casey practice digest

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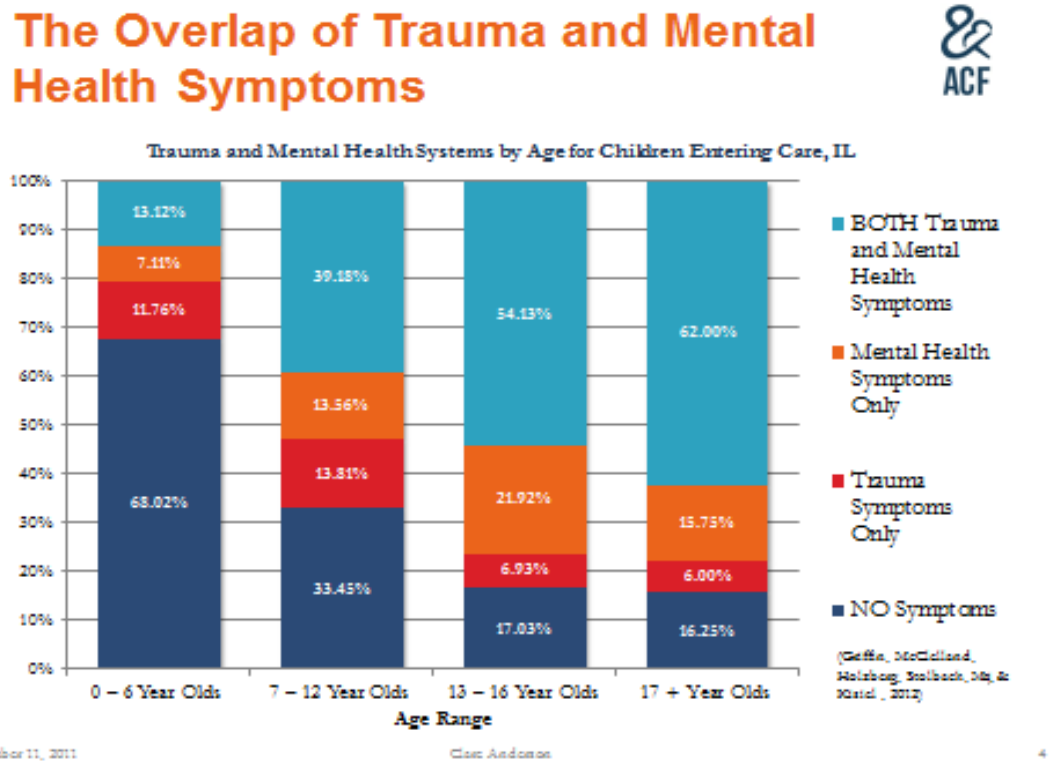

Chart developed by ACF, from: Griffin, G., McClelland, G., Holzberg, M., Stolbach, B., Maj, N. and Kisiel, C. (2012) Addressing the impact of trauma before diagnosing mental illness in child welfare. *Child Welfare*, 90(6): 69–89.

Trauma: Definition of Terms

What is Trauma?

According to the National Child Traumatic Stress Network (NCTSN), **Trauma** is an event. It is defined as, "extreme events that are threatening to physical safety or bodily integrity of oneself or loved one." **Acute Trauma** is a single event that is limited in time such as a car crash or a terrorist attack. **Chronic Trauma** refers to multiple traumatic events occurring over time. **Complex Trauma** is the exposure to a traumatic event and the subsequent development of a trauma reaction. Complex trauma can also be magnified by the trauma having been perpetrated or abetted by caregivers charged with protecting and caring for a child.

A **Trauma Reaction** is a response to a traumatic event, which leaves the person feeling terrified and powerless to respond. When this reaction becomes generalized to other situations, their normal response to danger becomes overwhelmed. Without a trauma reaction, trauma would not be a mental health problem. In fact, many persons who experience traumatic events will not develop a trauma reaction. In the Northwest Alumni Study approximately 25.2% of youth who were in foster care developed Post-Traumatic Stress Disorder (PTSD), even though most of them experienced a potentially traumatizing event (the child abuse or neglect that resulted in the attention of the child welfare system; the removal from their family; and occasionally further abuse or neglect that occurred while in foster care).[1]

It should be noted that the definition above addresses only the first criterion (stressor) of the Diagnostical and Statistical Manual of Mental Disorders (DSM) IV-TR definition of PTSD. The other five criteria include: intrusive recollection; avoidant/numbing; hyper-arousal; duration; functional significance.

These sequelae were initially understood as a result of the experiences of war veterans (PTSD was added to the DSM in 1980). Some experts state that trauma in the child population presents differently than it does for adults, with different symptoms and clustering of symptoms. Some researchers argue that trauma disorder definitions in the DSM are too narrow and exclude many children who may benefit from treatment, yet don't meet diagnostic criteria.[2] Additional criteria that have been proposed include: attachment concerns; biological concerns; disrupted affect regulation; cognitive problems; and behavioral control challenges.[3]

What is Trauma-Informed Care?

The term "**Trauma-Informed**" is often used to describe diagnostic criteria and service provider activities associated with responding to traumatic events. Bruce Perry discussed that there is no generally accepted definition for being a *trauma-informed* provider or system. While numerous instruments are available that can assist organizations in their journey towards becoming more responsive to trauma, none have been deemed the "gold standard." According to SAMHSA's National Center for Trauma-Informed Care:

When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers

[1] Pecora, Peter J., Roller White, Catherine, Jackson, Lovie J., and Wiggins, Tamera (2009). Mental health of current and former recipients of foster care: a review of recent studies in the USA. *Child & Family Social Work*, 14(2): 132–146.
[2] Kaminer, D., Seedat, S., and Stein, D.J. (2005). Post-traumatic stress disorder in children. *World Psychiatry*, 4(2): 121–125.
[3] For more information about PTSD and child traumatic stress, see the National Child Traumatic Stress Network (NCTSN) webpage: www.nctsn.org.

of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.[4]

The National Child Traumatic Stress Network defines a trauma-informed child- and family-service system as:

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

A service system with a trauma-informed perspective is one in which programs, agencies, and service providers: (1) routinely screen for trauma exposure and related symptoms; (2) use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) make resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and collaboration across child-service systems; and (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.[5]

[4] For more information on SAMHSA's National Center for Trauma-Informed Care (NCTIC), see: http://www.samhsa.gov/nctic/default.asp. For NCTIC's definition of Trauma-Informed Care, see: http://www.samhsa.gov/nctic/trauma.asp.

[5] For more information on NCTSN's definition of Trauma-Informed Care, see http://www.nctsn.org/resources/topics/creating-trauma-informed-systems.

Multiplying Connections, a Multi-Sector Trauma Initiative in Philadelphia

The Multiplying Connections program in Philadelphia serves as an example of progress towards developing Trauma-Informed Care. Established in 2007, the work of Multiplying Connections began a few years earlier, after a group of concerned leaders in health and child welfare became aware of the advances in research around trauma and adverse childhood experiences. Those professionals began meeting to discuss how to ameliorate the effects of trauma in children's lives so that they would be able to develop normally and live healthy, productive lives.

As a result of those discussions, Multiplying Connections was born, a multi-sector initiative aimed at enhancing the ability of child-serving systems in the Philadelphia area to address trauma. It was not enough to raise awareness regarding trauma; it was critical that the initiative identified practical strategies that professionals could use with children and their families. The activities of Multiplying Connections include:

- Creating a Cross-Systems Training Institute of professionals involved in public child serving systems to develop a group of local experts on developmentally appropriate practice, trauma prevention and trauma informed services.
- Developing policies, protocols, and practice standards that promote and support developmentally appropriate, trauma-informed practice and services for young children and their families.
- Evaluating outcomes by measuring whether the new strategies result in positive changes in policy and practice.

Several resources have originated from this collaborative endeavor sponsored by the William Penn Foundation and operated out of the Health Federation of Philadelphia. In 2008, Multiplying Connections created the Trauma Informed & Developmentally Sensitive Services for Children Core Competencies for Effective Practice. These standards set the bar for organizations in establishing a plan towards becoming more trauma-informed. Reviewed by experts in the field of trauma, including Dr. Vincent Felitti of the ACE Study and Dr. Gene Griffin of the Child Trauma Academy, these standards are currently used in hiring, program evaluation and training throughout Philadelphia County.

Multiplying Connections also sponsors cross-training that targets public health, social services, mental health and education systems. Developers of the curriculum tried to ensure that the learning does not occur in a one-off training, but rather through multiple opportunities to reinforce learnings. The trainings are also designed to be experiential and interactive so that participants can be challenged to apply the concepts they learn to real-life situations.

These are just a couple of the projects sponsored by Multiplying Connections. While this program represents a single version of a trauma-informed organization, many agencies who have an interest in addressing trauma histories of the kids and families they serve have called on Multiplying Connections as a role model for this work.[6]

[6] Multiplying Connections is led by Leslie Lieberman MSW, who can be contacted by email at info@multiplyingconnections.org.

Casey Practice Digest Interview #1:

A Conversation about Trauma Assessment and Intervention with Dr. Bruce Perry, author of The Boy who was Raised as a Dog, and Born For Love: Why Empathy is Essential and Endangered.

Which treatment programs or interventions have the greatest potential to help traumatized children involved in child welfare?

The programs and approaches that are flexible have the greatest potential. We tend to deliver our mental health services in a one-size-fits-all approach. In general, we usually develop treatment programs that are easy to export. That's one of the challenges of working in public systems—that the more flexible and the more individualized you become in the way you work, the bigger a challenge it is to distribute and disseminate that. There's always a tension between creating either an assessment or an intervention approach that is flexible enough to meet the needs of these incredibly diverse children, and the challenge of getting many sites to do that approach with fidelity. So, for example, there are highly manualized, easy-to-disseminate treatment models like trauma-focused cognitive behavioral therapy – which work best with single traumatic event or typical population samples (such as the majority of children following a school shooting or a natural disaster) and yet this "evidence-based" treatment is marginally successful with the most complex children who have myriad problems, many of them beyond the typical "mental health" domains (e.g., they have learning, speech-language, sensory integration and neuroendocrine problems all related to their trauma). Yet, because of the ease of exportability and the small evidence-base, a mental health system will use this one approach on every child with trauma—whether it is complex or simple. But, just because something is easy to learn and easy to study, doesn't mean it's the right thing to do for everybody. In my opinion, the treatment programs that have been most successful, and have the greatest potential to help children that have been maltreated or traumatized, are those that have the ability to have one foot in the emerging evidence-based practices, but also have one foot outside that—where you are able to be flexible and innovative.

The second core concept for programs is that they be fundamentally respectful of and aware of how important relationships are for children. These programs appreciate that how children learn, how they heal, and how they grow, is best understood in the context of relationships that are nurturing and attentive. A parallel part of that relationally-respectful approach is recognizing that you as the therapist, teacher, foster parent, or helping adult, you are not going to be in that child's life for 30 years. You are playing an important role, but we also need to identify and support the individuals who will have relationships with this child as they grow into adult life. And so, I always ask the question: Who is this child going to have Thanksgiving dinner with when he's 25? We need to think about how we can find that family, find those people, and you need to begin engaging them right now. We need to find people who will be in this child's life in an enduring way and build their capacity, and help them to understand the child. Because that's really where the long-term healing comes, in the relationships that are more permanent.

Can you discuss important discoveries regarding brain development during or following trauma that need to be understood by caseworkers, teachers, foster parents and others who work with maltreated children?

One of the important things to remember is that for a child who is very young and developing, and has had multiple adverse experiences, their stress response systems may be abnormally organized—these crucial systems work differently in maltreated children—and that, in turn, will underlie many of their emotional, behavioral, social and physical health vulnerabilities. One of the ways that they will be different is that their stress response system will be overactive and overly reactive to stress. One of the first implications is that because these systems are so important to many functions of the brain, they will

influence how multiple areas of the brain will develop, and then later on, how they will function. So, if you have a very young child who has experienced chaos, threats, trauma, attachment disruptions, these dysregulated networks will then play a role in contributing to abnormal organization of parts of the brain involved in speech and language, learning to read, forming relationships, some things as fundamental as coordination and fine motor control. As a result, probably the most important thing to learn about brain development for people who work with these children is that there will be an array of relative vulnerabilities in the way these children function that are caused by their dysregulated stress response systems. The reason that's important is because it essentially means that if you can begin to utilize strategies that help regulate those systems, interventions and activities that help those systems become better integrated, more smoothly regulated, then, you'll see improvement in a lot of areas of functioning.

The fascinating thing is, for example, if you have a child who has learning problems that are related to this dysregulation of the stress response, what is more effective for helping the child to learn how to read would be something like giving them an opportunity to walk several times a day, or giving them opportunities to make music several times a day, as opposed to sending them off to a tutor. Our typical response is: Billy has speech and language problems, let's send him to a speech and language therapist. We often don't understand that what's frequently underlying that problem are these dysregulated stress response systems. So, if we can help them to use regulating strategies, all of a sudden, they're better at relationships, they're better at learning, and a whole cascade of improvements can be seen from things that appear to be disconnected from those functions. This is something seen in other areas of neurology: if someone has a stroke, and part of the cortex is damaged and they lose the ability to speak, most people would think it is logical to provide remedial speech and language to help the person catch up and rebuild that part of the brain that was damaged. But, it turns out that if people do physical therapy, in other words, walk, swing their arms, and do typical physical therapy activities, they learn how to speak faster than if they just sit down and go to a speech therapist. And it's the same principle with these children, that many of the strategies that help them may seem to be counterintuitive, but if you understand the biology, it makes a lot of sense. For children in foster care settings, this is broadly referred to as physical hygiene. If you can help them to have good sleep, if you have structure for when you have meals, if you bring exercise into the day, if you bring sensory breaks into the day, it creates an external regulating structure that literally provides the template to organize the internal disorganization that many of these children experience.

How can foster parents and adoptive parents be better prepared to care for traumatized children?

One of the things that we find is that many of these parents have been really successful in the way they raised children who are typically organized. But, when they get children who have these trauma-related differences they will respond differently to typical parenting approaches. This will manifest, for example, in the way they deal with transitions, the way they distort interactions and process information differently. This can be very puzzling to the foster parents —*I've got 3 healthy children in the community and the parenting style that worked for them doesn't work with our foster child*. Part of our responsibility as professionals, is to teach adoptive and foster parents a little bit about the fundamentals of how these children are organized. So, we've been working really hard on the development of case-based training approaches, where we will have foster parents who will present or talk about a challenging problem or issue with one of their children, and then we will use that as a teaching vehicle to problem solve around that issue. We try to talk about what's going on in ways that allow the foster parent to generalize to different situations, and to recognize where the behavior is coming from, why they act that way. It's amazing how just a little bit of education about the trauma and brain–and the stress response, developmental trauma and few other key concepts–can help these foster parents become incredibly healing presences in the lives of these children. It's been our experience that didactic teaching tends to be nowhere near as effective as hands-on, real-life problem-solving. And so,

for example, we have a model program with New Mexico CYFD[7] where we have a web-based teaching opportunity, where foster parents from all over New Mexico, are able to get on a webinar, and we'll talk about a different foster family and child each month. Even though the problems about that specific child are going to be clearly that child's own issues, many of those are common to foster children throughout New Mexico.

What are a few prognostic indicators useful in identifying children and youth who are recovering or not recovering from early severe maltreatment?

Well, there are a few things we begin to see as very good evidence that children are becoming better regulated. One is sleep—a lot of these children when they come into an environment will have terrible sleep issues, including a difficult time falling asleep, waking up in the middle of the night and wandering around and sleeping few hours a night. When children start to become regulated one of the key indicators are changes in sleep—when they can start to fall asleep more readily, have good sleep patterns, and sleep through the night, that's a really good sign that there are significant positive regulatory changes in the key stress response systems.

The second is the more obvious, overt, externalizing behavior. A lot of children, when they're dysregulated, will have attentional problems, they'll be impulsive, they'll be aggressive, they'll be socially inappropriate, and as you see those things improve, that's an indication that something positive is happening.

But, overall, one of the most powerful indicators that meaningful progress is being changed is when the children begin to shift in the way they are relationally connected. It's actually hard to describe, but when you talk to foster or adoptive parents where that's happened, they know exactly what I'm talking about. They begin to feel a relational difference, where the children will be a little bit warmer, there will be more humor, more spontaneous laughter, they'll have a different quality of sincerity when they engage with each other. When the foster parents feel that, they know they've got the child back on a healthy developmental trajectory. One of the things you run into in disrupted placements is that you can even see times when the overt behaviors are better, but that relational connection hasn't happened. As a result, the foster family will be much more willing to let a child go, or want a child to go—even though there's not as much overt acting out, even compared to another child in their own home, which has been counterbalanced by this glue. That's an interesting and very powerful, very primitive recognition, that the child who still may be acting out a little bit, but who has this relational glue, is actually making more progress than the child who is disconnected, even if they are not as dysregulated.

What advice would you offer to child welfare caseworkers, supervisors and managers involved in helping efforts with traumatized children?

Well, the first thing that I think they should hear is that they are doing really hard work, and they need to be given permission to feel exhausted at times, to feel frustrated. But, the work they do is very important. Sometimes, even the tiniest contact with a client that has the quality of being honest and compassionate, can be something that child will draw on for the rest of their lives. I have literally been told hundreds of stories by foster children who are now adults, about a single contact with one person, whether it was a policeman, a caseworker, a night-nurse in the ER—those interactions can be powerful and transforming. One of the great qualities of the human brain is the ability to have memory. So, if you can remember and revisit a moment when you were really important to somebody, when you really felt that they cared about you, even though it was a brief interaction, that can give these children hope, in ways that can keep them in the game, so to speak. The saddest thing about these abused children is how much they give up. Their reactivity and their difficulties in relationships early on often gets them so discouraged and demoralized about school, about sports, about being part of a healthy group, that they

[7] New Mexico's Children, Youth and Families Department

choose to be marginalized, even when people want to pull them in. We see this all the time, you'll have a child who comes into a foster home, and the foster parent will be loving and consistent, and the child literally rejects that attention. That happens—in part, because they just give up—I'm unlovable. I'm stupid. Why should I try in school? Why should I try in sports? You're just going to move me. I'm just going to blow up. If you can make a child feel special, help them to understand they are special, help them find a little gift, something that they believe that they are good at, something that they can get some reward from—that can be a powerful thing in helping them to move forward in healthy ways. And although caseworkers have relatively brief interactions with children, they can still be really powerful in connecting with them and making an impact.

Bruce Perry, M.D., Ph.D., is the Senior Fellow of The ChildTrauma Academy, Adjunct Professor in the Department of Psychiatry and Behavioral Sciences at Northwestern University, and author of The Boy who was Raised as a Dog, and Born For Love: Why Empathy is Essential and Endangered.

Casey Practice Digest Interview #2:

A Conversation about Trauma Treatment and Resiliency with Deborah Gray, author of Nurturing Adoptions: Creating Resilience after Neglect and Trauma.

How can foster parents and adoptive parents be better prepared to care for traumatized children?

They can be better prepared just by understanding what symptoms of trauma look like at each stage of development in children. They need to look beyond specific behaviors and instead look for a cluster of symptoms—more difficulty settling in at night, nightmares, places that children avoid, dissociation, and a constant hyper-alert way of going through life. Looking at the symptom cluster, they would be able to get behind the behaviors to the actual causes. They could intervene to find out what is frightening children, and help calm them down, and make them feel safe. By the time you get to older children and teens, many times they've perfected the art of avoidance. You can see the affective dysregulation, that is the mood changes, but they're avoiding and putting up behavioral obstacles so that you don't know what's causing it. It just looks like irrational behavior, or misbehavior, when in actuality, they're trying to avoid something that scares them badly, or has a lot of negative feeling to it.

So, if we can recognize the symptoms early in children, then we can help with that constellation of traumatic memory, and help children to really see a before and an after—that the traumatic memory is really in the past. We keep our defenses up as long as we think we're still in a situation of threat. A lot of times our children have traumatic grief and that causes such a painful despair in them. We have to gradually help them process that grief and bring them close, so that they can grieve that loss. If the parent is really stuck on—well, why can't we get this kid to sleep, or why does this kid throw my lunches in the garbage can—without pursuing what's behind those behaviors, we stay stuck on the behavioral level.

Can you say more about traumatic grief and how that manifests for kids involved in the foster care system?

Most of our children, when they're moved from their birth parents, are moved suddenly. They're often moved with interventions that involve police. Many times, they've been traumatized earlier, or severely neglected earlier, so they don't have great stress regulation systems to begin with. And then, if they move suddenly, they've lost those people that they are closest to, and the things they are familiar with. What we know about children and grief is that children don't grieve with strangers. At the same time, they don't have the resources to grieve alone. When we see a child who is grieving for their birth parents, or relatives who were consistent in their lives, or an older brother or sister, if we don't surround that child with people they know and feel close to, they don't move into their grief process and grieve effectively.

If there are traumatic elements around the grief, frightening elements, then it's frightening for children to even think about the people who were lost to them. So, the result is that they really get stuck in this delayed grief reaction, Just by virtue of keeping children safe, sometimes we remove everything in their environment that made them feel known, loved, safe; that things were predictable. Then, they're really disoriented. Sometimes it takes 6 months or longer for a foster parent or a kin placement to get close enough to a child that they can begin to do their grieving. Sometimes our kin or foster parents are not prepared for the things they are going to hear from the child. And so they'll say things back like, "Oh, I'm sure they meant the best," or, "I know your mother loved you," which is very confusing for children because there's a disparity between where the adult is and what the child is thinking and feeling. So, we have to do a better job in helping parents to hear the ambivalent feelings that children have about the people lost to them—how they're angry with them, and yet, how they miss them terribly.

How can foster parents and adoptive parents help traumatized children gain control of their emotional reactions to stress?

We need to teach calming to children, just as a strategy. We tell children to calm down, but we don't teach them in a step by step way, or give them opportunities, or reward them for actually practicing calming. And then we need to practice real-time feeling of feelings, naming those feelings, and talking about feelings. It has to start with the child feeling and naming their feelings, and then later, talking about the effect their feelings have on others, and vice versa—how those feelings change once they feel mirrored back in the mind and heart of another. Also, when children name feelings, they move into the more linguistic areas of their brains. We need to practice helping children learn to cope. Many of them are dissociative, or they tantrum, or they avoid. But, if we can help them to cope with a situation and feel powerful, that is something that we can enhance in their development, so that they wouldn't have to rely as much on more negative choices. Instead of tantruming, I like to ask children to come up with ideas, or ask for hints with ideas, as to what they could do. That gives them a sense of self-agency, which is so valuable for all of us.

Can you discuss some resiliency factors for traumatized children, and ways that caseworkers, and systems, can better support resiliency?

Yes, stop moving kids so much—that would be one thing. We know that moves cause neuro-endocrine shifts in the brain. We also know that secure attachments have something to do with developing good attentional systems. We need to be working on the security of attachment as soon as possible. We know that children are sometimes going to be giving ambivalent signals or confusing signals to attachment figures. We need to really honor their attachments, help caregivers to stay sensitive to children, steady caregivers so that they can respond in a sensitive way, because that secure attachment will help children to settle and reset their psycho-biologic systems. Early on is also a good time to introduce therapy. One of the reasons we don't want to wait until children are older, is that they begin to consolidate the use of defenses. Instead, we want them to know that the past is really the past, as far as trauma goes, so that they can set aside defenses and begin to really use coping, and also start to enjoy life more. Childhood is a critical period in general, in terms of being able to explore life, find out what you're good at, learn how to connect with other people, and have some positive wiring run in your brain. Negative wiring continues to predominate in traumatized children. One of the things that happens when you process a lot of the trauma and make meaning of it, is that the meaning of self begins to become detoxified—for lack of a better word—you like yourself better. You tend to think of yourself in a more empathic, positive way, but also, you connect with the world in a more positive way. You're freed from all of the energies that make you distanced from others. It takes a lot of energy to distance from trauma, bundle it up, keep away from it, and a lot of that energy is freed up to just enjoy life and enjoy others. You're not afraid all the time, you're not avoiding life, you're part of the mainstream again. I want more of their childhood to be safe and to feel safe, where kids can actually like themselves.

In terms of other things that can foster resiliency, look for things that they are good at; where there is some sense of mastery, do more of those things. Teach them self-skills, how to calm, how to reach out to others for help, how to feel the feelings of another and act in accordance with those feelings. If we could pin down their learning disabilities, or work around them, what we would find is that many children actually have pretty good genetic potential, and we can get them caught up academically. We need to teach our parents how to navigate the IEP system, how to advocate for their children, and we need to have more neuro-psych testing done for our kids. It's pricey in the beginning, but it really pays off, as far as accommodating children, and getting them to do well in the educational system, and believing in themselves. Good ethnic identity, strong belief in themselves and their ethnicity, strong positive connection within their ethnic group is important. And then there's Learned Optimism, that's a big one. That's a resiliency quality that really needs to be supported after children have been neglected.

Can you say more about Learned Optimism?

We need to set by example, “Oh, that feels good to get that done,” or, “I wonder what good things will happen today,” or, “That was something good that I didn’t expect.” You learn how to have a positive frame of mind, to be optimistic, to look for the unmet friend, to notice the positive. In the early developing structures of the brain, our kids tend to run too much wiring in being fearful, ashamed, sad, bored, or lonely. We have to really support the development of positive frameworks, optimistic viewpoints, in order to run new wiring. For some kids, we have them come up with calendars, and then they write two good things that happen every day. At the end of the month, one girl looked at the calendar and said, “Look, my life has turned from sad to happy.” But, we have to support a schema that your life story can change. Unfortunately, once we have a schema for how life works, we tend to store things that are true to the schema. With the child, we have to develop a sense that their life has changed in some way, that there’s been an intervening variable of some kind, and help them to identify it.

What are some ways to restore moral development or conscience to traumatized children who seem to lack concern or guilt about hurting others?

You teach children to have empathy for themselves, for what they’ve suffered through. They internalize an internal caring voice, which is often your voice. They’re able to share the shame and the hopelessness, and also, that they are deserving of something better. In their narrative, they are able to access that empathy and share it outwards with others. Part of the therapeutic process—whether done by foster parents, adoptive parents, caseworkers, or therapists—is to begin to help children to recognize when other people feel a certain way, and help them identify in their life story when they experienced or felt something similarly. What did they wish someone had done for them? How can they do that for someone else? Trauma can make people brutal, but trauma work opens up the opportunity for sharing compassion and caring for other people. Then, they can begin to access a sense of compassion towards themselves and memories of care, so that they can be compassionate towards others. So, yes, trauma or loss is where the damage is, but they are also where the child’s gift to the community can be.

Deborah Gray, a clinical social worker specializing in the areas of attachment, grief, and trauma, is the founder of Nurturing Attachments, and the author of Nurturing Adoptions: Creating Resilience after Neglect and Trauma, and Attaching in Adoption: Practical Tools for Today’s Parents.

Title IV-E Waiver Demonstration Projects and Trauma-Informed Care

At the time of the application deadline for 2013 Title IV-E Waiver Demonstration Projects, 22 states are either extending an existing Waiver (CA, FL, IN, OH, OR), have been approved and are working toward Waiver implementation (AR, CO, IL, MA, MI, PA, UT, WA, WI), or are currently working toward approval of a new Waiver application (DC, HI, ID, MT, NE, NJ, NY, RI).

One area of priority for new Waiver Demonstrations, includes assessing for, addressing, and reducing trauma and the effects of trauma. Several jurisdictions are moving towards developing trauma-informed child welfare systems. Of particular note is the use of functional assessment tools. Child welfare planners recognize that child/family-level data, as well as system-level data, are essential for identifying needs, effective interventions, and appropriate investments. A regular and routine use of functional assessments can help planners with these goals. The table below summarizes the nine approved 2012 Waiver states' activities.

State	Target Population	Demonstration Project Highlights
Arkansas	Statewide, with 8 counties in Year 1. All children referred to CWS regardless of removal status or eligibility for assistance	Building on existing collaborations (University of Arkansas for Medical Sciences' (UAMS), Arkansas Building Effective Services for Trauma (AR BEST)) to provide trauma-informed care. Currently researching several screening tools and functional assessments. Plans to identify and implement more treatment programs capable of meeting the needs of children, youth, and families affected by trauma.
Colorado	Statewide, all children with screened-in reports of abuse or neglect and those already receiving services through an open child welfare case	Family engagement, trauma-informed child assessment, and trauma-focused behavioral health treatments will be integrated into and coordinated with existing initiatives in Colorado to create a trauma-informed system of care. Individual counties will implement other service interventions based on local needs and readiness to implement.
Illinois	Cook County, children ages 0-3 in out-of-home placement and their caregivers	Provide evidence-based interventions (EBI) to enhance caregivers' capacity to respond to the regulatory, emotional, and behavioral needs of the young child. Guided by screening and assessment of children and families, the waiver demonstration will incorporate three EBIs: Child-Parent Psychotherapy for children with the highest level of risk/need and their caregivers; Nurturing Parenting Program for moderate risk biological parents; and Circle of Security for moderate risk caregivers. A variety of screening tools are under review as possible replacements and/or additions to the current measures that are being used.
Massachusetts	Statewide, children and youth ages 0-21 transitioning out of congregate care settings into the community, as well as those at risk of congregate care placement, and their families	Follow Along Services, intensive home-based interventions to prepare for residential placement, as well as following the transition back to the home/community; Stepping Out Services, ongoing supports for youth transitioning to independent living settings; Continuum Services, intensive supports to children and youth at risk for residential placement and their families; and Family Partners, which are available to all families on a voluntary basis.
Michigan	Kalamazoo, Muskegon, and Macomb counties, families with children	Efforts to expand its secondary and tertiary prevention service array. Under the waiver, private agency contractors will be required to administer a trauma screening tool and, when indicated, refer

State	Target Population	Demonstration Project Highlights
	ages 0-5 determined by the child welfare agency to be at high and intensive risk for maltreatment and in need of longer-term services	children and families for comprehensive trauma assessments and interventions. Following assessment, a clinician will determine whether intervention would be appropriate.
Pennsylvania	Philadelphia, Allegheny, Dauphin, Lackawanna, and Venango counties. All children ages 0-18 who are in foster care, discharged from care, or are receiving in-home services (at-risk of entering foster care)	Scaling up the use of Parent-Child Interaction Therapy (PCIT) and Multi-Systemic Therapy (MST). Also expanding the use of several assessment tools, including the Child and Adolescent Needs and Strengths (CANS) Assessment, Service Process and Needs (SPANS), the Ages and Stages Questionnaire (ASQ), the Child and Adolescent Functional Assessment Scale (CAFAS), and the Restriction of Living Environments Measure (REM-Y). Additional interventions and practices may be implemented by counties based upon local need.
Utah	Statewide, all children and families who require ongoing services, based upon SDM assessments. Possible expansion to children entering for juvenile delinquency or in need of reunification services	Three primary components: 1) the implementation of an evidence-based child and family functional assessment tool; 2) the development and implementation of caseworker tools and training, including a focus on trauma-informed practice, screening and assessment as well as strengthening families' protective and protective factors; and 3) increased community coordination and implementation of evidence-based programs including the implementation of at least one new evidence-based or evidence-informed in-home service.
Washington	Statewide, families of low to moderate risk to the child's immediate safety, health and well-being, who are able to have their children safely remain in the home, with the help of services and supports.	Family Assessment Response (FAR), a differential response pathway for screened-in allegations of abuse and neglect. Three primary components: 1) a comprehensive assessment of the child's safety, health and well-being and any barriers the family faces in keeping the child safely at home; 2) concrete supports and voluntary services, such as housing vouchers, food, clothing, and utility assistance, mental health services, drug and alcohol treatment, and medical and dental care; and 3) linkages to an expanded array of evidence-based programs and services that promote family stability and preservation.
Wisconsin	Initial implementation in Milwaukee County with all newly reunified children and families. The state may then expand these activities to the 71 other counties targeting children aged 0-5.	Wisconsin has been involved in implementing trauma-informed services for a number of years, creating a base of trauma-informed service capacity. The demonstration project will focus on the development of individualized 12-month post-reunification plans. The plans include, as appropriate, trauma-informed evidence-based practices such as Parent Child Interaction Therapy (PCIT); Child-Parent Psychotherapy (CPP); and Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Additional services may include crisis stabilization; in-home therapy; substance abuse and mental health services for parents; and linkages to other community services.

Funding for Trauma-Informed Care:
Integrating screening and assessment practices into the routine provision of health care for foster children

In recent years, many child welfare agencies have developed initiatives to imbed trauma-informed thinking in their casework practices. A child welfare agency's initial interactions with a maltreated child include screening and assessment. For example, Illinois data indicates that young people enter the child welfare system with a complex array of behavioral symptoms and needs.[8] Behavioral health symptoms, especially externalizing "acting out" symptoms, may be only part of the story. Often, these symptoms are a response to complex trauma the young person has experienced.

Complex trauma fundamentally affects a young person's ability to develop and maintain relationships. Research demonstrates that healthy relationships are essential for social and emotional well-being, and ameliorating the impacts of complex trauma seen by some as a critically important function of child welfare agencies.

A robust and useful screening and assessment protocol in child welfare practice will adhere to a few main tenets:

- An array of screening and assessment options should be available.
    - Agencies need flexibility to meet the needs of the various children they serve and to be attentive to children's life experiences. Age, cognitive functioning, temperament, assessment history and available historical information are some factors that commonly affect screening and assessment. A variety of tools allows clinicians to better address these factors and arrive at meaningful conclusions about children's needs.
- Screening and assessment should occur periodically at regular intervals, not at a single point in time.
    - Creative, flexible, and individualized case planning requires real-time information and access to data. In particular, lengths of stay in care, moves into, out of, and within care, and decreases or increases in adaptive functioning are opportunities to initiate screening and assessment.
- Screening and assessment tools are clearly related to the agency's vision and goals for child well-being.
    - Screening and assessment tools initially provide important individual-level information about child functioning to support comprehensive case and treatment planning. Additionally, many tools (CANS, CAFAS, for example) provide population-level data that can be useful for agencies in the allocation of resources and development of programs. Assessment data can also provide objective information about the efficacy of the interventions used – *have youth and families improved after an episode of care*? Assessment data also provide information about population-level needs: *what are the most pressing issues for babies, preteens, and teens served by the agency*? Child welfare agencies are best served when a functional assessment capable of providing population-level data is included in their suite of screening and assessment tools.

Funding:

As needs are identified through screening and functional assessment processes, Medicaid is a primary source of reimbursement for the medical services that children and youth are referred to, including those who have experienced trauma or have other behavioral health needs.[9] The Early and Periodic

[8] See chart on page 1 of this issue, titled: "The Overlap of Trauma and Mental Health Symptoms."
[9] Teich, J.L., Buck, J.A., Graver, L. and Zheng, D. (2003). Utilization of public mental health services by children with serious emotional disturbances. *Administration and Policy in Mental Health* 30(6): 523-534.

Screening, Diagnostic, and Treatment (EPSDT) benefit requirements apply to Medicaid eligible children under age 21, including Medicaid reimbursement for covered services (listed at section 1905(a) of the Social Security Act).[10]

Under the EPSDT benefit, eligible individuals are required to be provided periodic screening services (e.g., well child exams) as defined by statute. Additionally, as the statute states, other necessary health care, diagnostic services, treatment and other measures coverable under the Medicaid program must be made available to "correct or ameliorate" any physical and mental illnesses or conditions identified through the screening services, whether or not the services are covered under the state plan.

The EPSDT benefit is Medicaid's comprehensive preventive child health service designed to make health care services available and accessible, and to assist eligible children and their families to effectively use their health care resources. The preventive intent of EPSDT ensures that health problems, including behavioral health issues, are diagnosed and treated early before they become more extreme and their treatment more costly.

One required element of screening services defined in section 1905(a) is "a comprehensive health and developmental history (including assessment of both physical and mental health development)." If, during a routine periodic screening, a provider determines that further assessment is needed, the child should be referred to an appropriate provider who can furnish any additional necessary diagnostic and/or treatment services under the EPSDT benefit.

Since children in foster care are categorically Medicaid-eligible, reimbursement would be available for covered services identified through mechanisms like EPSDT and delivered via service-delivery approaches such as those described below.

States may also design benefits to meet the needs of children with behavioral health needs and take into consideration special populations and local strengths and challenges. Enhanced Federal Financial Participation (FFP) is available for certain new services authorized by the Patient Protection and Affordable Care Act (ACA), as noted below.

Fee-for-Service

Except for federal rules requiring sufficient fee-for-service provider payments and equal access, states have flexibility within broad Federal requirements to set rates for covered services.

To help keep participants well, starting in 2013, section 4106 of ACA provides state Medicaid programs an **enhanced federal match for use of preventive services** that meet U.S. Preventive Services Task Force's (USPSTF) guidelines for effectiveness. Included among clinical preventive health care services are screening for depression, alcohol misuse counseling, and other mental health needs.[11]

Medicaid Waivers and Plan Amendments

In addition to services covered under section 1905(a), there are other Medicaid authorities that provide opportunities to meet individuals' behavioral health needs. Section1915 (i), State Plan Home and Community-Based Services (HCBS), permits states to provide a full array of home and community-based services to individuals who do not qualify for an institutional level of care but have significant needs, which can include individuals with mental health conditions, among others. Section 1915(c), home and community-based services waiver programs, encompass similar services and serve individuals with significant needs who meet institutional level of care criteria. Services and supports

[10] For more information, see: http://www.ssa.gov/OP_Home/ssact/title19/1905.htm.
[11] For more information, see: http://www.uspreventiveservicestaskforce.org/3rduspstf/behavior/behsum1.htm

beyond those covered under the state plan may include psychosocial rehabilitation, respite care, transition services and social skill development.

Managed Care

Managed care plans are used to deliver Medicaid-covered services in 38 states. In these states, the managed care plans are required by contract to deliver covered services as well as provide care management and coordination activities. States receive approval from the Centers for Medicare and Medicaid Services (CMS) to operate a managed care delivery system–either through the State Plan, waivers or demonstration projects.

Managed Care entities bring novel, flexible, and outcome-driven approaches to health care that can benefit special populations, like traumatized youth, in particular. All Managed Care entities are operated through a contract with the State Medicaid agency that is periodically reviewed and amended by state staff. Child welfare administrators should seek opportunities to participate in reviews and revisions.

Health Homes

Section 2703 of ACA provides states with the option to create health homes. Health Homes providers will seek to integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. While this option is not limited to children in foster care, health homes cover Medicaid-eligible individuals with chronic conditions, including mental health disorders. This option qualifies a state for an enhanced federal match on these services for eight quarters, and provides an opportunity for states to create models of care that better integrate preventive, primary, acute, mental health and long term services and supports for persons with chronic illness.

In collaboration with SAMHSA, CMS has developed a guidance document[12] to assist states in evaluating their preparedness for implementing health homes for individuals with behavioral health needs. The state of Wisconsin is embarking on the nation's first child welfare focused health home through the implementation of a 1937 State Plan Amendment. This model will allow foster youth who are in out-of-home care or who are entering care to receive coordinated, expert, high quality and cost efficient care.[13]

Finally, of particular note is the recently released CMS bulletin regarding services and good practices for individuals with a behavioral health disorder: "Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders.[14]"

[12] To access SAMHSA's guidance document titled: "Health Homes and Individuals with Behavioral Health Issues, SAMHSA's Guidance Document Affordable Care Act Health Home Provision," see: http://www.samhsa.gov/healthreform/docs/Guidance_Doc_Health_Homes_Consultation_Process.pdf.

[13] For more information on Wisconsin's State Plan Amendment, see: http://www.dhs.wisconsin.gov/mareform/foster/FosterCareMedicalHome.pdf

[14] CMS Bulletin available at: http://content.govdelivery.com/attachments/USCMS/2012/12/03/file_attachments/178580/CIB-12-03-2012.pdf

ACYF's Funding Opportunities to Improve Access to Evidence-Based Mental Health Services in Child Welfare

Under Commissioner Bryan Samuels' leadership, the Administration for Children, Youth and Families (ACYF) is seeking to strengthen the capacity of child welfare systems to improve the social and emotional well-being of children. Central to this effort is an emphasis on trauma: "Across Federal agencies, preventing trauma and mitigating its impact on healthy development is a growing priority."[15] Accordingly, ACYF has aligned its funding opportunities around this new vision. In FY 2012, these funding opportunities included nine Title IV-E waiver demonstration projects and $46.6 million in discretionary grants to states, tribes, territories and local entities.

In FY 2012, approximately $5.7 million in discretionary funding was allocated for nine grantees to improve child welfare systems' capacities to provide effective mental and behavioral health services to children and families, with a particular emphasis on addressing the effects of trauma. In FY 2011, five grantees received a total of $3.2 million for this purpose. The mental and behavioral health grants are intended to support the implementation of trauma-focused treatment models and encourage grantees to divert existing resources away from ineffective interventions and into evidence-based services.

The 14 grantees from FY2011 and FY2012 have each identified a target population within the child welfare system and are using or planning to use a variety of techniques and practices to improve mental health outcomes, including

- Training and consultation for child welfare agency staff, caregivers, court personnel, primary care physicians and other private providers on ways to improve mental health outcomes;
- Universal trauma screening, assessment and referrals;
- Culturally responsive prevention, detection and treatment;
- Scaling up evidence-based practices while descaling practices that don't work; and
- Improved monitoring of psychotropic medications, among others.

The projects will implement a wide variety of evidence-based practices, including Trauma-Focused Cognitive Therapy (TF-CBT), the National Child Traumatic Stress Network's Child Welfare Trauma Toolkit (CW TT), and Child-Parent Psychotherapy (CPP). Each project includes an evaluation component. The following table identifies the ACYF Discretionary Grantees from FY 2011 and FY 2012:

FY 2011 Grantees	FY 2012 Grantees
MA Department of Children and Families	Western Michigan University
NC Division of Social Services	Dartmouth College (NH)
CT Department of Children and Families	NYU School of Medicine
National Native Children's Trauma Center at th University of Montana	Rady Children's Hospital-San Diego
University of Colorado at Denver	University of Washington
	Franklin County Children Services (OH)
	Tulane University (LA)
	DC Child and Family Services Agency
	OK Department of Human Services

[15] Administration for Children and Families (2013). "Integrating Safety, Permanency, and Well-Being for Children and Families in Child Welfare: A Summary of Administration on Children, Youth and Families Projects in Fiscal Year 2012," available at: https://www.acf.hhs.gov/sites/default/files/cb/acyf_fy2012_projects_summary.pdf.

Casey Practice Digest Book Review:
Collaborative Treatment of Traumatized Children and Teens, by Glenn Saxe, B. Heidi Ellis, and Julie Kaplow[16]

The strength of this book is the authors' clear and cogent explanation of traumatic stress as "a disorder of the regulation of emotional states." According to the authors, "survival is at the core of traumatic stress" which "is enacted at the moment we perceive that our lives are in danger …" However, histories of trauma distort survivors' capacity to accurately perceive danger so that "The individual's brain and body are responding to a past life threat in the present." Traumatized children's response to perceived danger "can be immediate, extreme and outside of conscious control," set off by a trauma trigger and processed through the "low road" survival circuit that utilizes the *amygdala*, a part of the brain that "prepares the body for emergency responses." The advantage of the "low road" emotional processing of the *amygdala* is its speed. "This pathway is unconscious and does not contain contextual information." Experiences of threats in this system are decontextualized and highly fragmented. Survivors may have little or no memory of their actions during these survival-in-the-moment episodes.

The "high road" survival circuit, on the other hand, utilizes the cortical areas of the brain and memory systems to process danger signals, assess the degree of threat and transmit signals to the *amygdala* regarding safety or danger. The "high road" survival circuit makes use of context and explicit memories to evaluate possible threats; for this reason, the "high road" is slower to respond to threats but more accurate in its appraisal of situations, according to the authors.

Given this understanding of trauma, much of this book is about helping children develop the capacity for "high road" responses to perceived threats. The authors provide a useful discussion of a goal of infant development related to emotional control. They write: "A key job of the infant is to attain control over the switches between emotional states so that a more desired state is maintained for longer periods of time and across different situations;" and "The parent's role is to help the infant transition from less desired states to more desired states," by responding to the baby's distress and "leading him / her back to a calm state." The authors maintain that "When parents do this hundreds or thousands of times, the young child learns how to calm and self soothe." However, in abusive or neglectful families "the parent on whom the infant depends for calming and soothing is either causing the distress or ignoring it." For this reason, abused and neglected children often have serious long-term problems in regulating emotional states, the authors maintain.

The authors focus on a "trauma system" that consists of (a) the traumatized child's difficulty in regulating emotional states, and (b) the inability of the social environment and/or system of care to help the child effectively manage these emotional states. The authors provide an analysis of emotional states which includes awareness, affect and action. Caregivers and professionals can help children to become conscious of what they were aware of, their feelings and their actions, both immediately prior to and during survival-in-the-moment "melt downs" or dissociated states of mind. Little by little, children and their caregivers can identify trauma triggers that lead to "revving" emotional reactions as children move into a survival mode that may include extreme behaviors, with the goal of regaining conscious control over these responses to perceived threats.

The authors outline an approach to trauma treatment focused on changing the social environment to help children regulate emotional states. Their Trauma Systems Therapy (TST) approach goes well beyond addressing a narrow range of PTSD symptoms in a mental health setting. TST is about redesigning social environments, especially family life and schools, to help children feel safe and learn the emotion regulation skills they will need to effectively cope. These skills are needed in order to

[16] Saxe, Glenn, Ellis, B. Heidi and Kaplow, Julie (2007). *Collaborative Treatment of Traumatized Children and Teens.* New York: Guilford Press.

effectively respond to challenging and novel social environments, where children must be able to cooperate and compete with others without losing self-control.

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