eReview

Center for Excellence in
CHILDREN'S MENTAL HEALTH

The *eReview* summarizes children's mental health research and implications for practice and policy

Child Welfare Series • March 2011

Creating Trauma-Informed Systems of Child Welfare

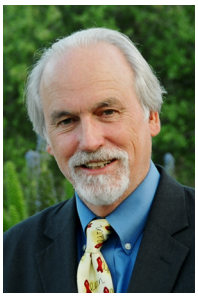
This is the third issue in a series focusing on trauma and child welfare. This issue addresses systems-level changes that can help improve communication and service delivery and ultimately reduce trauma for children. The pool of literature pertaining to trauma-related systems change is limited. However, the National Child Traumatic Stress Network (NCTSN) has identified several Essential Elements of Trauma-Informed Child Welfare Practice (http://www.nctsnet.org/nctsn_assets/pdfs/CWT3_SHO_EEs.pdf). They are —

- *Maximize the child's sense of safety*
- *Assist children in reducing overwhelming emotion*
- *Help children make new meaning of their trauma history and current experiences*
- *Address the impact of trauma and subsequent changes in the child's behavior, development, and relationships*
- *Coordinate services with other agencies*
- *Utilize comprehensive assessment of the child's trauma experiences and their impact on the child's development and behavior to guide services*
- *Support and promote positive and stable relationships in the life of the child*
- *Provide support and guidance to the child's family and caregivers*
- *Manage professional and personal stress*

To better understand how child welfare systems are incorporating these elements into their work, representatives from three different geographical areas were interviewed for this issue. Respondents represent different areas of expertise and utilize different lenses from which they view the child welfare system. Respondents were chosen because of their perspectives about what trauma-informed child welfare looks like as well as their knowledge of specific practices related to assessment, reducing traumatic symptoms, coordination of services, and public policy. This issue illustrates how child welfare systems are changing to better meet the trauma needs of children, with specific attention to policies and practices in Minnesota.

Charles Wilson, MSSW, is Executive Director of the Chadwick Center for Children and Families. Lisa Conradi, PsyD is Clinical Psychologist at the Chadwick Center and Project Manager of the NCTSN SAMHSA Grant at the Chadwick Center for Children and Families. Erika Tullberg, MPH, served as the Executive Director of Clinical Systems and Support in New York City, and is currently Administrative Director of the Administration for Children's Services New York University Children's Trauma Institute. Erika and Charles also serve as Co-Chairs of the National Child Traumatic Stress Network (NCTSN) Child Welfare Committee. Erin Sullivan-Sutton, JD, is the Assistant Commissioner of Children and Family Services at the Minnesota Department of Human Services. Christeen Borsheim, MPA, is the Director of the Child Safety and Permanency Division at the Minnesota Department of Human Services.

University of Minnesota | Extension
Driven to Discover℠



Charles Wilson, MSSW

Executive Director, Chadwick Center for Children and Families

Lisa Conradi, PsyD

Clinical Psychologist, Chadwick Center for Children and Families
Project Manager, NCTSN SAMHSA Grant at the Chadwick Center for Children and Families

How can trauma-related information be gathered when a child enters the child welfare system?

Many child welfare systems have incorporated practices that address trauma, perhaps particularly related to screening and assessment. A challenge of developing new practices for use in child welfare systems is that jurisdictions are like apples and oranges – the same practice may not fit all settings. One way the National Child Traumatic Stress Network (NCTSN) has addressed this diversity is by utilizing the Breakthrough Series Collaborative (BSC) Model to improve the way child welfare systems identify, engage, and deliver services to children and families experiencing trauma. The Breakthrough Series concept was created by the Institute for Healthcare Improvement (IHI). The model brings together subject matter experts with application experts to help organizations select, test, and implement changes in direct service delivery [see box titled Breakthrough Series Collaborative (BSC) Model].

NCTSN uses the BSC model to engage teams of professionals across the United States in a 9-18 month process in which they engage in learning sessions and action periods designed to promote adoption of trauma-focused treatment practices in diverse settings. Currently NCTSN supports nine teams representing nine child welfare jurisdictions partnered with mental health providers. The focus of this Breakthrough Series Collaborative project is specific to trauma-related practice and placement stability. Each team has struggled with issues related to who conducts the screening, content of the screening, and how screening relates to mental health and assessment. Initial recommendations from these teams are leading toward teams creating a new trauma-related screening tool, not simply adding questions to a current tool. The tool would integrate the child's experiences, the impact of these experiences, behavioral responses to the trauma (avoidance, problems in school), and so on. It is important to assess whether a child entering a child welfare system is currently impacted by traumatic events they have experienced, recently or in the past. Those who are can be referred for a much more thorough assessment by a mental heath professional with trauma-related expertise. Some children may be asymptomatic upon entry, so a follow up screening is recommended. This may occur anywhere from 3-6 months later, or when a child changes placement. The tool would guide the worker to gather information from case reports, birth parents and family members, and other sources in order to gain as complete a picture as possible. It is not recommended to dive too deeply into the trauma-related information at this point. While it's important to understand the array of a child's traumatic experiences and their current functioning, we recommend that the bulk of this information is gathered using resources already available to the worker (reports, case notes, etc), rather than questioning the child directly.

eReview Resources

Breakthrough Series Collaborative (BSC) Model

The Institute for Healthcare Improvement developed the Breakthrough Series to help health care organizations make "breakthrough" improvements in quality while reducing costs (Institute for Healthcare Improvement, 2003).

A Breakthrough Series Collaborative is a short-term (6- to 15-month) learning system that brings together a large number of teams from hospitals or clinics to seek improvement in a focused topic area.

For more information, visit: http://www.ihi.org/IHI/Results/WhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchieving+BreakthroughImprovement.htm

How do you suggest screening for trauma-related symptoms after a child enters a child welfare system?

Trauma screening tools are designed not to assess the complete emotional state of the child, but to determine if the child needs a professional, clinical trauma-focused assessment and intervention. Most child welfare systems don't conduct specific trauma screenings – we are still in the process of developing this practice throughout the country. We use an assessment tool we developed within the Chadwick Center in partnership with NCTSN. There are a number of other tools as well, including the UCLA PTSD index [see more information at: http://kb.nctsn.org/SPT/SPT--FullRecord.php?ResourceId=1036]and the Traumatic Events Screening Inventory [see more information at: http://www.ptsd.va.gov/professional/pages/assessments/tesi.asp]. All of these are similar in that they ask questions about the child's experiences and the impact of those experiences. There is varied evidence for trauma-related assessment tools – most are in the early stages of research.

It is critical to not only have the appropriate tool but also the proper training for the child welfare worker administering it. Many child welfare workers could administer a screening tool, but specialized training is needed to make the most of this process. The worker should inform the assessment with information gathered from other sources, ask questions to the child sensitively and effectively, and respond to the child's needs as trauma-related experiences are discussed. The child welfare worker typically knows what brought the child into the system, but is not familiar with the child's traumatic history or what he or she thinks is the most troubling traumatic event. The worker should be prepared to respond to the child's needs as a result of the assessment, or else gather information from sources other than the child. Not every child who has experienced trauma needs a trauma-focused treatment. On the other hand, there are some traumatic experiences that indicate the need for an immediate referral. Child welfare workers have a range of experience and training, which can make it difficult to design new screening tools that can be administered by all. Generally, we are in the early stages of creating, researching and effectively administering trauma-related assessment tools in child welfare. This is a critical area of work that needs attention.

How might child welfare professionals work to reduce the overwhelming emotions that are often associated with trauma?

The child welfare worker can make an accurate assessment of whether or not a child needs a mental health referral. The worker can also help the foster parent, perhaps in concert with a mental health provider, to assist the child in regulating emotions. We want foster and birth parents to be able to manage a child's trauma-related behavior where it is occurring (at home, in school, etc.). A number of things in these environments can serve as triggers to trauma. Providing psychoeducation and skill-building to parents will help them manage day-to-day experiences with the child.

Case workers can also use a trauma lens in their interactions with the child. At all times, they can ask the question "Am I making this child feel safe?" The child who feels safe can better manage his or her emotions. In theory as well as practice, staff members are trained to view the child welfare population through a variety of lenses (for example, a child development lens or a cultural lens) – we recommend using a trauma lens as well. Many are doing this work already. There is a distinction between "big Traumas" with a capitol "T" and "little traumas" with a small "t". Big Traumas threaten your life or your relationship with your caregiver, and produce biological shifts such as a change in cortisol level. Children in child welfare systems can experience situations that create anxiety and trigger big Traumas. The worker who uses a trauma lens can interact with the child in a way that avoids intensifying the trauma and instead promotes healing. An example is in the way children are removed from the home. Often this process can ignore the psychological safety of the child, who may think he's being sent to Mars. If the worker uses a trauma lens, he or she will consider asking the child what attachment items they want to bring with them, what clothes they want to wear to school tomorrow, etc.

Asking a birth parent to write to a foster parent about what the child likes and dislikes can better equip the foster parent and increase the likelihood that the child will do well in placement. Often birth parents are also trauma victims – asking for their input shows that their perspective is valued and empowers them to continue parenting as they are able.

The NCTSN has developed a worksheet for foster parents designed to provide a structure in which the birth parent can share information about his/her child with the foster parent. This will help the child feel more comfortable and increase his/her psychological safety. See "My Child Worksheet" at: http://www.nctsnet.org/nctsn_assets/pdfs/rpc/RPC_PH_MyChildWksht.pdf.

How can child welfare professionals respond to the underlying causes of trauma as well as related behaviors that are adaptive during trauma but maladaptive at other times?

One helpful way to view challenging behaviors is to ask not "why are you doing this?" but "what has happened to you?". This new frame shifts the child welfare professional's perspective about the child. Paying attention to potential triggers also helps us to understand these behaviors in the moment. For example, in one environment a child who has experienced a great deal of fighting at the dinner table may be allowed to eat alone as a safety mechanism. In a new foster home, the child may express a preference to eat alone and learn that this is not allowed. The child's safety plan is not working in the new environment, and this could trigger a trauma response. A trauma-informed foster parent recognizes that the child is not stubborn but using a safety tactic, and can work with the child so that the dinner table is not perceived as a safety threat.

How can child welfare systems work to minimize disruptions in relationships and/or placements in order to prevent further trauma?

Child welfare professionals have known for decades that moving children around is bad for them – it's also hard for case workers. The National Survey on Adolescent and Child Well-Being, a national study of children who are at risk of abuse or neglect or are in the child welfare system [see http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw], indicates that the number of placement moves is disturbing. In fact, most children don't move a lot but a small percentage of children move very often. We should ask the questions: How can we reduce entry into the child welfare system? Who are the children who are frequently moved? Why are they moving? Many placement changes are system-related in order to move siblings closer together, a child closer to school or birth parents, or other planned changes. It's important to consider when a move is helpful to a child. For example, a child may benefit from a placement move if she has just been placed and has the option of moving to a home with a sibling. She may not benefit if she has a long-term placement and doesn't know her sibling.

Using a trauma perspective to reduce the number of moves a child experiences is the essence of the Breakthrough Series Collaborative (BSC) Model mentioned earlier. Findings associated with this work suggest that child welfare teams were able to reduce the number of moves for children in the system by utilizing this model of organizational change [see www.nctsnet.org/nccts/asset.do?id=715]. Practice recommendations from the NCTSN that are consistent with this model include —

- Conducting a good trauma screening when the child enters care;
- Maintaining a strong connection between child welfare and mental health services/trauma-focused treatment;
- Training child welfare workers to understand trauma and operate through a trauma lens in the best way they can;
- Training resource parents – foster, kinship, etc. on how to understand trauma and manage overwhelming emotions;
- Connecting foster and birth parents through letters, worksheets, and team meetings;
- Connecting children with all service delivery systems and ensuring that these systems also utilize a trauma lens.

In considering trauma-informed systems of care, are there specific recommendations you have for children of color?

Children of color are dramatically overrepresented in child welfare systems. One consideration for the child welfare worker is to focus not only on the child's individual trauma but also the historical trauma experienced by the child and family – this is a big issue. When an American Indian family interacts with a government dominated by Whites, they aren't likely to think the government will be helpful to them. Historically, removal from the home means something different to an American Indian or African American family. We need training and development in this area.

In what ways should trauma-related evidence-based practices be incorporated into mental health intervention work?

Trauma-focused Cognitive Behavioral Therapy (TF-CBT) is a commonly-used therapeutic treatment we recommend. There are a number of other useful tools as well. The National Child Traumatic Stress Network (NCTSN) maintains a Measures Review Database, which provides easy access to comprehensive clinical and research information so that a user can determine whether a measure is appropriate for a specific individual or group. Users can search the database at: http://www.nctsnet.org/resources/online-research/measures-review.

In what ways can family members (biological and foster parents) be supported to manage the child's trauma-related behaviors?

We are seeing greater focus on supporting birth parents, particularly in cases where reunification is a possibility. We can refer parents to their own trauma therapy in preparation for reunification. Doing trauma work with both birth parent and child is likely to improve visitations and relationships with foster parents, as well as promote safety for the child. Consider a child who has experienced sexual abuse and is reunified with his birth mom, who has also experienced significant trauma but never received services. Without treatment, the birth mom may not be aware of appropriate boundaries and may continue to put her child at risk until she receives support and education about the trauma.

The child protection worker who perceives the job as limited to ensuring a child's physical safety will view their role differently than the individual who sees a bigger picture including psychological safety, permanency and adoption, and well-being of the family. The child lives within a family system, but our child welfare systems are not set up to serve the family. If they were, then the point of intervention would be the parent and the perspective could be "the more you help the parent, the more you help the child". We could move toward a family protection system, and approach child protection from a preventive perspective. Even if people in leadership positions agree with this approach, we need political will to make it happen. The good news is that trauma-informed and evidence-based practices have support across the political spectrum, and from those interested in the cost effectiveness of intervention as well as those interested in the child's future.

eReview Resources

National Child Traumatic Stress Network Resources

The **Child Welfare Trauma Training Toolkit** teaches basic knowledge, skills, and values about working with children who are in the child welfare system and who have experienced traumatic stress (http://nctsnet.org/products/child-welfare-trauma-training-toolkit-2008).

Helping Children in the Child Welfare System Heal from Trauma: A Systems Integration Approach reports on the results of a survey of representatives from child welfare agencies, family and dependency courts, foster care systems, schools, and mental health agencies to assess (1) the ways the agencies gather, assess, and share trauma-related information and (2) the basic training about child trauma their staffs receive (http://nctsnet.org/sites/default/files/assets/pdfs/A_Systems_Integration_Approach.pdf).

The **Child Welfare Trauma Referral Tool** helps child welfare workers make more trauma-informed decisions about the need for referral to trauma-specific and general mental health services (http://nctsnet.org/sites/default/files/assets/pdfs/cwt3_sho_referral.pdf).

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents (2010) is a PowerPoint-based training curriculum designed to be taught by a mental health professional and foster parent as cofacilitators (http://nctsnet.org/products/caring-for-children-who-have-experienced-trauma).

Child Traumatic Stress: What Every Policymaker Should Know educates policymakers about the scope and impact of childhood trauma and offers effective solutions that can be implemented with the support of informed public policy (http://nctsnet.org/sites/default/files/assets/pdfs/PolicyGuide_CTS2008.pdf).

Erika Tullberg, MPA, MPH
Former [at time of interview]: Executive Director, Clinical Systems and Support NYC Administration for Children's Services
Current: Administrative Director, ACS-NYU Children's Trauma Institute

How is trauma-related information gathered from referral agencies and others when a child is referred to your system?

New York City's child welfare agency, the Administration for Children's Services (ACS), employs approximately 3000 child protective staff members. Most services offered to families subsequent to a child protective investigation are provided by outside agencies with whom ACS contracts. These include about 30 agencies that provide family, therapeutic and residential foster care and about 80 preventive agencies. Child welfare staff work closely with a variety of professionals from these agencies. There are many ways child protective staff members gather trauma-related information about a child entering care. Sometimes a report to child protection originates from a staff member at a preventive agency or another social services provider, like a school or doctor. In this case, the child protection specialist gathers as much information as possible from that person.

If, during the course of an investigation, we think that the risk is high enough to consider removal, whenever possible we utilize a family team conference model prior to the removal, which means that a trained facilitator brings together an interdisciplinary group of professionals to jointly discuss and make decisions with the family on behalf of the child [see Annie E. Casey decision-making model at: http://www.aecf.org/MajorInitiatives/Family%20to%20Family/Resources/TeamDecisionmaking.aspx]. This team includes a child protection specialist, parents, sometimes a parent advocate, and other providers currently working with the family, including mental health providers, if available and appropriate. Children may be included as well, and are considered on a case-by-case basis depending on the maturity of the child and the information being discussed at the conference. The focus of this early meeting is child safety and the goal is to determine whether the child can remain at home. Part of the discussion includes gathering of historical information, including trauma. This discussion provides an early opportunity for all participants to develop a more thorough understanding of the child's trauma experiences.

Parents may not feel comfortable disclosing all that is happening with the child at this initial meeting, so there are other ways information about the child's trauma history is obtained. If a child comes into foster care and kinship care or another placement is not immediately available, then he or she comes to the Children's Center, where the child stays for a short time (typically overnight) until a placement is identified. When a child comes into care at the Children's Center, he or she is interviewed by a master's-level staff member about experiences, needs, etc. Although trauma experiences are likely underreported at this early time, when the child is new to the system and the staff member is not familiar with the child, this is an important step in building a more complete picture of the child's experiences. Children's Center staff are utilizing a version of the Child and Adolescent Needs & Strengths (CANS) tool, an information integration tool that includes questions about trauma. The CANS is administered by the master's-level staff at the Children's Center, and the results – which are sent to the receiving foster care agency – help to inform recommendations around foster care placement and other supports the child might need. Other child welfare systems are using versions of the CANS instrument with more trauma content. For more information about the CANS instrument, see the National Child Traumatic Stress Network website at: http://www.nctsnet.org/nctsn_assets/pdfs/measure/CANS-MH.pdf.

There are two additional points early in placement when trauma information could be shared. ACS has introduced a "transition meeting" that is held within 72 hours of when a child is placed in foster care. At this meeting child protection staff, foster agency staff and parents discuss the reason for foster care and the immediate plan for care. During the same timeframe, there is also a "parent to parent" meeting between the birth parent and foster parent to discuss details about the child's care. While this second meeting is more informal, it can provide the foster parent with helpful information about the child's background and needs.

Upon entry, how do you assess for trauma-related symptoms?

There has been a general increase in recognition about trauma within New York City's child welfare system during the last several years. Staff members are more aware of trauma's impact on kids and their subsequent movement through the child welfare service system. Following September 11th, 2001, many people in the city developed a broader understanding and recognition of trauma and its effects. The City of New York received a large FEMA grant for crisis counseling services and a portion of this funding focused specifically on children, families and staff in the child welfare system. Ultimately the experiences of people in the city and the work following September 11th resulted in a greater understanding of trauma among families within the child welfare system, as well as the secondary trauma often faced by staff members. The grant also supported more extensive trauma-focused training for child welfare staff.

ACS's standards require that the foster care agency complete a mental health screening (as well as other screenings) of the child within 30 days of placement. The agency is not required to use a specific tool, but the tool must be validated and under ACS's updated standards will have to include trauma content. If the screening is "positive" for trauma or other mental health issues, then a more thorough assessment is required that addresses both the cause for referral and the child's history.

It is important to note that many trauma tools are not geared toward a child welfare population – they address a single traumatic event such as a car crash, which is not as applicable to children experiencing neglect, recurrent sexual abuse, and other chronic, traumatic conditions. In addition, early assessment may not capture all of a child's traumatic history. The presence of sexual abuse-related trauma, for example, is rarely the reason for foster care placement, but it is very common among this population and is typically revealed only after some time in placement. Given this, it's important that trauma assessment continue after a child is placed.

How might child welfare workers and others within the system help to reduce the overwhelming emotions associated with trauma for children?

ACS has a strong emphasis on reducing the number of foster care placement moves, which create more stress for the child. If a foster parent expresses concern about being able to maintain a child in his or her home, this triggers a family team conference with the goal of preserving placement when appropriate and improving the connection between the child and foster parent.

If the child is in therapeutic foster care, there is a focus on teaching him or her healthy ways to respond to experiences, emotions and behaviors. Foster parents also need training to understand the child's reactions and to assist with this type of psycho-education. This type of training is not always consistent, but is needed.

There has been a lot of work done around the country to create tools and therapeutic interventions to respond to the trauma-related needs of foster children. This is important work, but not all children have access to such evidence-based treatment, and even for those

eReview Learn more

Visit the CECMH website to find trauma-related articles, educational materials and other resources related to this *eReview* issue. Go to www.cmh.umn.edu and click on "eReview".

Join the CECMH listserv to receive weekly updates about training opportunities, job announcements, new research, publications and more — email cmh@umn.edu.

Attend the 2010-2011 CECMH Lessons from the Field, "More than just mean girls: A series on relational aggression". Go to www.cmh.umn.edu and click on "Lessons from the Field".

Evaluate this issue of eReview at https://umsurvey.umn.edu/index.php?sid=11926&lang=um

who do, there are many hours outside of therapy and many other people who work with and influence the child. It's critical that we pay attention to the time that the child is not in therapy and work to infuse trauma knowledge into settings such as foster homes, tutoring and mentoring programs, and after-school groups, and to support events such as visitation with birth parents. This will help minimize disruptions in foster care settings as well. For example, a mentor who understands the traumatic experiences of the child and how these affect behavior may be more effective in helping the child and less likely to quit because the child is not responding to them in the way they expected. The responsibility of responding to the emotions associated with trauma needs to be jointly held and delivered by everyone who works with the child.

How do you respond to the underlying causes of trauma as well as related behaviors that are adaptive during trauma but maladaptive at other times?

This is where the foster parents come into play. It helps to re-frame a child's difficult behavior so that the foster parent understands it's not about defiance or disrespect. Training and psycho-education about trauma and trauma-related behaviors is critical for foster parents. They are most aware of and affected by these behaviors, and need coping skills to manage them. Even when foster parents know where the behavior comes from, they still need to know how to depersonalize it and how to respond more effectively. It's important for them to understand that the behaviors they see are not unique to their child, and their experiences are not unique to them. With support and training, this can get better over time. Much of the child's behavior is related to fear – they are in a hyper-aroused state and feel threatened much of the time. We need to help parents keep this perspective.

Many foster parents have experienced trauma as well, either in their own lives or vicariously through their experiences of being a foster parent. They want to help and support children, and they also need support. Foster parents often request feedback and support from professionals in the child welfare system, but busy schedules can prevent staff members from responding in a timely way. It is important to view this problem in light of the needs of the child, rather than seeing this as a foster parent problem – foster parents need ongoing support to continue responding to the trauma needs of the children in their home.

In considering trauma-informed systems of care, are there specific recommendations you have for children of color?

This is a good question. Obviously, there is a huge issue related to the disproportionate numbers of children of color in the child welfare system generally and the foster care system in particular. Some populations are over-represented in the system and others are under-represented. There are many questions about these statistics that different jurisdictions are studying, including New York City. Also, trauma is perceived differently in different cultures and we need to be sensitive to this. In New York we have a huge immigrant population. Child welfare staff members need training about how children may be perceived and labeled differently according to background and culture. We miss the big picture of how to work with individual people if we don't understand their perspectives. It is important to address not only the intergenerational trauma but also the historical trauma experienced by many children and parents.

How do you consider a child's trauma experiences (current and history) when you make referrals?

This is an area where we need to continue to improve. Child welfare staff have some training about available services for children with varied needs, but more is needed. In New York, we have programs with funding to address early childhood mental health – most of these have a trauma focus. These programs are few in number but are generally more cohesive and clearly defined in terms of addressing trauma than programs for older children. Child welfare staff need more information and training about services for older children, and more services have to be developed in this area.

In New York City there is an initiative that involves partnerships between five foster care agencies and five mental health clinics, under which mental health clinic staff are physically located within the foster care agency offices. These satellite clinics make it easier for mental health professionals to collaborate with foster care staff and participate in activities like family team conferencing. A common barrier for mental health providers is that conferencing is not a billable service; co-located services reduce the time it takes for them to participate and potentially allow them to bill the time as a collateral session.

This group of foster care agencies and mental health clinics have worked with Dr. Glenn Saxe of the NYU Child Study Center to implement Trauma Systems Therapy with children who screen positive for trauma. This type of treatment is designed for children who have difficulty regulating their emotions as a result of the interaction between the traumatic experience and the social environment [for more information about Trauma Systems Therapy, see: http://www.bu.edu/atssa/TST_Information.pdf]. This has been good work, but five partnerships is a drop in the bucket.

In what ways are family members (biological and foster parents) provided support to manage the child's trauma-related behaviors?

Ideally, family members are supported regularly by child welfare workers. In reality this varies from agency to agency. It's a real challenge in any system, particularly one as large as ours, to keep a high level of knowledge among staff members with high turnover. For some caseworkers, this is their first or second job after college graduation. In these cases the staff person does not have a great deal of experience or preparation for the job and may not stay long – they may find the work too overwhelming, or themselves develop symptoms of secondary traumatic stress. But child welfare staff should have the skills and support they need to in turn be a source of support to foster parents – this is as important as the foster parent's support of the child. While training is needed for staff members, it's very important to focus on the needs of the foster parent, who can sometimes feel besieged in their own home. A caseworker may visit the child only once per month, but the parent is with the child most of the time. We can't expect them all to be trauma clinicians, but we can provide basic psycho-education about what trauma is and what it looks like in their child, and help them in both managing and hopefully reducing the child's challenging behavior.

Erin Sullivan Sutton, JD

Assistant Commissioner, Children and Family Services, Minnesota Department of Human Services

Christeen Borsheim, MPA

Director, Child Safety and Permanency Division Minnesota Department of Human Services

What is the role of public policy in developing trauma-informed child welfare systems?

Minnesota's child welfare policy and practice is increasingly reflective of the growing awareness of the science and research on infant and early childhood brain development, and how healthy and normal development is adversely affected by exposure to stress and traumatic experiences. Although a trauma-informed system was not an explicit goal at the outset of efforts to improve the state's child welfare policy and practices in the past decade, actions we have taken do align well with the trauma-informed practices identified by the National Child Traumatic Stress Network.

Over the past decade, with legislative support, Minnesota has implemented broad and innovative child welfare system reforms that have supported efforts to provide services earlier and more broadly to at-risk families. We have shifted our policy and practice from a deficit-based, unilateral planning and compliance monitoring system – which is more likely to cause further trauma – to a family assessment-centered, strength-based and collaborative intervention with families and communities – practices that are more likely to minimize trauma and foster healing. In addition to being less traumatic to children and families, we have demonstrated through formal evaluation —

- Decrease in re-reports of child maltreatment
- Decrease in the rate of foster care placement
- Improved family satisfaction
- Increased utilization of services
- Positive worker attitudes

For more detail about these outcomes, see the Extended Follow-up Study of Minnesota's Family Assessment Response: Final Report at: https://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5005-ENG and the Minnesota Parent Support Outreach Program Evaluation: Final Report at: http://iarstl.org/papers/PSOPFinalReport.pdf

In early 2009, the Child Safety and Permanency Division convened a broad stakeholder group to develop a child welfare practice model. The practice model, largely an expression of the values and principles that guided child welfare system reform efforts, serves as a touchstone for ongoing development of policy and practice. The values and principles set out in this document are supportive of and consistent with essential elements of trauma-informed practice: child safety is paramount; children and youth need and have the right to lifelong, nurturing and stable relationships; children's well-being is dependent upon strong families and communities; the safety and well-being of children is dependent on the safety and well-being of their family; families, communities, and the child welfare system are essential partners; children and families are best served when we approach them with respectful engagement; and cultural competence.

The Minnesota Child Welfare Practice Model and system reforms already accomplished provide a solid foundation on which to build a more trauma-informed policy and practice. Over the next three to five years, Minnesota plans a more systematic and systemic approach to creating a trauma-informed child welfare system that will be supported through training as well as improved capacity, access and availability for therapeutic services.

How is trauma-related information gathered when a child enters the child welfare system?

The hallmark of the state's child welfare reform efforts is Family Assessment Response (FAR). By 2009, nearly 70 percent of all responses to reports of child maltreatment were FAR, a non-adversarial family encounter focused on child safety and family needs. An underlying premise of FAR is that approaching a family in this way will increase their engagement, lead to more thorough and accurate assessments , and improve safety planning, all of which will ultimately improve child safety. In addition to safety and risk assessments, a Family Strength and Needs Assessment (FSNA) that includes ranking on 13 child and parent characteristics is completed in each FAR case. In a version of an FSNA currently under development, seven additional child characteristics, such as emotional/behavioral, physical health/disability, family relationships, alcohol and other drug use, education, child development and peer/adult social relationships will be assessed which will help inform need for further, more formal assessment and help guide case planning and services for the child and family.

What was achieved and learned through FAR was the foundation for launching Parent Support Outreach Program (PSOP) in 2005. PSOP is a voluntary, early intervention program operating in 30 counties. PSOP is a response to reports of maltreatment for children under ten that have been screened out. Families are offered voluntary services and accept them in nearly 50 percent of the cases. Family Strength and Needs Assessment are completed for families in PSOP, and families who are served through PSOP share very similar characteristics to those served through FAR. Positive outcomes, similar to those in FAR, have been demonstrated through formal evaluation.

Since July 2004, state policy has required that a mental health screening be completed for children who have an open child protection case, have been in foster care for 30 days or longer, or are receiving adoption or guardianship services (except for children meeting certain exemptions using standardized tools approved by the state's Children's Mental Health Division). Child welfare workers are trained in completing screening tools and the screening requirement is supported through an allocation to counties based on completed screenings. Continued efforts are needed to train and support child welfare workers in how to engage with families and children to participate in this voluntary screening.

How is further trauma minimized when a child enters the child welfare system?

When children enter the child welfare system for reasons of abuse or neglect, attention to safety is paramount; and in a growing number of counties in Minnesota, Signs of Safety (SoS) is becoming the preferred practice for safety planning. Unique features of SoS practice include mapping child safety and engaging children in safety planning using developmentally appropriate interviewing techniques.

Entry into foster care can be a traumatic event for a child, even when necessary to provide for their immediate safety. Making every effort to place children with relatives or kin, making placements as close to their homes as possible, keeping siblings together, maintaining important cultural connections for children, maintaining placement and school stability, and ensuring frequent and quality visits between parents and children are essential to reducing overwhelming emotions associated with trauma and minimizing disruptions in relationships. Family engagement strategies such as Family Group Decision Making have been successful in facilitating relative placements that subsequently help achieve other positive outcomes. Concurrent

permanency planning is another practice that promotes stability and timely permanence for children when they cannot be reunited with their parent.

Foster, adoptive and kinship (FAK) care providers have important roles that are supported through the child welfare system through pre-service and ongoing training. The Minnesota Child Welfare Training System has recently introduced training specific to child trauma. FAK providers are also supported through regular visits from their licensing worker or the child's caseworker. Thorough assessment of FAK providers' needs and provision of services to meet those needs are best practices for case planning.

Culturally competent practice is another component of maintaining stable relationships and connections for children that can help minimize trauma. Compliance with Indian Child Welfare Act and early involvement of the child's tribe in decisions about services and placement are important to maintaining connections for children.

Are efforts being made to develop a trauma-informed child welfare system? If so, what are these efforts?

The Child Safety and Permanency (CSP) Division at the Minnesota Department of Human Services is coordinating with the Children's Mental Division to systematically and systemically develop a trauma-informed child welfare system in Minnesota. The Children's Mental Health Division of the Minnesota Department of Human Services, through a partnership with Ambit Network, has been working to build a capacity for trauma-informed mental health practitioners. Now that practitioners with competencies in providing trauma therapy are available around the state, efforts will focus on the child welfare system to raise awareness of child trauma and make trauma-centered referrals to the network of providers.

The CSP Division is helping support a statewide conference on traumatic stress in children and families along with the University of Minnesota's Ambit Network, Harris Programs, and Center for Excellence in Children's Mental Health, the Minnesota Community Foundation, and NAMI-MN [see more information at: http://www.cehd.umn.edu/FSoS/Ambit/conference/]. This conference will be marketed to child welfare and children's mental health workers as well as mental health practitioners and policy makers, and will be the launch of developing the trauma-informed child welfare system.

The statewide conference will be followed by in-service training for CSP Division policy and program staff. Later in the year, trauma-informed practice training will be provided to child welfare supervisors, and later to child welfare case workers. These trainings will eventually be fully integrated into the Minnesota Child Welfare Training System.

References

The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

eReview Editorial Information

The *Children's Mental Health eReview* was created in partnership with the Center for Advanced Studies in Child Welfare at the University of Minnesota (cehd.umn.edu/SSW/CASCW)

Editor: Cari Michaels, MPH

Center for Excellence in Children's Mental Health
University of Minnesota
270 A McNamara Alumni Center
200 Oak Street S.E.
Minneapolis, MN 55455

Tel: (612) 625-7849
Fax: (612) 625-7815
Email: cmh@umn.edu
Web: www.cmh.umn.edu

This document funded in part by grant #439481, 000000013744 awarded to the Center for Advanced Studies in Child Welfare, School of Social Work at the University of Minnesota. Grant funds are Title IV-E funds made available through the Minnesota Department of Human Services, Children and Family Services Division.