Chapter 1
Introduction: Developing Trauma Sensitive Child Welfare Systems

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Achieving trauma-informed child welfare systems and services is a major challenge facing child welfare at the beginning of the twenty-first century. Bryan Samuels, former Commission of Administration on Children, Youth and Families, states that "The research is clear that the experience of abuse or neglect leaves a particular traumatic fingerprint on the development of children that cannot be ignored if the child welfare system is to meaningfully improve the life trajectories of maltreated children, not merely keep them safe from harm" (Samuels, 2011).

Much has been studied, advocated, and written about the trauma history and needs of children coming into the child welfare system (Kisiel, Ferenbach, Small, & Lyons, 2009; Kolko et al., 2010; Greeson et al., 2011; McMillen et al., 2005). Harris, Lieberman, and Marans (2007) noted that most children with trauma histories in child serving systems like child welfare do not receive mental health treatment. There is a genuine concern among both practitioners and researchers about how to better serve traumatized children and families (Ai, Foster, Pecora, Delaney, & Rodriguez, 2013; Black-Pond & Henry, 2007; Hendricks, Conradi, & Wilson, 2011; Ko et al., 2008).

Recently, The Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) identified six key principles to guide a trauma-informed approach: (1) safety; (2) trustworthiness and transparency; (3) peer support and mutual self-help; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) attention to cultural, historical, and gender issues. In addition, the National Child Traumatic Stress Network has created a policy statement for the development of trauma-informed child welfare systems as follows: "Increasing knowledge and building skills among caseworkers and other child welfare person-

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nel are critical to identifying and providing early intervention for children traumatized by maltreatment." (http://www.nctsn.org/sites/default/files/assets/pdfs/Service_Systems_Brief_v1_v1.pdf). These principles and policy statement do not, however, provide sufficient direction for child welfare agencies in regard to *how to* apply these.

Trauma theory offers a conceptual framework to guide a process for more effective infusion of knowledge about trauma, its impact, and empirically supported interventions in child welfare agency practice with children and families. This framework also provides a foundation for understanding the impact on staff working with traumatized children and families in child welfare. In this chapter, the literature on trauma, its impact, and the nature of effective trauma treatments is used to highlight the types of revisions needed in child protection, preventive, foster care, and adoption services.

The Relevance of Trauma Theory and Knowledge

The Impact of Trauma

Trauma is defined as an adverse life experiences that overwhelm an individual's capacity to cope and to adapt positively to whatever threat they face. "Traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory. Moreover, traumatic events may sever these normally integrated functions from one another." (Herman, 1992) We now know that these experiences can cause debilitating behavioral and health difficulties in adulthood (Felitti et al., 1998) as well as adverse outcomes for older youth (McMillen et al., 2005) and adults emerging from the foster care system (Pecora, 2010). The complex impact of trauma on children and families is well articulated (Cook et al., 2005, Courtois, 2004). When children have been exposed to chronic and/or severe trauma, functioning is often compromised across a number of domains (Lieberman & Knorr, 2007).

Of primary concern is the effect on the development of secure attachment (Blaustein & Kinniburgh, 2010), but affective, cognitive, behavioral as well as somatic functioning is typically impacted along with the child's attachment (Cook et al., 2005; Lieberman & Knorr, 2007). The child's perception of self and others may become distorted and the world in general viewed as unsafe. As children and adolescents seek to cope with these adverse experiences and changed worldview, they may employ avoidance strategies, demonstrate hyperarousal to trauma reminders, and have difficulty modulating feelings or regulating behavior. Interpersonal relationships may be perceived as a source of danger, leading to isolation or hostile interactions with others (Cook et al., 2005; Lieberman & Knorr, 2007; Saxe et al., 2007).

A history of abuse and neglect brings children to the attention of the child welfare system. We now know that a majority of children and often their primary caretakers

(Chemtob, Grifing, Tullberg, Roberts, & Ellis, 2011) have experienced trauma. Kolko et al. (2010) found that while the prevalence of posttrauma stress symptoms was on average 12% in a national sample of children referred to child welfare, the rate was almost double for children entering care (19.2% for out of home and 10.7% for those maintained at home). Critical to the experience of trauma is the child's sense of betrayal when the abuse or maltreatment has occurred at the hands of a parent or caretaker. When an intervention placing children in out-of-home care in order to keep them safe inadvertently place the child at further risk for secondary adversities (Appleyard, Egeland, van Dulmen, & Sroufe, 2005) the social contract dictating that a child should have been safe in any substitute care arrangement provided by the state has been breached. Children are then often faced with many new challenges, losses, and stressors. The cumulative impact of these stressors, if unaddressed, often leads to additional emotional difficulties and behavioral disruptions. The challenge for child welfare is to offer children and their families trauma-sensitive services while preparing and sustaining staff impacted daily by direct and vicarious exposure to traumatic events.

The experience of overwhelming danger that occurs at the time of a traumatic event affects the body's neurobiology, which mobilizes to ward off danger, often through fright, flight, or fight responses (Perry, 2008; Saxe et al., 2007). With severe and persistent trauma, even when the child is safe and regulated, the body responds to associations – an event, person, smell, sound, or activity – with past dangers as if they are occurring in the present. For the child and those around him – parents, caregivers, teachers, and peers – these inadvertent, automatic responses to past events can appear unprovoked. It is these reactions to trauma triggers that caregivers and staff need to be attuned. According to the US Substance Abuse and Mental Health Services Administration (SAMHSA) "trauma informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization" (SAMHSA, 2010). The need to put into place trauma-informed services is foremost for child welfare agencies.

If emotional well-being is defined in regard to the internal life of the child, social well-being is focused on the external environment. A trauma-informed definition of social well-being for a child or adolescent rests on the establishment of a secure attachment with at least one primary caregiver. Social well-being is reflected in peer relationships, and there is evidence that children with at least one close friend and who can maintain friendships over time function better. Children who are supported in school achievement through the communication of positive expectations have been found to do better (Lipschitz-El, 2005). From a trauma perspective, children living in safe, protective, and nurturing families, where family values and socialization practices encourage a child's sense of efficacy, promote responsibility and facilitate support from extended family networks as well as the community at large, are more likely to flourish (Werner & Smith, 2001).

Successful Trauma Interventions

We know a great deal about what works effectively with traumatized children, adolescents, and adults that can be used to inform the development of a trauma-informed workforce. There are a number of evidence-based trauma treatments which have been found to be effective with maltreated and violence-exposed children. (Chaffin & Friedrich, 2004; Cohen, Mannarino, & Deblinger, 2006). While there is varying emphasis across empirically supported trauma treatments, common elements found in most include attention to safety, regulating emotions, achieving behavioral control, addressing cognitive distortions, building or sustaining attachment relationships, processing and integrating the traumatic experiences, and attending to posttrauma growth. Posttrauma growth can be understood as an increase in mastery, competency, and self-esteem (Blaustein & Kinniburgh, 2010; Saxe et al., 2007; Strand, Hansen & Courtney, 2013).

Phase-oriented trauma treatment is widely accepted as a defining characteristic of trauma-informed interventions (Brown, Scheflin, & Hammond, 1998, Courtois, 2004) and has been utilized as a framework in treatments for children in the child welfare system (Collins, Strieder, DePanfilis, Tabor, Clarkson, Linde, & Greenberg, 2011). The names given to phases of treatment may vary but the phase-oriented dynamic is present. Most interventions acknowledge either explicitly or implicitly a stage-oriented approach for effective intervention which includes:

1. Stabilization: the establishment of physical safety and emotional stabilization, characterized by an emphasis on the present; a focus on trauma-informed assessment and the development of adaptive coping strategies to better modulate affect dysregulation, stress responses, behavioral dysregulation, and cognitive distortions. The focus is on the here and now.
2. Integration: Processing traumatic memories and experience with the goal of reducing their impact on current functioning; characterized by a focus on acknowledging the reality of traumatic events, harmful relationships, and making meaning of past events. Implicit in the stage is the achievement of a secure attachment relationship. The focus is primarily on the past.
3. Consolidation: Return to a normal developmental trajectory, characterized by the consolidation of personal and interpersonal growth and mobilization of energy to focus on developmental tasks for the future. The focus is on the future.

Trauma-focused cognitive behavioral therapy (Cohen et al., 2006), is an example that aligns with this phase-oriented approach. It is a trauma intervention receiving the highest scientific rating on the California Evidence-Based Clearing House for Child Welfare, http://www.cebc4cw.org/search/results/?scientific_rating[]=1&q_search=Search&realm=scientific_rating) and is rated by SAMHSA National Registry of Evidence-based Programs and Practices as a program with effective outcomes (http://nrepp.samhsa.gov/AdvancedSearch.aspx).

TF-CBT is an example of an evidence-based trauma treatment which illustrates the phase-oriented nature of intervention. The TF-CBT treatment components that

fit into the "stabilization" phase are psychoeducation, parenting skills, relaxation, affect expression and modulation, and cognitive coping and processing. Their "integration" phase trauma processing component is defined as a "trauma narrative", followed by cognitive coping and processing II, in vivo mastery conjoint child–parent sessions components. Their "enhancing future safety" component can be thought of as a consolidation element.

The child welfare outcomes of safety, permanency, and well-being align with this conceptual framework for phase-oriented treatment. Safety is achieved through stabilization, permanency through integration and well-being through consolidation of the traumatic experiences. In terms of the impact of trauma on the child, integration of the trauma experience can only happen once the child is safe and stabilized. Attention to well-being, however, is an iterative process and can begin during the stabilization phase, as children are helped with stress reduction and emotional regulation. A complicating factor for child welfare is that both birth and foster parents (kinship and nonkinship) may have their own unresolved trauma experiences, as well as additional psychosocial problems and stressors (substance abuse, homelessness, serious mental illness) which they will need help addressing in order to provide a psychologically safe environment for the child. Without the integration of the traumatic experience, attempts at reunification may fail, or foster placement, even adoption, be disrupted. Permanency can be achieved through the integration of traumatic experiences, and the role of primary caregivers – birth parents, foster parents, or adoptive parents – is crucial in this process. Consolidation is the foundation for child well-being, as it positions the child and primary caregiver to continue the developmental trajectory with emotional energy freed to direct to on-going maturational tasks.

Resolution of the impact of exposure to trauma will help a child move toward emotional and social well-being. Emotional well-being, using a trauma lens, is defined as the successful integration of traumatic experiences, resulting in emotional and psychological energy being available for the child or adolescent to attend to the developmental tasks at hand, free form preoccupation with danger and safety. The diminishment of internal arousal to trauma reminders, coupled with mastery of coping strategies to deal with some unavoidable physiological and emotional arousal, positions the child or adolescent to bring appropriate affect, attention, and action to the educational, peer, and family challenges facing him or her. It is the attention to these coping strategies which begin in the stabilization phase. Additionally, critical to the sustainability of emotional well-being will be the development of a secure attachment, whether with a biological parent or other primary caregiver.

The next two chapters expand on this framework, first at it relates to the provision of agency services, and secondly, as it relates to workforce development. Chapter 4, with its emphasis on cultural competence, is included in the introduction due to its salience for both direct practice and organizational change. Chapter 4 discusses cultural responsiveness and reviews how historical trauma has shaped the experience of children, families and workers, and what this means for successful engagement and service delivery by child welfare agencies. Historical trauma has been defined as the "cumulative and collective emotional and psycholgocial injury over the life span and across generations, resulting from a cataclysmic hisotry of

genocide" (Struthers & Lowe, 2003, p258). Understanding historical trauma is important for understanding disproportionality and disparity in child welfare and is critical to successful engagement. Subsequent chapters flesh out developments in the creation of trauma-informed child welfare services (child protection, preventive, foster care, and adoption) and in attention to a trauma-informed agency culture.

Organization of the Book

In Part II, the two chapters in the first section deal with the role of child protective services in stabilization and safety. Chapter 5 focuses specifically on trauma-informed family engagement with resistant clients. It will expand on the notion of collaborative practice with parents and caregivers. There is evidence that lack of engagement skills is associated with lack of cultural sensitivity. Some (Dettlaff & Rycraft, 2010) have found that cultural bias in staff was a barrier to equitable provision of services. Dumbril (2006), in his study of parents' experience of CPS workers, found that those parents who experience workers using their power with them, rather than over them, were much more likely to work with CPS, as opposed to fighting or "playing" along. This chapter will identify specific engagement strategies and approaches for child protective services work.

Chapter 6 describes and discusses a specific evidence-informed trauma treatment, trauma system therapy (Saxe, Ellis, & Kaplow, 2009) and describe how it has been implemented in both state and large metropolitan child welfare agencies. With an emphasis on work in the social environment as well as with the individual child and family, the role for CPS is clearly articulated.

A second section in Part II focuses on permanency and the role of preventive services. As children and families move from the crisis of child protective services report to either preventive services, whose goal is to prevent placement, or to foster care, the immediate need for physical safety subsides. This is the time for intervention to ameliorate the impact of traumatic experiences that were identified in the CPS phase of intervention. The section starts in Chap. 7 with an examination of successful implementation of standardized assessment tools in many state-wide child welfare agencies, highlighting the facilitating factors as well as barriers to the implementation of comprehensive trauma assessments.

Chapter 8 continues the discussion of trauma-informed assessment, identifying ways in which the public agency can partner with community agencies for trauma assessments. Again, the goal is to fully assess the trauma impact and to plan for evidence-based trauma treatment where relevant.

Chapter 9 describes the successful implementation of an evidence-based trauma treatment, child–parent psychotherapy (Lieberman & Van Horn, 2009) in a state-funded preventive services program. Designed for children under six and their parents/primary caregivers, this implementation uses both a home- and office-based intervention. Successes, including the use of fidelity instruments with both clinicians and supervisors are discussed; on-going challenges are also identified.

The final three chapters in Part II focus on permanency and the role of foster care, as well as the need to work with preadoptive parents from a trauma perspective. As children move into foster care, there is an important opportunity for intervention to help resolve the impact of the trauma that brought the child(ren) into care, for both children and birth parents. Starting with an emphasis on the importance of establishing psychological safety as well as physical security in the foster home, Chap. 10 will focus on innovative methods that are available to help foster or resource parents become trauma-informed and better able to assist children in their care with emotional and behavioral regulation. Chapter 11, by contrast, will focus on the therapeutic work that can be undertaken with birth parents to assist them in resolving their own histories of trauma that often contribute to disruptions in parenting, and Chap. 12 focuses on a trauma-informed intervention model for supporting pre-adoptive parents.

In Part III, the focus shifts to creating trauma-informed agency culture. The first chapter in this part, Chap. 13, introduces commonly accepted principles for implementation of new practices. Steps associated with each stage are discussed, and examples of implementation are provided. The next three chapters outline a framework of macro strategies aimed at creating stabilization and safety in the organizational culture. Chapter 14 outlines a guiding framework for trauma-informed care in public child welfare, with a focus on organizational policies, practices, workforce development strategies, and evaluation methods that have been successfully used to create a trauma-responsive culture and promote the goals of safety, permanency, and well-being in an effective manner. Building upon this framework of care, Chaps. 15 and 16 will focus on specific tools that public child welfare personnel at all levels can use to assess and monitor progress toward the goal of creating a trauma-informed system of care and promoting and maintaining a secondary traumatic stress informed workplace. In addition to providing an evaluation strategy for child welfare personnel, these tools serve as a checklist of activities that can be used to design a trauma-informed organizational development plan.

Two chapters (17 and 18) focus on micro strategies for the development of safe and stable organizational culture. They include strategies for trauma-informed staff recruitment and selection, as well as a description of a widely disseminated caseworker training tool.

Successful and sustained implementation of the trauma-informed principles and strategies outlined in this text are only realized when this guiding framework is successfully integrated into the agency's workforce development and support practices. In fact, a healthy, committed child welfare worker is one that is capable of delivering trauma-informed care in a sustained way and who works in an environment that is physically and psychologically safe, empowering, trustworthy, and collaborative. In this section, physical safety and psychological security are presumed, and activities are focused on "healing", creating optimism and competency through the integration of current and past traumatizing work experiences.

Two approaches for achieving these goals of strengthening the workforce's attachment are highlighted. Chapter 19 discusses an innovative approach to trauma-informed supervision and support that provides child welfare workers with the

knowledge and skills to regulate and process responses to working with trauma exposed clients on an on-going basis without sacrificing engagement. Chapter 20 describes professional development approaches to equip the worker with the skills needed to navigate the delivery of trauma-informed services. Finally, Chap. 21 outlines the challenges ahead for national transition to trauma-informed agencies and services.

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