiences of secondary trauma may build understanding across disciplines and “break the ice” for systems to work toward partnership in other areas, as well.
- **Case conferencing.** Talking about specific children and families can be another way to build investment and relationships across systems. Working together to solve problems and promote healing for a specific child, about whom all participants share concern, fosters communication and relationships that may carry over into work on other cases in the future.

- **Funding.** Funding can be used in various ways to encourage and support cross-system collaboration to better serve children’s trauma needs. This is happening at a Federal level among the Administration for Children and Families, Centers for Medicaid and Medicare Services, and SAMHSA (for more information, visit <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>). At a local level, this might include strategies such as providing incentive payments to encourage mental health clinics to provide evidence-based trauma treatment services to children in the child welfare system, or funding a cross-disciplinary trauma learning collaborative.

Although collaboration can be challenging, the benefits to children and families are great as communities move from a fragmented approach to a cross-system approach that treats each child as a whole person.

Conclusion

Increased attention to childhood trauma within child welfare agencies across the country reflects a growing understanding of the significant impact that trauma can have on children’s well-being and the community as a whole. Left untreated, trauma may have serious, complex consequences for children throughout their lifespan. Addressing trauma effectively is more than an isolated practice; it requires a coordinated, system-wide approach. Working together, staff at all levels of the child welfare system and related agencies—as well as resource families—can implement the screening, assessment, and treatment practices needed to better help the children and families in their care heal from trauma.

For more information and resources, see the Treatment and Trauma-Informed Care section of the Child Welfare Information Gateway website at <https://www.childwelfare.gov/topics/responding/trauma/>.

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