



Helping Children in the Child Welfare System Heal from Trauma: A Systems Integration Approach

From the National Child Traumatic Stress Network
Systems Integration Working Group

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Helping Children in the Child Welfare Systems Heal from Trauma: A Systems Integration Approach

The Issue

Numerous organizations touch the lives of children and their families following incidents of maltreatment. These agencies include the family/dependency courts, child welfare agencies, foster parent associations, foster care agencies or substitute care facilities, mental health agencies, and others. The way these organizations work together is critically important. They have the potential to promote child safety and reduce the harmful impact of maltreatment on children, but also, unfortunately, at times their actions may worsen the traumatic experience for children and their families. While some attention has been given to understanding and improving the interaction of systems that become involved with a child immediately following maltreatment (for example, the child protective and law enforcement systems), less attention has been paid to some of the agencies that become involved much later in the process. The literature about the integration of trauma-related information and expertise into the responses of these agencies and systems has been scant or nonexistent.

The Project

“Helping Children in the Child Welfare System Heal from Trauma: A Systems Integration Approach,” by the National Child Traumatic Stress Network’s Systems Integration Working Group, reports on the results of a survey conducted among some of these later-stage agencies in a number of states. The survey was used 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. The goal was to determine how the various service systems communicate with each other about trauma and whether, alone or through interaction, they retraumatize the child or, more positively, promote the child’s healing following a traumatic event. This survey is small, representing 53 agencies in 11 communities, and is a first step in a larger project. The ultimate goal is to identify gaps in communication among agencies and systems and to develop training and educational materials to improve collaboration on issues associated with child maltreatment and trauma.

Findings

The following are among the study’s findings:

- Regardless of whether the respondents worked in courts, child welfare system, foster care agency, mental health agency, or schools, they seldom receive in-depth information about a child’s trauma history when a child is first referred to them by another agency or system.

- Many agencies do not conduct a standardized post-traumatic stress assessment with a child who has experienced maltreatment and been referred to the child welfare system.
- Fewer than half of the stakeholders interviewed train staff on available evidence-based treatments for child traumatic stress.
- Over a third of stakeholders interviewed did no training with their staff about assessment of child trauma.
- About a third of those interviewed said that they never make referrals to a treatment provider or placement based upon its use of evidence-based practices, and another third said they rarely did so.
- Overall, trauma reminders/triggers are asked about less frequently at intake than are other trauma issues, even though trauma reminders can retrigger a serious traumatic stress reaction.
- Stakeholders gather relatively more information on traumas' resulting behavior and school problems than on such topics as the duration of abuse, the number of trauma episodes, and internalizing symptoms.
- Overall, stakeholders report interactions with schools as being less helpful with regard to trauma-related issues than interaction with other agencies or organizations.

Recommendations

Members of the National Child Traumatic Stress Network

- Together with other national child welfare and dependency court organizations, develop and promote training about child trauma.
- To facilitate better information exchange between agencies, develop and disseminate a trauma profile instrument that can be shared with the family/dependency court, multidisciplinary teams, and those mental health professionals working with the child and the child's caretakers and/or foster family. This profile will capture important information about all traumas in the child's history, developmental levels at the time of the trauma(s), as well as trauma reminders.
- Promote the use of appropriate standardized assessment measures within service systems, including public child welfare and the courts, to assess both trauma-related and general symptoms when working with child trauma victims. (Information on available measures is available through the measurement review database on the website of the National Child Traumatic Stress Network at www.NCTSN.org.)
- Explore how trauma information can link to and inform treatment planning and encourage service providers in NCTSN centers to become educated on the interpretation of different standardized assessments used with traumatized children.
- Seek out promising practices and identify evidence-based practices that already exist for working with traumatized children across the different service systems. Share this information with system representatives.
 - Develop a bench guide for judges to promote knowledge and access to information about evidence-based practices.
 - Partner with experts within the service systems to develop trauma training materials and educational events that are appropriate and beneficial to those service systems.

- Promote the dissemination and spread of promising and evidence-based practices using strategies developed for this purpose (e.g., the Institute of Healthcare Improvement’s quality improvement strategy, <http://www.ihl.org/>). Use strategies that accelerate the rate of change so that promising practices with growing evidence bases become the standard of care across the country, and so that individual variability in quality of care is dramatically reduced.
- Seek funding to explore on a larger or nationwide scale the interactions between different service systems when treating child trauma.
- Encourage the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand their National Registry of Effective Programs to include more focus on evidence-based programs relevant to traumatized children. Encourage SAMHSA to seek out programs that are related to child welfare populations and ensure that they are listed in the registry.

Family or Dependency Court

- Seek out education and training to understand how a child’s trauma history impacts the child’s development and current functioning. Encourage state and national judicial educational bodies to include trainings on child trauma issues.
- Explore the use of standardized trauma assessment tools and trauma profile instruments to collect better information about a child’s trauma history and trauma’s impact on the child.
- Review existing information and resources about available evidence-based practices in treating child trauma in order to make informed decisions about placement, treatment, and visitation choices for children.

Public Child Welfare Agencies

- Consistent with public child welfare’s current goals of improving assessment of child well-being, provide education and training for both front-line staff and supervisors on trauma assessment, evidence-based trauma treatment, and the importance of traumatic reminders. Seek out training materials on child trauma that are appropriate for your organization to assist in reaching this goal.
- Increase the use of standardized assessment measures that identify trauma-related and non-trauma-related symptoms to help caseworkers have adequate information to meet the diverse needs of the children with whom they work.
- Integrate into child assessment and interview protocols the completion of a child trauma profile instrument so that workers have a complete understanding of the child’s trauma history.

Foster Care Agencies

- Seek training for staff and foster parents about trauma assessment, evidence-based trauma treatment, and the importance of traumatic reminders.
- Gather complete information about a child’s trauma history so that staff can see the impact of trauma on a child’s development, skills, and competencies. Share this trauma history profile with foster parents so both staff and foster parents can assist the child with organizing his/her experiences and developing a sense of continuity about his/her life. Use of a trauma profile instrument can facilitate this process.

Mental Health Agencies

- Develop strategies to better integrate your work with the work of school systems in order to become allies in assisting traumatized children in coping with change and loss.
- Seek out training on standardized trauma assessment measures, evidence-based trauma treatment, and the importance of traumatic reminders so that clinicians are better able to assist a child in coping with trauma.
- Incorporate the use of a trauma profile instrument when assessing children in order to gain a deeper understanding of a child's traumatic experiences and the way these may have influenced the child's development.
- Develop a mechanism for more effective cross-agency sharing of information so that clinicians have a clear understanding of systems issues that may be worrying or affecting the child, such as changing placements or schools. This will help clinicians target areas of difficulty for the child and will also help them assist the child in establishing feelings of continuity in the child's life.

Schools

- Educate teachers and staff so that they can recognize traumatic reactions, reminders, and triggers and identify when a child may be having a traumatic reaction as opposed to behavioral problems for other reasons. Include training on some of the more subtle or invisible symptoms seen with children who become depressed or withdrawn following a trauma.
- Identify strategies to enhance liaisons between schools, foster care providers, child welfare, and mental health systems to better meet the needs of traumatized children. Include strategies for sharing information about a child's experience and trauma reactivity, while still being sensitive to confidentiality issues.
- Seek out tools to educate teachers about the incidence, prevalence, and impact of child trauma and how to work effectively with children who have trauma histories.

Introduction

The traumatic experience of child abuse, neglect, and separation, especially when combined with environmental factors such as poverty, can lead to a variety of emotional problems for children and a greater likelihood of social, behavioral, and psychiatric problems. For children with previous traumas, prior victimization, or other environmental stressors, problems are often compounded. Intervening with these children can be more difficult. Children who have been removed from their homes due to abuse and neglect and placed in substitute care have an extremely high risk for mental health problems, especially traumatic stress. Traumatic stress involves intense feelings of terror, horror or helplessness, especially in response to serious injury to self, witnessing serious injury or the death of others, imminent threats of serious injury or death, or a violation of personal physical integrity. (Pynoos et al. 2004).

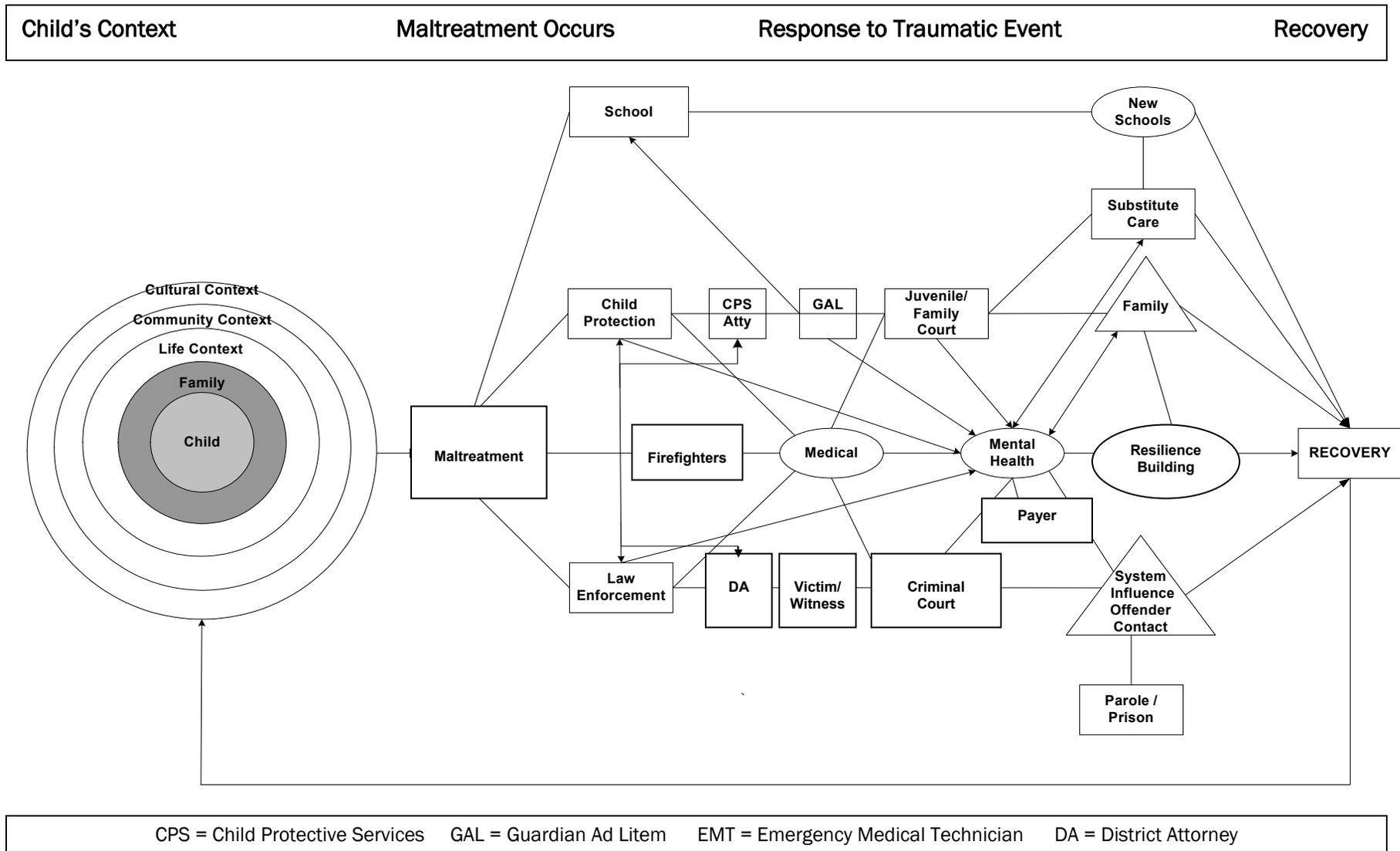
The mental health needs of children and families in the child welfare system require consistent, ongoing attention of all of the systems that work with the child. The child welfare system, schools, and the network of community-based organizations serving the needs of maltreated children will be most effective by working both individually and jointly to respond to the unique mental health needs of children and youth with histories of abuse and trauma.

Within the National Child Traumatic Stress Network (NCTSN), working groups are examining different service systems that work with children following episodes of maltreatment. The goal of the NCTSN Systems Integration Working Group (SIG) is to gain an understanding of how these various service systems communicate concerning trauma, and how, alone or in interaction, they may promote healing of a child following a traumatic event, or, conversely, how they may exacerbate a child's experience of trauma or even retraumatize a child.

The group first diagrammed the trauma recovery system, identifying the various service systems that interact with a child following a traumatic event (see figure 1). Literature about the integration of trauma information into the work of many of these systems is scant or nonexistent. Given the great deal of attention that has already been given to understanding and improving the child protective system and other systems, such as law enforcement, that become involved with a child immediately following a traumatic event (Marans 1995; Berkowitz and Marans 2000; Drotar et al. 2003), the group focused its efforts on agencies that become involved with a child much later in the process. These agencies include the family/dependency courts, child welfare agencies, foster parent associations, foster care agencies or substitute care facilities, mental health agencies, and others.

The Systems Integration Working Group created a survey (see Appendix A) to uncover the ways in which trauma-related information is gathered, assessed, and shared among some of these agencies. This survey is a tool that helps identify how agencies can coordinate to provide more continuity and better informed care of traumatized children. The group's larger intent is to identify gaps in communication between agencies and systems and to develop training and educational materials to improve collaboration among them with regard to traumatic events.

Figure 1
Trauma Response Pathway



Methods

In an effort to gain a greater understanding of the systems that interact with traumatized children, Systems Integration Working Group members interviewed community stakeholders who represent child welfare agencies, family and dependency courts, foster care systems, schools, and mental health agencies. The task of the NCTSN interviewers was to identify representatives from their communities that had knowledge of their agency's policies regarding child assessment, referral information, and interactions with other agency representatives and to interview them concerning the type and amount of trauma information and training they receive.

Survey questions focused on coordination among these agencies in addressing trauma-related issues. Quantitative questions (questions with multiple choice replies that can be scored and averaged for an objective picture of practices at the agencies) were used to gain information about the amount and type of trauma information gathered by agencies and communicated when referrals are made between service systems. Stakeholders were also interviewed about the training their staff receives on trauma-related issues, how they use trauma information in day-to-day practice, and how effective their interactions are with other service systems. Through open-ended questions, interviewers explored barriers to integrating trauma information into these agencies' work and sought to identify effective practices the agencies currently use to integrate trauma information.

Representatives from NCTSN sites conducted over 50 interviews in mid- and large-size cities in 11 geographically diverse locations: California, Connecticut, Maine, Michigan, Missouri, New York, Tennessee, Washington state, Maryland, and Wisconsin.



Why Information about a Child's Trauma Is Crucial for Systems

Long after they are over, traumatic experiences continue to take priority in the thoughts, emotions, and behavior of children and adolescents. The experience of trauma may lead to psychiatric conditions such as post-traumatic stress disorder, depressive disorder, and anxiety disorders. Traumatic experiences in childhood can also have profound effects on developmental progression, relationships with peers and family members, academic achievement and motivation for learning, memory, and full participation in society. This is especially likely to occur if the traumatic experiences are intense or prolonged, and the child faces substantial post-trauma adversity for an extended period (Pynoos 1993).

There are scientifically sound treatments that have proven to be effective in ameliorating effects of trauma on children. These treatments are based on a thorough understanding of a child's history of traumatic experience as well as a child's trauma reactions, symptoms, and trauma reminders. Many organizations working with traumatized children focus only on addressing traumatic reactions, such as anger and irritability, or symptoms such as avoidance. They fail to address the underlying trauma that gives rise to problematic behavior and the trauma reminders that can trigger post-traumatic reactions.

The ways in which systems share information about a child's trauma history and treatment can have a direct impact on the quality of care given to the child and on the child's well-being.

For example, following a traumatic event, some children become anxious, fearful, or withdrawn. They experience sadness, fear, guilt, shame, and confusion—symptoms that are referred to as *internalizing symptoms*. Other children externalize their problems and express their fears by being hostile or using aggression as a way of solving conflicts with adults or with peers. Without information about a child's trauma exposure and history, a caregiver or service provider may interpret a child's symptomatic behavior as part of a larger mental health problem rather than as a reaction to trauma.

The same goes for traumatic reminders. Sometimes a particular person, place, sound, or situation will make a child think about or remember something about a traumatic experience. An anniversary date may serve as a strong reminder, renewing early reactions and feelings and increasing worries about something similar happening again. Reminders act to restart post-traumatic stress reactions or behavior. They can evoke a range of negative emotions including sadness, anger, and anxiety. A child may not be consciously aware of having been reminded, but it is important for caregivers and others to anticipate reminders and to help a child recognize and learn to cope with them (Pynoos 1993).

The Systems Integration Working Group survey addressed the sharing of this kind of information among agencies.

For many children, new traumatic events are experienced within the context of previous traumas. These histories of multiple and varied traumas provide assessment and treatment challenges for children attempting to cope with trauma and for those in the service fields attempting to help these children recover. Many family systems are chaotic or disruptive for children with histories of multiple traumas, reducing the supports that are available to these children. Organizations involved in assisting the child must work together to put together a full trauma profile, including the disruptions that may have occurred in the child's development. Without understanding these complex histories, organizations may miss opportunities to address the underlying causes of behavioral and emotional problems and the ongoing factors that rekindle them. They may also miss opportunities to build a successful supportive environment in which the child can recover.

Survey Results

As a preliminary step in understanding how various systems communicate about trauma-related issues, Systems Integration Working Group members interviewed representatives from their communities about the amount and type of information they request when they receive a referral of a child from another agency. Respondents were then also asked what kind of information they collect themselves and what types of information they pass along to other agencies working with a child. The survey also tried to determine how information about a child's trauma experience was used by various organizations to shape care and treatment and whether some agency interactions were more problematic than others. Finally, agency representatives were asked about the types of trauma training they received.

General survey results and agency-specific results are discussed below.

Information Received by Agencies When a Child Is Referred

Overall, regardless of whether the stakeholders worked in courts, the child welfare system, a foster care agency, a mental health agency, or schools, stakeholders indicated that they do not often receive in-depth information about a child's trauma history when a child is first referred to them by another agency or system. Eighty-four percent of the stakeholders indicated that they receive "none," "a little," or "some" information about a child's trauma history when they receive an initial referral. Further, the information gathered is often limited to information about only the referring trauma and does not address other possible traumas in the child's history.

Significance: It is important that professionals working with children and families get a thorough history of traumatic events that have occurred to the child over the course of his or her life. A thorough history helps caregivers and others have an appreciation of the seriousness of the child's experience. It could provide clues to gaps in a child's development of skills and help caretakers and others be more supportive of the child's recovery. A thorough trauma history also helps clinicians form a more comprehensive and appropriate treatment plan and helps them target the causes of the child's problems to ensure more complete trauma resolution.

One positive finding in the survey is that many agencies have developed standardized protocols for gathering information when a child is referred to their center. This was overwhelmingly true for dependency courts, public child welfare agencies, and foster care agencies. Mental health agencies were more varied, with about half of those interviewed stating that information gathered was part of a standard protocol and about half indicating that information was gathered when offered. Schools were less likely to gather information as part of their standardized protocol, but rather, obtained information only when it was offered.

Types of Trauma Information Gathered by Agencies

When asked about the types of information that they gathered at intake, about 87 percent of all of the agencies interviewed said they gather information about the referring incident, and about 75 percent of all agencies gather information about other traumas in the child's history, about the child's involvement with other agencies, and about specific details concerning the traumatic event. Only 69 percent of the agencies interviewed said they gather information about the duration of the trauma and number of episodes of trauma, and remarkably, only 47 percent asked about trauma reminders and triggers.

In addition to gathering information about the referring incident, agencies also gathered a great deal of information about the child's presenting symptomatology, with an emphasis on social, interpersonal, school, and externalizing problems. (Over 85 percent of the time on average, agencies gathered information on these particular symptoms). They gathered less information on other symptoms, asking about trauma reminders and triggers less than half the time on average, and gathering information on the more subtle, internal problems only a little more than 50 percent of the time. About 66 percent of the time, agencies asked about coping skills or strengths the child possesses, an indication that there is at least some awareness of the importance of adopting a strength-based approach to treatment. Although post-traumatic stress is one of the most common consequences of a traumatic event for children, only about half of the agencies interviewed stated that they did a diagnostic assessment for PTSD.

In addition, although the majority of respondents indicated that they gathered a great deal of information on a variety of trauma-specific symptoms and more general problem behaviors, there was a wide variety in the types of information gathered at any particular site. For instance, more than 30 percent of the agencies stated that they gather information about other traumas in a child's history for fewer than half of their cases. Table 1 presents the average percentage of cases for which specific types of information is gathered.

Table 1
Transferring Information Between Agencies
 Data presented in order of survey questions. See Appendix A.

Type of information	% of cases for which information is gathered by your agency at intake (X, SD)	% of cases for which information is provided when a referral is made to another agency (X, SD)
1. Information on the referring traumatic incident	X = 87.4% SD = 26.3	X = 88.1% SD = 22.8
2. Information about other traumas in the child's history	X = 73.5% SD = 27.9	X = 80.8% SD = 28.4
3. History of child's involvement with other agencies	X = 74.5% SD = 29.7	X = 80.9% SD = 30.7
4. Duration of trauma/episodes of trauma	X = 68.7% SD = 33.3	X = 77.8% SD = 33.4
5. Specific details concerning the traumatic events	X = 77.1% SD = 31.1	X = 78.3% SD = 32.1
6. Trauma reminders/triggers	X = 46.7% SD = 31.1	X = 65.8% SD = 35.1
7. Child's internalizing, anxiety, or depressive symptoms	X = 61.7% SD = 33.1	X = 77.2% SD = 29.9
8. Family/systems problems associated with the trauma	X = 72% SD = 31.7	X = 78.9% SD = 30.9
9. Family/systems problems resulting from the trauma	X = 71.2% SD = 32.7	X = 78.0% SD = 31.4
10. Child's post-traumatic stress symptoms	X = 68.8% SD = 34	X = 76.6% SD = 32.3
11. Diagnostic Assessment of PTSD	X = 54.2% SD = 39.3	X = 77.5% SD = 37.3
12. Child's externalizing/behavioral problems	X = 87.7% SD = 20.1	X = 87.3% SD = 24.3
13. Social, interpersonal, and school problems	X = 88.8% SD = 16.5	X = 87.0 SD = 23.5
14. Coping skills or strengths child possesses to assist in coping with the trauma	X = 66.2% SD = 33.5	X = 78.0% SD = 29.7

As table 1 illustrates, there is a great deal of variability in the percentage of cases-per-organization for which various pieces of information are gathered during the referral process. Also, there are certain categories of information that agencies often do not gather. Specifically, information about trauma reminders and triggers are gathered for an average of only 47 percent of the cases across agencies, and a diagnostic assessment of PTSD is done for just 54 percent of the cases on average.

Children with PTSD may live in a constant state of fearfulness, reliving the experience over and over again in their play, their dreams, their drawings, their speech, or their relationships with others. Some children show disorganized and agitated behavior; younger children may regress to earlier behaviors. Many children become irritable and have difficulty sleeping or concentrating (National Child Welfare Resource Center for Family-Centered Practice 2002). Agencies, caregivers, and guardians would be better able to serve these children if they understood children's level of post-traumatic stress symptoms and if they identified children's trauma reminders and triggers. Understanding trauma cues and anniversary dates is key to knowing how to assist traumatized children and how to help them cope with the post-trauma reminders they are exposed to every day.

Because some adults do not believe that children can be affected by trauma or believe that children will just forget about a traumatic event, children's symptoms are frequently overlooked or dismissed and many children never receive treatment. Because many trauma symptoms are less obvious, they are easy to miss or misinterpret (National Child Welfare Resource Center for Family-Centered Practice 2002).

For all of these reasons, it is important for those agencies and organizations that work with maltreated children to be systematic about how they collect information about children and how information gets shared with other organizations and individuals involved in the child's care. Through increased systematization, workers at the agencies involved can improve their ability to make planned, thoughtful, and coordinated responses to a child's trauma.

Information Provided to Other Agencies When Making a Referral

In addition to gaining an understanding about the type of information that different agencies receive when they take a new case, the Systems Integration Working Group was interested in exploring how much information various agencies provide to others when making a referral. As table 1 indicates, agencies provide trauma and symptom information to other organizations about as often as they receive this information when taking a referral. Overall, however, agencies report that they do a better job of providing comprehensive trauma information when making a referral than do agencies from whom they receive referrals.

Significance: As agencies become more adept at providing the agencies with whom they work with complete assessment information, they are improving communication regarding trauma and ultimately improving the services that child maltreatment victims receive and improving continuity of care.

Agency-Specific Results Regarding Information Gathering and Exchange

Dependency Courts

Every Dependency Court respondent reported that they receive narrative summaries concerning the child from referring agencies at least 90 percent of the time, and at least 75 percent of the time they request a history of the case from the referring agency. (A narrative summary might include only current problems or events; a history provides information about a child's traumatic experiences over time.) On average, they gather copies of standardized assessment measures from referring agencies only a little over half of the time, and gather their own assessment data only 35 percent of the time.

Significance: Judges and others involved in the courts need an accurate picture of a child's history, symptoms, and current functioning in order to make good decisions about placement, visitation, the need for services, and permanency. Having

adequate information about a child's mental health enables parents, agencies, and courts to make recommendations for appropriate services. Whether the goal is reunification or another placement, children benefit from appropriate services and parents benefit from education and support services related to their children's care (National Child Welfare Resource Center for Family-Centered Practice 2003).

Public Child Welfare Agency

The vast majority of the time (94 percent on average), public child welfare agencies gather information on their clients from histories provided by the referring agency. They also rely upon information provided by the child and caregiver in about 75 percent of cases. They rarely get information from narrative summaries and rarely request standardized assessments from referring parties. Several public child welfare agency representatives interviewed indicated that they administer their own standardized assessment batteries as part of their standardized protocol.

Significance: Child and Family Service Reviews, conducted within the public child welfare setting, have traditionally examined permanency of placement and child safety. With increasing emphasis from the federal government on facilitating the child's mental and emotional health within this context, it becomes more and more important to assess child well-being.

The integration of standardized assessment measures into agency protocols provides an opportunity for advancement in public child welfare. Many measures do not need to be completed by a licensed psychologist. The use of such standardized measures that identify trauma-related symptoms and non-trauma-related symptoms would inform child welfare agencies as well as other service providers working with children. They would give caseworkers a sense not only of what the child's experience has been but also of how the child is coping in social, emotional, educational, and other areas of life and how the trauma may be interfering with a child's current development. Caseworkers with a more comprehensive view of the child will be better able to organize resources and support to aid the child's recovery, and to help integrate a child into school, a substitute care setting, or a foster family.

Potential trauma specific instruments include the child report Trauma Symptom Checklist for Children (TSCC) or the caretaker report Trauma Symptom Checklist for Young Children (TSCYC). Specific post-traumatic stress symptoms can be assessed using a measure such as the UCLA Post Traumatic Stress Reaction Index. A more general screening tool can capture non-trauma-related symptoms. One of the most common measures is the Child Behavior Checklist for Children. No advanced training is necessary to administer this measure and other general tools, making them practical in most trauma-related service settings. Information about all of these measures can be obtained from the website of the National Child Traumatic Stress Network (www.NCTSN.org).

Along with an assessment of symptoms and functioning, it is very important for caseworkers to obtain a detailed trauma history that captures not only information about the current trauma but also information about previous traumas and the child's age/developmental level at the time these traumas occurred. A sample of a trauma profile template is available from the National Center for Child Traumatic Stress.

Foster Care Agency/Substitute Care Facility

The foster care agencies interviewed unanimously indicated that they gather narrative summaries from referring agencies as part of their standard protocol. About 75 percent of the time, these referring agencies obtain a history provided by the child or caregiver. Three foster care agencies stated that they administer their own standardized assessment measures when children are referred and added that part of their protocol was to request standardized data from referring parties, although there was a wide variation in how often they actually received the standardized assessments they requested.

Significance: It is important that foster parents and guardians have thorough and accurate information about the child's traumatic experiences so they will be informed about not only trauma symptoms such as sleep disturbances and anxiety but also about traumatic reminders, triggers, and reactions that may influence the child's behavior.

In addition to the immense stressors related to the traumatic incident, children in placement must contend with concerns about birth parents and worry about siblings from whom they have been separated. These added stressors and distractions may keep the children from focusing on school work, from sleeping, or from engaging in other healthy, adaptive activities.

When foster children display serious emotional or behavioral problems, placements may fail and children may be moved to new homes. It is important for foster parents and others to know that behaviors that would be considered unusual for some children may be appropriate adaptive behaviors for a child whose environment has lacked stability or certainty. Foster parents are in a key position to know about and care for a foster child's emotional well-being. Their role as emotional stabilizers and mediators is critical, and their influence upon the child is far reaching (National Child Welfare Resource Center for Family-Centered Practice, 2003). Accurate and complete information helps those involved in the child's care to advocate on behalf of the child and to provide appropriate treatment and supports.

Often children who are removed from their homes have a history of multiple placements with relatives, family friends, and others prior to court-ordered removal due to abuse or neglect. No one may have the complete history of the events, both positive and negative, experienced by the child prior to foster care placement (CWLA 2004). It is important to remember that the child also lacks a sense of continuity about his or her life. Foster parents/foster care agencies are in a position to help ease the burden of multiple traumas, which can lead to increased traumatic stress reactions and behavioral problems. By gathering more information about a child's history, relationships, strengths, and accomplishments, foster parents, caseworkers, and others can help organize the child's life and help create a map to assist the child in gaining a better sense of his or her life.

Mental Health Agency

The mental health agencies received information predominantly from the child and caretaker. Every mental health agency interviewed stated that in at least half of their cases they obtain histories from the referring agencies. However, they varied widely on how often they received narrative summaries, and they received copies of existing standardized assessments only about 25 percent of the time. The majority of the mental health agencies indicated that they administer their own standardized

assessment batteries when they receive a referral, and seven mental health agencies stated that 70 to 100 percent of the time they completed their own standardized assessments.

Significance: It is encouraging that mental health agencies are assessing children in the child welfare system more widely. However, it is not clear how often their assessments focus on trauma-related concerns, which are critical for this population. Mental health providers need to obtain a thorough trauma history and profile of the child, otherwise they will have an incomplete picture of how traumatic events may have impacted the child's development and current functioning. Having information about the current or referring situation alone is insufficient. In addition, mental health professionals who are assessing and treating children in the child welfare system must have a clear understanding of the child's current health care needs, how the child is coping in social, educational, and other areas of life, and the child's medical, education and placement histories in order to provide optimal care (CWLA 2004).

Mental health professionals will gain a more accurate and complete understanding of the child by gathering information directly from the child. If professionals do not use self-report instruments, they may miss a child's suicidal thoughts, difficulties at school, trouble with traumatic reminders, etc. Treatment will also be improved if providers understand a child's trauma reminders and enhance a child's ability to cope with these.

Inadequate access to information concerning a child's permanency plans and placement changes can frustrate a clinician's ability to provide continuous, coordinated assessments and effective interventions (CWLA 2004). It can also be a source of anxiety and confusion for the child. Children who have been put into placement in the foster care system, for example, still face uncertainty. They may be unaware of plans to return them home or terminate parental rights and place them for adoption. Their fears and worries may prevent them from focusing on recovery and making plans for a positive future. Clinicians need to be made aware not only of a child's trauma history but of what child protective agencies and courts are doing currently in order to help the child handle the uncertainty of their situation and ultimately heal and move forward.

This information is especially important to the mental health professional's ability to enhance the child's sense of continuity about his or her life, especially if the child has experienced multiple placements. Trauma leaves a child feeling that he or she is "not the same" as before. Mental health professionals can help a child get a sense of the continuity of his or her life by helping the child to structure his or her thoughts and memories into a coherent narrative (CWLA 2004).

Schools

Schools had the most variability in terms of the information they received from referring parties. Very few gathered referral information in a consistent manner. The most consistent information was history provided by the child, and not all schools gathered this type of information. Only a few schools surveyed had a protocol in place to conduct standardized assessments, and the scope of these assessments was not trauma focused.

Significance: Schools can play a critical role in helping a child recover from a history of trauma. They can be a point of stability in lives that can be battered by change. They can play a critical role in helping children forge social relationships and achieve

success. Additionally, children spend most of their day and receive most of their mental health services through educational settings such as schools and after-school programs.

But schools often do not have sufficient information about a child's trauma history to assist appropriately with recovery efforts. Without a more thorough social history of the child, including information about a child's trauma triggers, cues, and anniversary dates, school staff may not recognize the reasons behind aberrant behavior or may place a child in special education unnecessarily, often with a diagnosis of attention deficit disorder (Ford, Racusin, and Ellis 2000; Weinstein, Staffelbach, and Baiggio 2000). They may spend time addressing the behavioral consequences of trauma rather than their root causes. Or they may even work at cross purposes with outside mental health providers serving a child.

Unfortunately, schools can be forgotten or treated as a side issue as various service providers worry about protecting children from neglect or abuse, finding them new homes, or transferring them if a placement doesn't work out. While some efforts are being made to assist children with multiple school placements (Vera Institute 2004), clearly much more can and needs to be done to help children heal from traumatic experiences by assisting teachers and others in schools to gain a better understanding of child trauma and to work collaboratively with other organizations.

How Organizations Use Trauma Information

There was not enough data to determine if a true difference exists in how different agencies utilize information about a child's trauma history when interacting with a child. However, within this small sample, schools descriptively reported using trauma information less than other agency types, and mental health agencies used trauma information more than other agencies.

More than three-quarters of the agencies stated that they consider expertise in trauma when selecting a treatment provider or placement. There was not a statistically significant difference based upon type of agency. However, within the small sample, schools descriptively reported that they rarely considered expertise in trauma when selecting a treatment provider, whereas the other agencies reported that they did so more frequently.

Despite the fact that the majority of agencies consider expertise in trauma when selecting a treatment provider, 31.4 percent of the respondents stated that they never make referrals to a treatment provider or placement based upon their use of evidence-based practice, and an additional 34.3 percent state that they rarely do so. This may speak to the definition of "expertise" and suggest that many individuals believe that, regardless of the use of evidence-based techniques at an agency, providers within that agency may have expertise in trauma. Agency representatives identified very few specific evidence-based practices. The ones listed included "attachment disorder treatment," "cognitive-behavioral therapy," and "specific sexual abuse expertise."

Significance: It is clear that much more information about best practices in the treatment of child trauma, or at least about trauma-informed practices, needs to be disseminated to frontline agencies and organizations working with children and families.

Interactions Among Different Service Systems

Interestingly, there were no significant differences in perceptions about how well one agency interacted with another agency based upon the type of agency. Although agency representatives noted some problematic interactions or some problematic relationships between service systems, generally they reported fair to above-average interactions with other service providers.

Mental health agencies did more to facilitate coordination between different service providers than other agency types. Given this, it makes sense for mental health agencies to continue to facilitate multidisciplinary meetings between service providers in an effort to improve services to children.

Training

In an effort to identify gaps in knowledge about how to work with children who have been traumatized, the Systems Integration Working Group interviewed agency representatives about the type of training they provide for their staff surrounding trauma-related issues. Table 2 provides a summary of the amount of training provided for various trauma-related topics, regardless of the type of agency, from least training to most training.

Table 2
Trauma-Related Training

Type of training	% of agencies providing training
1. Available evidence-based treatments for children with trauma histories and their applicability to different child maltreatment populations	44.7%
2. How to assess for trauma in children	61.2%
3. Information on how other systems respond to children with trauma	61.2%
4. Special considerations in working with traumatized populations	70.2%
5. Information on caretaker trauma history	70.8%
6. Relationships between caretaker substance abuse and trauma	72.3%
7. Information on caretaker mental illness	76.6%
8. Short-term impact of trauma on children	77.6%
9. Long-term impact of trauma on children	80.0%

The greatest training deficiencies related to (1) evidence-based treatments for children with trauma histories and their applicability to different child maltreatment populations, (2) assessing trauma in children, and (3) training in how other systems respond to children with trauma.

It is vital for organizations working with abused and neglected children to have current information about how trauma is assessed and treated. Information about effective assessment instruments and interventions has expanded greatly over the last ten years, and the knowledge base continues to

grow. The findings suggest, however, that much more needs to be done to disseminate this information adequately to frontline organizations working with traumatized children.

Different agencies placed different emphases on training about how other systems respond to children with trauma. Foster care agencies, mental health agencies, and schools placed more emphasis on training in this area; the dependency courts placed less emphasis on this area. This is a surprising finding, given the court's central role in ordering or ensuring services for maltreated children and their families. Child welfare agencies were split on their emphasis on training in this area. The remaining training topics were not significantly different based upon the agency type.

Themes from the Survey

After interviewing 53 different community stakeholders, members of the Systems Integration Working Group reviewed responses to open-ended questions concerning barriers to working with children who have experienced traumas and processes that facilitate productive work with them. Feedback was gathered from family/dependency court judges, public child welfare agencies, foster parent associations, foster care agencies, mental health agencies, schools, and other community agencies.

Several themes appeared to cross disciplines and different geographical locations:

- Many agency representatives expressed concern that **multiple child placements**, although unavoidable, often exacerbate the child's traumatic experience.
- Well-established **collaboration and communication** between stakeholders can reduce additional trauma for the child as the child moves between different agencies.
- Well-structured **multidisciplinary teams** can help different agencies respond to a child's trauma more effectively.
- On-going **trauma-related training** helps ensure that staff are equipped to help traumatized children.
- **Lack of systemic processes** creates unnecessary variability in quality of interventions.

Multiple Child Placements

At any given time, an estimated 542,000 children are in foster care (National Clearinghouse on Child Abuse and Neglect Information [HHS] 2003). Many of these children experience multiple placements, which results in discontinuity of care and treatment. These multiple placements have the potential to exacerbate a child's experience of trauma. As the child transitions from one system to another, communication between systems becomes a critical task but is often inefficiently performed. Standardized procedures for transferring information between sites, appropriate understanding of what is currently the best available practice in working with these children, and training on how to work with traumatized children are secondary problem issues that emerge from placing a child multiple times. A related concern involves limits to information that can be shared between agencies due to confidentiality rules.

Collaboration and Communication

Stakeholders value collaboration and open and continuous communication with other agencies involved in providing services to a child following a traumatic event, and many stakeholders had made some efforts to establish communication with other agencies, although their interactions did not necessarily involve communication over trauma-specific issues. Stakeholders were concerned

that lack of communication among agencies may cause a child to reexperience the traumatic event with each person with whom they interact, exacerbating or restarting their traumatic stress reactions. By failing to share information, organizations also miss opportunities to assist the child.

Multidisciplinary Teams

Professionals from different service systems agree that multiple transitions can exacerbate a child's trauma. Many systems' stakeholders recognize the importance of helping systems communicate more efficiently in the process of helping a child and his or her family deal effectively with trauma. Multidisciplinary teams and collaborations between service systems are the most frequently identified best practices to improve communication across different service systems. Some child welfare agencies, for instance, offer family unity meetings at which different systems involved with the child work together, helping the child through the transition. Stakeholders from other systems specifically note that referrals to appropriate systems are an important process in meeting a child's needs. Some systems employ family advocates, who help families negotiate among different service systems, easing the burden on the family and allowing the members to focus on healing. Despite the general consensus that collaborative work is beneficial, some sites noted that there can be too many different workers with too many different viewpoints on a child maltreatment case, and this can be counterproductive. The structure of the multidisciplinary teams is, therefore, crucial to their success.

Trauma-Related Training

Training staff on trauma-related issues is another area identified as both a problem area and a best practice when incorporated into different service systems. Workers often have high caseloads and inadequate training. This is even more of a problem with provider positions that have a great deal of job turnover. Some stakeholders noted that infrequent trainings are not adequate and that individuals working in the different service systems that work with traumatized children would benefit from ongoing training on trauma-related issues. Specific deficits in trauma-related training include general trauma information, trauma triggers, child PTSD, how to communicate with caregivers, and how to handle vicarious traumatization among staff members. Another training deficit identified is the link between trauma and high-risk behaviors such as alcohol and drug use.

Lack of Systematic Processes

Some stakeholders expressed concern over the lack of objectivity in the child protection service system and suggested standardizing processes. Stakeholders noted that the quality of service varies with different agencies and fluctuates by individual case managers. According to research, there is wide variability in the quality of interventions. The well being of children in the public welfare system is highly dependent upon the skills and attributes of individual caseworkers. Often caseworkers are not adequately trained because of the high level of job turnover (Colarelli, Montei, and Matthew 1996). This is an inherent flaw in the system. Results from this survey support the importance of appropriately training staff in an ongoing manner and using systematic training materials so that services are appropriate, standardized, and objective and that workers' actions will not vary greatly from one individual professional to another.

Other Themes

Additional themes or practices were identified that **facilitate** work with child victims.

- Generally, agencies viewed **involvement of child attorneys and guardians ad litem** as positive for children.
- Stakeholders expressed support for **family reunification programs**.
- Many jurisdictions used **family group decision-making or family unity meetings** (at which every person involved in the child's care meets in one location at one time to discuss the child's needs and the best ways to meet these needs). These are viewed positively.
- Survey respondents view **referrals to therapy services** as positive practices, (especially with agencies that use evidence-based practices).
- The **increased use of standardized assessments** by organizations was seen as positive.
- **Cultural competence in service delivery** was believed by many respondents to be important to children and families.
- **The availability of aftercare services for children once they leave the child welfare system** was believed to assist children in healing.

Additional practices and issues that **exacerbate** a child or family's experience following a trauma were also identified.

- **Financial constraints** often limit the treatment options available to families or the duration of treatment for trauma.
- **Issues related to managed care and insurance**, such as restrictions on the number or types of treatment sessions, were seen as troublesome.
- **Lack of transportation to treatment settings** impedes the ability to provide effective services, because of the difficulty maintaining consistency in appointment attendance.
- **Administrative problems and paperwork requirements** were cited as hindrances to good service delivery to traumatized children, taking up valuable time that could be devoted to clinical care.
- Some survey respondents cited **language and cultural difference** as barriers to delivering good trauma services.
- Some jurisdictions reported a **delay in receiving mental health services following child maltreatment** as a barrier to effectively treating the child's trauma.
- Many people surveyed believe that **reinterviewing children multiple times** is potentially retraumatizing for children.
- Some stakeholders said that **worker burnout caused field workers to become desensitized to the needs of children they serve**.
- **Policy and funding changes that impact the way children receive services and the continuity of services** were cited as problems by some survey respondents.
- **Confidentiality issues that prevent sharing of information between different agencies** was also cited by many survey respondents as problematic, as children are required to repeat information multiple times in multiple contexts.

Stakeholders said that sometimes a child's trauma is exacerbated or compounded because the courts do not adequately promote family reunification, while in other cases the child is inappropriately left in the home and may be retraumatized. They believed this is related to training staff appropriately in order to correctly identify the child's best interests.

Schools Need Additional Attention

Although schools were not initially included as one of the core service system groups in the survey, many different sites chose to interview school personnel in their communities. Schools emerged as one service system that could benefit from more systematic intervention. Often when a child changes a placement he or she is required to change school districts. Most research shows that transfers have harmful effects on educational outcomes (Galton, Gray, and Ruddock 1999, 37). Each transfer requires the child to adjust to new teachers and peers and to a curriculum that may differ considerably from the previous school's. Too many transfers can cause a child to disengage and give up on school. Transfers can also play havoc with continuity of special education services (Vera Institute 2004). In addition, public schools often do not understand how to work with these children, and schools are quick to reprimand or suspend children who misbehave without looking at reasons for behaviors.

A lack of coordination among the child welfare, courts, foster care, mental health, and educational systems can be an obstacle to helping abused and neglected children succeed in school. In many cases, there is a fundamental lack of understanding in each system of how the other systems work (Vera Institute 2004). Educating schools about the impact of trauma and helping them develop strategies to assist children transitioning from school to school would benefit children who are required, as a result of a traumatic event, to change school systems.

Schools can also play a critical role in building on and reinforcing the messages and skills a child is learning in therapy. Both schools and mental health providers could benefit from concrete tools to help them better integrate their work and become allies in assisting traumatized children.

Courts Need Additional Attention

Some stakeholders identified problems within the court system (referred to as *family court*, *dependency court*, or *juvenile court*, depending on jurisdiction) when it is involved with child placement. They expressed frustration with the lack of child-centered interventions for children in the court system. They especially identified gaps in appropriate referrals to mental health services from the courts. Many stakeholders also expressed frustration with the delays in the court system and the stress that these delays place on children. Suggestions were made to promote the use of mediation and advocacy whenever possible.

Limitations of the Survey

One of the major limitations of this survey is that the sample of communities used is small and not particularly representative of other communities nationwide. Surveys were completed in geographical locations that surrounded those of working group members, and individual interviewees were selected, for the most part, because they were known to the members of the Systems Integration Working Group. For this reason, it is hard to draw more general or nationwide lessons from the data. The study does, however, identify some interesting themes, and it would be beneficial to follow-up on this survey with larger-scale studies that are able to capture a more representative assessment of how systems work together in treating child trauma.

Conclusions and Recommendations

Children who experience terrifying or traumatic experiences often face serious psychological and emotional consequences as a result of their experiences. Compounding the initial trauma, children are sometimes removed from the home or separated from parents and siblings. These secondary stressors can exacerbate symptoms, creating additional stress on a child who is already contending with a great deal. Children may experience traumatic stress and symptoms of post-traumatic stress disorder or other trauma-related symptoms such as depression, anxiety, or behavioral problems. A child at school may manifest these through inappropriate behavior with peers, at home, or in placement. Some children will act out behaviorally; others will withdraw, experience somatic problems, or have trouble sleeping. Recurring intrusive memories of an event can cause a child to remain in a perpetual state of fear and anxiety, on the lookout for signs of danger. Or children may react with avoidance and diminished responsiveness and be unwilling to engage in meaningful relationships.

Historically, child welfare agencies and courts have been more keenly concerned about the immediate safety and continuity of placement than about the long-term recovery of the child. Recently, there has been increased interest and concern in the broad well-being of the child. Goals for safety and continuity of placement do not have to conflict with goals for improving the child's well-being. In fact, they can complement each other.

It is important that professionals working with maltreated children and their families get a thorough history of traumatic events that have happened to the child over the course of the child's life. A thorough history will help caregivers and others have an appreciation of the seriousness of the child's experience(s), gain an understanding of the context of the full range of traumatic experiences, and be more supportive of the child's recovery.

Based on the results of examining cross-systems issues and interactions, the National Child Traumatic Stress Network's Systems Integration Work Group recommends the following:

General Recommendations for the National Child Traumatic Stress Network

Several general needs were identified for improving the communication between systems on trauma-related issues. As a national organization that is concerned with these issues, these general recommendations are directed toward members and working groups within the National Child Traumatic Stress Network. There may be opportunities for other community agencies to assist in meeting these general objectives as well.

- Together with other national child welfare and dependency court organizations, develop and promote training about child trauma.

- To facilitate better information exchange between agencies, develop and disseminate a thorough trauma profile instrument that can be shared with the family/dependency courts, multidisciplinary teams, and those mental health professionals working with the child and the child's caretakers and/or foster family. This profile will capture important information about all traumas in the child's history, developmental levels at the time of the trauma(s), and trauma reminders.
- Promote the use of appropriate standardized assessment measures within service systems, including public child welfare and the courts, to assess both trauma-related and general symptoms when working with child trauma victims. (Information on available measures is available through the measurement review database on the website of the National Child Traumatic Stress Network at www.NCTSN.org.)
- Explore how trauma information can link to and inform treatment planning and encourage service providers in NCTSN centers to become educated on the interpretation of different standardized assessments used with traumatized children.
- Seek out promising practices and identify evidence-based practices that already exist for working with traumatized children across the different service systems. Share this information with system representatives, including information from the *Child Physical and Sexual Abuse Guidelines for Treatment*, revised by the Office for Victims of Crime in 2004 (www.musc.edu/cvc/guide1.htm) and the report published by the Kauffman Foundation, titled *Closing The Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices* (www.chadwickcenter.org/kauffman.htm).
 - Develop a bench guide for judges to promote knowledge and access to information about evidence-based practices.
 - Partner with experts within the service systems to develop trauma training materials and educational events that are appropriate and beneficial to those service systems.
- Promote the dissemination and spread of promising and evidence-based practices using strategies developed for disseminating information effectively (e.g., Institute of Healthcare Improvement's quality improvement strategy, <http://www.ihl.org/>). Use strategies that accelerate the rate of change so that promising practices with growing evidence bases become the standard of care across the country and so that individual variability in quality of care is dramatically reduced.
- Seek funding to explore on a larger or nationwide scale the interactions between different service systems when treating child trauma.
- Encourage the Substance Abuse and Mental Health Services Administration to expand the National Registry of Effective Programs to include more focus on evidence-based programs relevant to traumatized children. Encourage SAMHSA to seek out programs that are related to child welfare populations and ensure that they are listed in that directory.

Agency-Specific Recommendations

Family or Dependency Court

- Seek out education and training to understand how a child's trauma history impacts the child's development and current functioning. This information can then provide the basis for identifying the most therapeutic and appropriate placement, treatment, and visitation plans for children. Toward this aim, encourage state and national judicial educational bodies to include trainings on such issues as child trauma and its impact.
- Explore the use of standardized trauma assessment tools and trauma profile instruments to collect better information about a child's trauma history and trauma's impact on the child.
- Review existing information and resources about available evidence-based practices in treating child trauma in order to make informed decisions about placement and treatment choices for children.

Public Child Welfare Agencies

- Consistent with public child welfare's current goals of improving assessment of child well-being, provide education and training for both front-line staff and supervisors on trauma assessment, evidence-based trauma treatment, and the importance of traumatic reminders. Seek out training materials on child trauma that are appropriate for your organization to assist in reaching this goal.
- Increase the use of standardized assessment measures that identify trauma-related and non-trauma-related symptoms to help caseworkers have adequate information to meet the diverse needs of the children with whom they work.
- Integrate into child assessment and interview protocols the completion of a child trauma profile instrument so that workers have a complete understanding of the child's trauma history.

Foster Care Agencies

- Seek training for staff and foster parents about trauma assessment, evidence-based trauma treatment, and the importance of traumatic reminders.
- Gather complete information about a child's trauma history so that staff can see the impact of trauma on a child's development, skills, and competencies. Share this trauma history profile with foster parents so both staff and foster parents can assist the child with organizing his/her experiences and developing a sense of continuity about his/her life. Use of a trauma profile instrument can facilitate this process.

Mental Health Agencies

- Develop strategies to better integrate your work with the work of school systems in order to become allies in assisting traumatized children in coping with change and loss.
- Seek out training on standardized trauma assessment measures, evidence-based trauma treatment, and the importance of traumatic reminders so that clinicians are better able to assist a child in coping with trauma.

- Incorporate the use of a standardized trauma profile instrument when assessing children in order to gain a deeper understanding of children's different traumatic experiences and the way these may have influenced the child's development.
- Develop a mechanism for more effective cross-agency sharing of information so that clinicians have a clear understanding of systems issues that may be worrying or affecting the child, such as changing placements or schools. This will help clinicians target areas of difficulty for the child and will also help them assist the child in establishing feelings of continuity in the child's life.

Schools

- Educate teachers and staff so that they can recognize traumatic reactions, reminders, and triggers and identify when a child may be having a traumatic reaction as opposed to behavioral problems for other reasons. Include training on some of the more subtle or invisible symptoms seen with children who become depressed or withdrawn following a trauma.
- Identify strategies to enhance liaisons between schools, foster care providers, child welfare, and mental health systems to better meet the needs of traumatized children. Include strategies for sharing information about a child's experience and trauma reactivity while still being sensitive to confidentiality issues.
- Seek out tools to educate teachers about the incidence, prevalence and impact of child trauma and how to work effectively with children who have trauma histories.

References

- Galton, M., J. Gray, and J. Rudduck. 1999. *The impact of transitions and transfers on pupil progress*. London: Department for Education and Employment Research Series.
- Berkowitz, Steven J., and Steven M. Marans. 2000. The child-development-community policing program: A partnership to address the impact of violence. *Israel Journal of Psychiatry and Related Sciences* 37, no. 2: 103–14.
- Chadwick Center on Children and Families. 2004. *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices*. San Diego, CA, at www.chadwickcenter.org/kaufman.htm.
- Child Welfare League of America. 2004. *DRAFT: Practitionerg Guidelines for the comprehensive assessment of mental health and alcohol and other drugs (AOD) needs of children and adolescents entering the foster care system*.
- Colarelli, Stephen M., and Matthew S. Monte. 1996. Some contextual influences on training utilization. *Journal of Applied Behavioral Science* 32, no. 3: 306–22.
- Drotar, Dennis; Daniel Flannery, Elsie Day, Steve Friedman, Rosemary Creeden, Heidi Gartland, Lolita McDavid, Craig Tame, and Matthew J. McTaggart. 2003. Identifying and responding to the mental health service needs of children who have experienced violence: A community-based approach. *Clinical Child Psychology and Psychiatry* 8, no. 2: 187–203.
- Ford, Julian D., Robert Racusin, Cynthia G. Ellis. 2000. Child maltreatment, other trauma exposure and posttraumatic symptomatology among children with oppositional defiant and attention deficit hyperactivity disorders. *Journal of the American Professional Society on the Abuse of Children* 5, no. 3: 205–17.
- Institute for Healthcare Improvement (IHI). 2003. *The breakthrough series: IHI's collaborative model for achieving breakthrough improvement*. Boston: IHI.
- Marans, Steven. 1995. *The police–mental health partnership*. New Haven: Yale University Press.
- National Child Welfare Resource Center for Family-Centered Practice. 2002. *Best Practice/Next Practice* 3, no. 1.
- . 2003. *Best Practice/Next Practice* 4, no. 3.
- National Crime Victims Research and Treatment Center, University of South Carolina, CfSAaTS, Harborview Medical Center. 2004. *Child physical and sexual abuse: guidelines for treatment*. Charleston, S.C.: Office for Victims of Crime, at www.musc.edu/cvc/guide1.htm.
- Pynoos, Robert S., Alan Steinberg, and Ramesh Raghavan. 2004. Private correspondence.
- Pynoos, Robert S. 1993. Traumatic stress and developmental psychopathology in children and adolescents. In Oldham J. M., M. B. Riba, A. Tasman, eds. *American psychiatric press review of psychiatry*, vol. 12, Washington D.C.: American Psychiatric Press.
- Vera Institute of Justice. 2004. *Foster children and education: How you can create a positive educational experience for the foster child*. New York: Vera Institute.
- Weinstein, Dan, Darlene Staffebach, and Maryka Biaggio. 2000. *Attention-deficit hyperactivity disorder and posttraumatic stress disorder: Differential diagnosis in childhood sexual abuse*. *Clinical Psychology Review* 20, no. 3: 359–78.

Appendix A

National Child Traumatic Stress Network Systems Integration Group Stakeholder Survey

You are being asked to participate in a research study. This study involves a survey that explores the understanding of and integration of trauma and trauma-related issues within your organization and those organizations you interact with most frequently. The interview should take approximately 1 hour to complete. Questions address the role of the child's trauma history in your work with children as well as the coordination between child welfare organizations, family and dependency courts, foster care systems, schools, and mental health agencies when attending to trauma issues for child victims. For the purposes of this survey, trauma refers to distress experienced in the course of, or as a result of child maltreatment. You will not be asked about any specific children, families, or cases. If you are unable to answer any question, or if someone else in your agency would be better able to answer any of these questions, please let me know. Any information you provide will not be linked to you; we will not use your name, agency, or county name in any reports. Participation is voluntary and you are free to withdraw from the interview at any time.

Are you willing to participate in this study? Yes
 No

Introductory Information

1. Which of the following would **best describe** where you are currently employed?

- Family or Dependency Court
- Public Child Welfare Agency
- Foster Parent Association or other organization that represents foster parents
- Foster Care Agency or Substitute Care Facility (Must be an agency. Examples include group homes, RTCs)
- Mental Health Agency
- Indian Child Welfare Unit
- Other - please specify (e.g., schools, juvenile justice, or other agency in your community involved after the investigation is complete):

2. What is your current job title?

3. Please give me a brief job description (*i.e. what activities your job entails*):

4. **How often** does your job involve working with the Family or Dependency Court?

- 1 Never
- 2 Rarely
- 3 About half of the time
- 4 Most of time
- 5 Always

5. **How often** does your job involve working with children placed in foster or substitute care?

- 1 Never
- 2 Rarely
- 3 About half of the time
- 4 Most of time
- 5 Always

The following questions apply to any child who has experienced child maltreatment, such as physical, sexual, or emotional abuse, neglect, or exposure to domestic violence, and is at risk of being placed or is currently placed in foster or substitute care.

6. When a referral is sent to your agency, in general, how much information does your staff **receive** about a child's trauma history with the **initial referral**? *To clarify: when the referral is sent to your agency, what information about a child's trauma history is contained in the original referral paperwork?*

- 1 None
- 2 A little
- 3 Some
- 4 Quite a bit
- 5 A lot

7. What types of information does your agency collect for children being referred to you?

Interviewer: complete the following questions only for the YES responses:

8. Overall, in what **percentage** of your agency's cases is each type of information obtained?

9. For each data source, please tell me whether the information is obtained as part of your **agency's standard protocol**, or if it is **obtained when offered** by the caregiver, child, or referring agency.

	YES	NO	% of Cases:	How obtained (Select One):
a. Narrative Summaries from referring agency	YES	NO		<input type="checkbox"/> Standard agency protocol <input type="checkbox"/> Obtained when offered
b. History provided by the child	YES	NO		<input type="checkbox"/> Standard agency protocol <input type="checkbox"/> Obtained when offered
c. History provided by parent or other caregiver	YES	NO		<input type="checkbox"/> Standard agency protocol <input type="checkbox"/> Obtained when offered
d. History obtained from referring agency	YES	NO		<input type="checkbox"/> Standard agency protocol <input type="checkbox"/> Obtained when offered
e. Standardized assessments administered by your agency	YES	NO		<input type="checkbox"/> Standard agency protocol <input type="checkbox"/> Obtained when offered
f. Standardized assessments obtained from referring agency	YES	NO		<input type="checkbox"/> Standard agency protocol <input type="checkbox"/> Obtained when offered
g. Other (specify):	YES	NO		<input type="checkbox"/> Standard agency protocol <input type="checkbox"/> Obtained when offered

10. **What information** is obtained by your agency concerning a child’s trauma history? When considering trauma information, please consider all types of trauma, not just child maltreatment.

Interviewer: Refer to list below. Complete the following questions only for the YES responses:

10a. Overall, in what **percentage** of your agency’s cases is the information obtained?

10b. For each item, is the information obtained as part of your **agency’s standard protocol**, or if it is **obtained when offered** by the caregiver, child, or referring agency?

	YES	NO	% of Cases:	How obtained:
a. Information about the referring traumatic incident	YES	NO		[] Standard agency protocol [] Obtained when offered
b. Information about other traumas in the child’s history	YES	NO		[] Standard agency protocol [] Obtained when offered
c. History of child’s involvement with other agencies	YES	NO		[] Standard agency protocol [] Obtained when offered
d. Duration of trauma/episodes of trauma	YES	NO		[] Standard agency protocol [] Obtained when offered
e. Specific details concerning the traumatic event(s)	YES	NO		[] Standard agency protocol [] Obtained when offered
f. Trauma reminders/triggers	YES	NO		[] Standard agency protocol [] Obtained when offered
g. Child’s internalizing, anxiety or depressive symptoms	YES	NO		[] Standard agency protocol [] Obtained when offered
h. Family/systems problems associated with the trauma	YES	NO		[] Standard agency protocol [] Obtained when offered
i. Family/systems problems resulting from the trauma	YES	NO		[] Standard agency protocol [] Obtained when offered
j. Child’s post-traumatic stress symptoms	YES	NO		[] Standard agency protocol [] Obtained when offered
k. Diagnostic Assessment of PTSD	YES	NO		[] Standard agency protocol [] Obtained when offered
l. Child’s externalizing/behavioral problems	YES	NO		[] Standard agency protocol [] Obtained when offered
m. Social, interpersonal, and school problems	YES	NO		[] Standard agency protocol [] Obtained when offered
n. Coping skills or strengths child possesses to assist in coping with the trauma	YES	NO		[] Standard agency protocol [] Obtained when offered
o. Other (specify):	YES	NO		[] Standard agency protocol [] Obtained when offered

11. What information does your agency provide about a child's trauma history when you send a referral to another agency? When considering trauma information, please consider all types of trauma, not just child maltreatment.

Interviewer: Refer to table below. Complete the following questions only for the YES responses:

11a. Overall, for what **percentage** of referrals does your agency provide the information?

11b. For cases in which information about the child's trauma is provided, what **amount of information** is provided?

11c. For each item, is the information provided as part of your **agency's standard protocol**, or if it is **provided when requested** by other agency?

	YES NO	% of Referrals:	Amount of Information	How provided (Select One):
a. Information about the referring traumatic incident	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested
b. Information about other traumas in the child's history	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested
c. History of child's involvement with other agencies	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested
d. Duration of trauma/episodes of trauma	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested
e. Specific details concerning the traumatic event(s)	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested
f. Trauma reminders/triggers	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested
g. Child's internalizing, anxiety or depressive symptoms	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested
h. Family/systems problems associated with the trauma	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested
i. Family/systems problems resulting from the trauma	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested
j. Child's post-traumatic stress symptoms	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested
k. Diagnostic Assessment of PTSD	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested
l. Child's externalizing/behavioral problems	YES NO		[] Minimal [] Some [] A lot	[] Standard agency protocol [] Provided when requested

m. Social, interpersonal, and school problems	YES NO		<input type="checkbox"/> Minimal <input type="checkbox"/> Some <input type="checkbox"/> A lot	<input type="checkbox"/> Standard agency protocol <input type="checkbox"/> Provided when requested
n. Coping skills or strengths child possesses to assist in coping with the trauma	YES NO		<input type="checkbox"/> Minimal <input type="checkbox"/> Some <input type="checkbox"/> A lot	<input type="checkbox"/> Standard agency protocol <input type="checkbox"/> Provided when requested
o. Other (specify):	YES NO		<input type="checkbox"/> Minimal <input type="checkbox"/> Some <input type="checkbox"/> A lot	<input type="checkbox"/> Standard agency protocol <input type="checkbox"/> Provided when requested

Training

12. Do employees at your agency receive training on any of the following topics?

- | | | |
|-----|----|---|
| YES | NO | The short-term impact of trauma on children |
| YES | NO | The long-term impact of trauma on children |
| YES | NO | How to assess for trauma in children |
| YES | NO | Relationship between parental/caretaker substance abuse and trauma |
| YES | NO | Information on parental/caretaker mental illness |
| YES | NO | Information on parental/caretaker trauma history |
| YES | NO | Special considerations in working with traumatized populations |
| YES | NO | Information about how other systems respond to children with trauma |
| YES | NO | Available evidence based treatments for children with trauma histories and their applicability to different child maltreatment populations. |

13. To what extent does your staff **utilize information** about a child's trauma history when interacting with the child?

- 1 None
- 2 A little
- 3 Some
- 4 Quite a bit
- 5 A lot

14. How often does your agency consider **expertise in trauma** when selecting a treatment provider or placement?

- 1 Never
- 2 Rarely
- 3 About half of the time
- 4 Most of time
- 5 Always

15. How often does your agency make referrals to a treatment provider or placement based on their **use of evidence-based practices** (methods that have been supported in outcome studies or that have been evaluated as effective)?

- 1 Never
- 2 Rarely
- 3 About half of the time
- 4 Most of time
- 5 Always

Interviewer: If interviewee selected 3, 4, or 5: Please list any specific evidence-based treatments you look for when making a referral.

16. From your perspective, how often does your agency interact with each of the following systems in responding to a child’s trauma-related problems? *Interviewer: answer separately for each system. Leave the interviewee’s own system blank.*

	1 Never	2 Rarely	3 About ½ of time	4 Most of time	5 Always	NA
a. Family or Dependency Court						
b. Public Child Welfare System						
c. Mental Health System						
d. School System						
e. Foster or Substitute Care system						
f. Foster Parent Association						
g. Other (specify)						

From your perspective, how well do you think the following systems interact and work with your agency in treating children’s trauma-related problems?	1 Very Poorly	2 Poorly	3 Average	4 Well	5 Very Well	N/A
h. Family or Dependency Court						
i. Public Child Welfare System						
j. Mental Health System						
k. School System						
l. Foster or Substitute Care system						
m. Foster Parent Association						
n. Other (specify)						

17. How much of a role does your agency play in **facilitating coordination** between the different service systems? Examples – hosting meetings, trainings, or case conferences, supporting liaisons positions between agencies, etc.

- 1 None
- 2 A little
- 3 Some
- 4 Quite a bit
- 5 A lot

The remaining questions examine facilitators and barriers to addressing trauma concerns.

18. Does your agency have any practices in place designed to **help** the child and his/her family deal with trauma more effectively? Please describe:

19. Does your agency have any practices in place that you believe may **exacerbate** the child or family’s experience of trauma? Please describe:

20. Do the other service systems **facilitate your work** in helping a child or family recover from traumatic experiences? Please describe:

21. Do the other services systems **impede your work** in helping a child or family recover from traumatic experiences? Please describe:

22. Are there other comments or feedback about trauma-related services that you would like to share