TRAUMA-INFORMED CARE

BEST PRACTICE GUIDE

"StrengthenIng FamIlIes Practice Model:

Trauma-Informed Care"

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Introduction and Purpose of this Practice Guide

Children and youth who receive DCF services have typically experienced or been exposed to traumatic events such as physical abuse, sexual abuse, chronic neglect, sudden or violent loss of or separation from a loved one, domestic violence, and community violence and historical trauma, such as racism, discrimination, immigration problems and poverty. Often these children present with emotional, behavioral, social and mental health challenges that require special care, treatment and worker sensitivity. It is essential that the DCF workforce be trauma-informed to address the multiple challenges serving children and families who have been exposed to trauma. A trauma-aware and trauma-informed workforce seeks to change the conceptual paradigm about children and families in need from one that asks, "What's wrong with you?" to one that asks, "What has happened to you and how can healing be facilitated?" Trauma-informed care is a culturally and linguistically responsive approach to engaging individuals with histories of trauma that recognizes the long-ranging effects of trauma on human development and the presence of trauma symptoms. Trauma-informed care also acknowledges and responds to system level activities that may further harm or re-traumatize children and their families. The Connecticut Department of Children and Families and its partners must identify trauma exposure and make every effort to prevent re-traumatization by promoting healing relationships and environments through embracing the "key" trauma-informed principles of respect, safety, trust, collaboration, choice and empowerment. In addition, we should use evidence-based trauma-specific services and treatments for recovery pathways.

Trauma-informed care is a practice approach that can dramatically improve the outcomes for children, youth and their families. Trauma-informed care requires an integration of the Strengthening Families Model, the six principles of partnership, protective and risk factors, the seven cross-cutting DCF themes, cultural competency, gender responsiveness and trauma knowledge and competencies. A trauma-informed approach requires the following understanding:

- Children need to feel physically and psychologically safe. Traumatized children can be hypervigilant about danger and safety issues. Children can have traumatic stress reactions when they feel unsafe.

- Protective services intervention, including placement in a stranger's home, can be a traumatic event, and efforts need to be made to make sure that all interventions are provided through a trauma-informed lens.

- Trauma can interfere with a child's development and can have long-lasting effects (physical health, mental health, cognitive development and behavior).

- It is very important for parents, other caregivers and DCF staff to understand and recognize trauma and its effects in order to support the child.

- Acknowledging with a child and his or her family and other caregivers that trauma has occurred and its potential impact helps the family begin the process of natural recovery and to engage in services if necessary.

- Caring for a traumatized child requires a shift from seeing a child with "bad" behaviors to seeing a child who is coping with adverse experiences.

- A child's behavior or distress may be in response to experiencing a traumatic trigger.

- Trauma-informed treatments may be more effective interventions for many children who have had adverse life experiences.

- A culture's group experiences with historical trauma can affect their responses to trauma and loss and a family can be impacted by multigenerational trauma as well.

- Working with trauma-exposed children can evoke distress in providers and caregivers, often referred to as "vicarious trauma." Self-care is an important component of working with children and families who have experienced trauma.

The purpose of this Trauma-Informed Care Practice Guide is to promote a system that recognizes, understands and appropriately responds to trauma and its effects to create a system where services are responsive to children and families who have experienced trauma.

The Trauma-Informed Practice Guide includes information about: trauma and its impact on children and their caregivers; evidence-based treatments to reduce child traumatic stress; the essential elements of a trauma-informed system; and elements of a trauma-informed best practice.

Understanding Child Trauma[1]

Trauma occurs when a child experiences an intense event or situation that harms or threatens harm to the child's physical or emotional well-being or to someone close to the child such as another family member or a friend. Typically, this is an extraordinarily frightening event that overwhelms the child with feelings of terror and helplessness.

Some examples of traumatic events are: physical abuse, sexual abuse; emotional abuse; psychological maltreatment; neglect; domestic violence; traumatic loss or separation from a loved one; bereavement; experiencing or witnessing violence in schools or neighborhoods; serious accidental injury or accident; serious illness or other medical condition; forced displacement such as loss of home, recent immigration or refugee experience; being exposed to a natural disaster such as a hurricane or flood; or exposed to events such as war, terrorism or political violence. Prolonged exposure to traumatic events may result in a toxic stress response.

There are different levels of exposure to traumatic events.

Acute trauma refers to a single traumatic event that is limited in time, such as an auto accident, a gang shooting, a parent's suicide or a natural disaster.

Avoidance is a symptom of traumatic stress that can result in adaptive (*e.g.,* exercise, journaling, deep breathing) or maladaptive (*e.g.,* substance abuse, self-injurious behavior, sexually acting out behavior) coping mechanisms. Avoidance also includes trying not to think about, talk about, or have feelings about the trauma or memories of the trauma. Avoidance is not always a conscious process; therefore, the child may not always be aware of this defense mechanism. Trauma screening is a helpful lens to safely engage children in a discussion about trauma exposure and related trauma stress reactions. Professionals can also experience traumatic stress when working with trauma victims, which may lead to avoidance. This form of avoidance includes not discussing the child's trauma at all or sufficiently, which may prevent the professional from having necessary conversations about trauma. Professionals need to be aware and reflective of their own emotions when working with children and families around trauma.

[1] The National Child Traumatic Stress Network http://www.nctsn.org/.

Chronic trauma refers to repeated exposure that impacts the child's mind and body, such as chronic sexual or physical abuse or exposure to ongoing domestic violence, neglect or a history of oppression, racism, forced immigration or poverty.

Complex trauma is a term used by some trauma experts to describe exposure to chronic trauma, often inflicted by parents or others who are supposed to care for and protect the child; the long-term impact of such exposure on the child and the impact on multiple areas of functioning.[2]

As a general rule, traumatic events overwhelm a child's capacity to cope and often result in intense emotional and physical reactions, referred to as child traumatic stress reactions.

Sometimes children will re-experience these intense and disturbing feelings that are tied to the original trauma if they are faced with any person, situation, sensation, feeling or thing that reminds the child of a traumatic event. These are referred to as traumatic reminders or triggers. Examples of potential trauma reminders are anniversary dates, physical locations, sounds, smells, physical appearance, touch, sense of vulnerability and power imbalance.

Trauma reminders can vary widely and be difficult to identify. A child may not be consciously aware of having been reminded; therefore, it is important for caregivers and DCF staff to help a child recognize and learn to cope with the reminders. When a child's trauma reminders are known, it is important to communicate them to others involved in the child's care so that distress and re-traumatization can be minimized and the child can be supported in all settings.

In addition, children may develop adaptive responses at the time of the trauma such as dissociation (*i.e.,* depersonalization, feeling outside of their body) or de-realization (*i.e.*, feeling that an actual event is not real) in order to cope with what is happening and escape pain or fear. Unfortunately, these responses may become permanent, continuing long after the traumatic event is over and interrupting healthy development. Children learning English as a second language may struggle to translate trauma-related needs or experiences.

Caregivers and DCF staff need to understand that often negative behavioral and emotional responses may be an adaptation to past trauma in the form of traumatic reactions. For these children, the Social Worker may seek consultation with the DCF Regional Resource Group staff or assessment and treatment by trauma-informed mental health providers.

Essential Elements of a Trauma-Informed Approach to Case Practice

A trauma-informed approach to care includes maximizing physical and psychological safety; identifying and meeting trauma-related needs to enhance child and family well-being, resiliency and permanency; and the incorporation of best practices to avoid re-traumatization. A trauma-informed approach to care includes early identification of trauma exposure and trauma symptoms through screening, and assessment for early prevention as well as clinical treatment.

Trauma-informed care is an approach to engaging individuals and families with trauma histories that recognizes the long term and significant effects of trauma on human development and the presence of trauma symptoms. A trauma-informed system of care is relational and reflective, and gives dignity to children and families by promoting safety, trust, collaboration, choice and empowerment.

[2] Cook, et al. "Complex Trauma in Children and Adolescents," Psychiatric Annals 35:5 (May 2005).

A trauma-informed approach recognizes that child welfare interventions, including removal and placement, can be traumatic. A trauma-informed approach is an understanding that when a child has been exposed to traumatic experiences he or she can develop traumatic reactive behaviors. Being "trauma-informed" means shifting one's view from that of a child with bad behaviors to understanding what happened to the child who is coping with adverse experiences. A trauma-informed approach also recognizes that a culture's group experience with historical trauma, racism, immigration and multigenerational trauma can affect individual and group responses to trauma, loss and engagement. Trauma-informed engagement is culturally and linguistically responsive.

Critical Elements of DSM-5[3] Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) is a psychiatric condition with specific symptoms and diagnosable criteria that is included in the DSM-5. Some children who have experienced traumatic events may be diagnosed with PTSD. The DSM-5 criteria for PTSD includes the following:

- the person was exposed to death, threatened death, actual or threatened serious injury or actual or threatened sexual violence;
- the traumatic event is persistently re-experienced through repetitive play, nightmares, flashbacks, physiological reactivity;
- persistent effortful avoidance of distressing trauma-related stimuli;
- negative alterations in cognitions or mood that began or worsened after the traumatic event (examples: inability to recall key features of the event, persistent negative beliefs about self or the world, persistent distorted blame of self or others, persistent negative trauma-related emotions, marked diminished interest, feeling alienated and constricted affect);
- alterations in arousal and reactivity (examples: irritable or aggressive behavior, self-destructive or reckless behavior, hyper-vigilance, exaggerated startle response, concentration problems and sleep disturbance).

Children who have had traumatic experiences are often misdiagnosed, commonly with ADHD, depression, anxiety, conduct disorder, oppositional defiant disorder or other conditions. Many clinicians do not receive adequate training in the identification and treatment of child trauma. It is essential that we ensure that all children are screened for trauma and those who are exhibiting traumatic stress responses receive effective mental health assessment and treatment from well-trained clinicians. DSM-5 includes an outline for cultural formulations when assessing, diagnosing and developing treatment plans.

Understanding How Trauma Affects Children and Birth Parents

Each child's reaction to traumatic experiences differs. Not every child who experiences a traumatic event will develop symptoms of child traumatic stress. Whether or not the child does develop symptoms depends on a range of factors. These factors can include the child's age and developmental state (although children of ANY age can be impacted by a traumatic event), his or her history of previous trauma exposure, the child's mental and emotional strengths and what kind of support (defined as the quality of positive relationships and close nurturing bonds) the child has at home and in the community to build resiliency and coping. (For information on impact of trauma by ages and developmental stages, see The National Child Traumatic Stress Network official website (http://www.nctsn.org/) and search

[3] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (5th Ed.) (2013).

for “ages and developmental stages.”

Traumatic experiences can impair a child's ability to function each day in the following ways:

- Brain development - When children experience excessive stress for too long, too often or too severely, brain functions can be altered. These biological effects interfere with critical brain functions such as focusing, learning, self-regulation and decision-making.

- Attachment - When the caregiver who is supposed to provide protection and safety is the source of hurt and harm, the child feels helpless and abandoned and views the world as an uncertain, unpredictable place. The child may find it extremely difficult to trust and empathize with others. The child may also transfer this mistrust onto subsequent caregivers or use extreme negative behaviors as a means to create emotional distance for self-protection.

- Emotional regulation – As a result of being exposed to traumatic experiences, children may develop traumatic reactions and therefore may have difficulty identifying and describing their feelings and internal states. Their reactions and behaviors may have nothing to do with what’s going on in the moment, but be triggered from past experiences. Children and caregivers may not understand why these reactive behaviors are occurring. Exposure to trauma impacts the child’s sense of safety, world view, and ability to appropriately respond under stress and current relationships with others. Trauma also impacts the child’s ability to develop close relationships with others.

- Behavioral regulation - Children may present with problematic behaviors relating to the trauma (*e.g.*, aggression, self-injurious or sexualized behaviors) and these behaviors may serve as survival adaptations to overwhelming stress.

- Cognition (learning and school performance) - Children may experience delays in language development, linguistic expression, deficits in overall IQ, learning disorders, difficulty concentrating, difficulty completing tasks, failure to learn from past experiences, and an inability to anticipate and prepare for future events. These children are at risk for low academic performance, dropping out of school and later employment problems.

- Self-concept - Maltreated children develop a sense of self as ineffective, helpless, deficient and unlovable. Children who perceive themselves as powerless may blame themselves for negative experiences and feel a sense of shame and guilt.

- Social development - Traumatized children may have poor social skills, fail to establish and maintain friendships, engage in unhealthy relationships and become socially isolated.

Survivors of repeated and severe childhood trauma generally experience a common set of problems as adults when they do not receive effective treatment. A decades-long scientific study, known as the Adverse Childhood Experiences Study[4] (ACE Study) found that these problems are serious and life-altering including increased suicidal attempts and other mental health disorders; promiscuity; use of street drugs; heavy alcohol consumption; intractable smoking; and physical health problems such as diabetes, hypertension, obesity, stroke, heart disease, certain forms of cancer, chronic lung disease and liver disease.

Many birth parents have their own histories of child or adult trauma. As described above, traumatic stress in childhood can impact the parent's ability to regulate emotion, maintain physical and mental health, engage in relationships, parent effectively and maintain family stability. Parents’ past or present experiences of trauma can also affect their ability to keep their children safe, work effectively with child

[4] www.acestudy.org

welfare or juvenile justice staff, and engage in their own or their children's mental health treatment. It is important to also consider the trauma history of the caregiver when formulating a case plan.

What is Trauma Screening?

Trauma screening is a process of asking questions about traumatic events and stress reactions from those events. Screening provides a lens to understand a child's behavior related to what happened to a child (vs. what is wrong with a child). This is a more helpful method for assessment and formulation that guides decision making for the most appropriate treatment intervention. Screening helps to understand behavior related to trauma rather than just treat the behavior as a symptom. From a trauma-informed lens, behavior is a form of communication about unmet needs, is adaptive and has meaning. The role of the Social Worker to identify and recognize trauma in a child's life early. The ultimate outcome is improved care for children. Trauma screening can provide immediate and early recognition of the impact of trauma for children and result in better assessment and treatment planning.

The Connecticut Trauma Screen (CTS) is a very brief, 10-item, empirically-derived screen for child traumatic stress that can be administered by trained clinical or non-clinical staff, including DCF Social Workers. The goals of the CTS are to 1) Identify children who may be suffering from traumatic stress and who would benefit from a trauma-focused assessment or treatment by a trained clinician and 2) function as an engagement tool to allow professionals working with children to briefly discuss the child's exposure to trauma and trauma-related reactions as required for their professional roles. The CTS is not a comprehensive screening tool or a clinical assessment, and does not screen for all symptoms of Post-Traumatic Stress Disorder (PTSD) or other traumatic stress reactions. It is not intended to promote lengthy discussions or detail about a child's trauma exposure or reactions. A number of other trauma screening measures for children exist for a clinical assessment.

The CTS is required in all Multidisciplinary Evaluations (MDEs) completed for children age seven years and older who are placed in DCF care. The CTS is administered by the MDE evaluator and the results and recommendations are shared with the DCF Social Worker following the MDE. Trauma-related recommendations and findings from the MDE screen are incorporated into the written case plan assessment, goals and objectives. Through case planning activities such as further assessment, trauma-informed clinical service provision and ongoing case plan reviews, the trauma-related needs for the child are addressed. This results in greater stability and permanency for the child.

This is the LINK to the Connecticut Trauma Screen:
http://www.chdi.org/our-work/mental-health/trauma-informed-initiatives/

What is a Trauma Assessment?

Assessment is often the next step with a child who has screened positive for trauma. Trauma assessment is a clinical process to understand human behavior in broader contexts including strengths, available resources and protective factors in a systemic understanding of a child's or family's needs. Assessment is a dynamic exploration and includes the collection of relevant information, from multiple sources and processes (*i.e.,* interviewing, record review, testing) that leads to an analysis or formulation that is used to guide treatment, usually in a written treatment plan. Children receiving outpatient treatment should have a written clinical treatment plan that is reviewed with the provider periodically. Assessment is ongoing or continuous in nature to measure progress with goals and objectives. If there are assessment tools mentioned in a written assessment that you are not familiar with, consult with the RRG or call the clinician. Screening and assessment are important processes for trauma in child welfare systems.

Using Evidence-Based Trauma-Specific Treatments and Services

Children who have been traumatized may be helped by various approaches to therapy including individual, family and group therapies. It is important for DCF staff to understand the goals of trauma-specific treatment and the types of effective services that children and their families may need.

The goals of trauma-specific treatment can include:

- safe expression of feelings;
- reductions of symptoms and post-traumatic behaviors;
- improved sense of mastery and control in life through the teaching of self-regulation skills;
- reframing of guilt and self-blame;
- restoration of a sense of trust in oneself and others and hopefulness about the future;
- development of a sense of perspective and distance regarding the trauma;
- an enhanced sense of safety and security; and
- providing support and skills to empower caregivers to cope with their own emotional distress and effectively respond to the traumatized child

Culturally- and linguistically-sensitive trauma-informed services consider the impact culture can have on the meaning a child and family assigns to traumatic events.

Children and youth who have experienced traumatic events and receive evidence-based trauma treatment have:

- improvements in safety, permanency and well-being;
- improved school attendance, grades and functioning;
- enhanced behavioral and emotional health;
- reduced suicidal thoughts and suicide attempts;
- reduced symptoms of PTSD and depression; and

- reduced future utilization of medical services.

The child's behavioral health treatment plan should be developed and monitored by those most closely involved in the child's life including the child, the primary caregiver, the therapist and the DCF Social Worker. It is important to inform the therapist that their input is essential and required in formulating the treatment plan and for ongoing progress. The RRG is available for consultation.

Trauma-Informed Questions for Potential Clinical Referral

When assessing a potential mental health professional's expertise, experience, reputation and specialization, ask these questions:

- In your intake, what is your trauma screening and assessment process?
- What evidenced-based treatment models do you use? What is your training level?
- If you are not using an evidenced-based treatment model, how do you approach therapy with traumatized children and their families?
- How do you involve the child's caregivers in treatment?
- How often will you see the child?
- How does your treatment approach identify and address the culturally diverse experiences of children and families?
- How do you measure treatment progress? What results will you be able to share with me to assess progress?

If the answers to the above questions are not forthcoming or clear, please consult with the RRG.

Evidence-Based Trauma-Specific Treatments

Evidence-based trauma-specific treatments are specially designed, research-based treatments that address directly and effectively the impact of trauma on a child and family's life and facilitate healing. Evidence-based treatments work, on average, better than traditional therapy or counseling for the specific problems they target. The following are examples of some effective treatments. The Regional Resource Group (RRG) staff may be consulted to assist in making an informed decision based on the child's needs and the services available in your area.

Attachment, Self-Regulation and Competency (ARC) is frequently used with children and youth ages 5 to 17 and focuses on enhancing resilience by building tangible life skills and encouraging a supportive care giving system. *(Co-Developers: Margaret E. Blaustein, Kristine M. Kinniburgh, 2010.)*

Eye Movement Desensitization and Reprocessing therapy (EMDR) involves recalling traumatic memories while focusing on personal strengths and engaging in distracting behaviors such as lateral eye movements. EMDR is generally conducted as only one part of a multimodal therapy program rather than a stand-alone treatment. *(Developer: Francine Shapiro, 1998.)*

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a short term, clinic-based, child and family-

focused treatment that is designed for children, ages 3 to 18 suffering from traumatic stress symptoms resulting from exposure to abuse, neglect, domestic and community violence and other forms of risk or harm. It is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Children and parents are provided with knowledge and skills related to understanding and processing the trauma, managing distressing thoughts, feelings and behaviors, and enhancing safety, parenting skills, and family communication. There are many trained TF-CBT teams located at outpatient psychiatric clinics across the state. For the listing of provider agencies and contact information for referral purposes, please refer to the website: http://www.ct.gov/dcf/lib/dcf/behavioral_health/pdf/tf-cbt_referrals_at_opccs.pdf. *(Co-Developers: Judith Cohen, M.D.; Anthony Mannarino, Ph.D.; and Esther Deblinger, Ph.D.)*

Child and Family Traumatic Stress Intervention (CFTSI) is a brief, four to six session treatment for children and youth ages 7 to 18 and their parents or other caregivers, delivered by a trained CFTSI provider that supports children and their families or other caregivers exposed to potentially traumatic events. Implemented immediately following a potentially traumatic event or disclosure of physical or sexual abuse, CFTSI enhances communication about the symptoms and responses to the event, and teaches the family the skills to manage the child's reactions. *(Co- Developers: Steve Berkowitz, Ph.D.; Steven Marans, M.S.W., Ph.D.*)

Child Parent Psychotherapy (CPP) is an intervention for children from birth through age five who have experienced at least one traumatic event and, as a result, are experiencing behavior, attachment or mental health problems including PTSD. The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent as a vehicle for restoring the child's sense of safety, attachment and appropriate affect and improving the child's cognitive, behavioral and social functioning. CPP is based on attachment theory and combines developmental, trauma, social learning, psychodynamic and cognitive-behavioral theories. *(Co-Developers: Alicia Lieberman, Ph.D.; Patricia Van Horn, Ph.D.)*

Parent Child Interaction Therapy (PCIT) is an empirically supported therapy for conduct-disordered children ages two to seven and their caregivers. It uses a combination of behavioral therapy, play therapy and parent training to teach more effective discipline techniques and improve the child-parent relationship. PCIT is divided into two stages: relationship development (child-directed interaction) and discipline training (parent-directed interaction) with three distinct assessment periods (pre-treatment, mid-treatment and post-treatment). *(Developer: Sheila Eyberg)*

Trauma Affect Regulation: Guide for Education and Training is a strengths-based model that teaches skills to regulate emotion, manage intrusive trauma memories, promote self-efficacy and achieve recovery from trauma. *(Developer: Julian Ford, Ph.D., 2006.)*

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) is a group intervention geared toward youth 12 to 19 years of age, and is intended to help teens cope effectively and establish supportive relationships. *(Developer: Mandy Habib, Psy.D.)*

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a school-based group and individual intervention for children in grades five through twelve. It is designed to reduce symptoms of PTSD, depression and behavioral problems and to improve functioning, grades, attention, coping skills and peer and parent support. (*Co-Developers: Pia Escudero, LCSW, Lisa Jaycox, Ph.D, and Sheryl Kataoka, M.D.)*

Importance of a Trauma-Informed System

Exposure to child trauma is very high in the general population, and even higher in the child welfare population. In the general population, at least 71% of all children are exposed to at least one, and often multiple, traumatic events by the time they reach 17 years of age.[5]. Research shows that 85% of children in the child welfare system are exposed to trauma[6].

Children served through the foster care system have a much higher rate of exposure. Former foster children are twice as likely to suffer from PTSD as Iraq war veterans.[7] We also know that most trauma exposure is never reported. The experience of trauma is prevalent among the children and families that we serve. DCF's work can only be improved by learning as much as we can about trauma and its effects on children and their families.

Systems-Induced Trauma

The responses by the DCF system can either help the child to begin a healing process or, unfortunately, sometimes further exacerbate the trauma. When traumatic stress is left untreated, further harm is likely to occur. Some actions or lack of actions that may cause Systems-Induced Trauma for the child include:

- not identifying a child's trauma history or misidentifying non-compliant behavior;
- despite a child's trauma history being identified, there is no referral or follow-through regarding trauma-specific assessment and trauma-specific treatment;
- failure to address ongoing physical and psychological safety needs, which compounds a child's traumatic stress; and
- placement instability and uncertain permanency which can involve abrupt, unexplained removals and further compounds the child's traumatic stress.

With appropriate supports and intervention, people can overcome traumatic experiences. An effective trauma-informed system will prevent re-traumatization, lead to early identification and result in trauma-specific assessment and treatment.

Essential Elements of a Trauma-Informed Practice and System

One of DCF's seven cross-cutting themes is Trauma-Informed Practice. This means delivering services to children and families with an understanding of the impact that trauma can have on their lives and using interpersonal skills and resources to ensure that our work is supportive of trauma recovery and is not re-traumatizing. It requires a partnership with all those involved with the child (caregivers, providers and other stakeholders), using the best available practices to facilitate and support the recovery and resiliency of the child and family.

[5] Finklehor, Turner, Ormrod, Hamby, "Children's Exposure to Violence: A Comprehensive National Survey," OJJDP (2009).
[6] Miller, et al. (2011).
[7] Pecora, et al, "2005 Northwest Foster Care Alumni Study" (2010).

The essential elements of a trauma-informed system include all of the following: [8]

1. Maximize the child's and family's sense of physical and psychological safety - It is important to identify and understand both potential and perceived threats to physical and psychological safety, including trauma triggers that a child or parent or other caregiver may experience.

2. Identify the trauma-related needs of children and families - This involves a process for DCF staff to identify children and youth with trauma histories and traumatic stress reactions, and to make the appropriate referral for trauma assessment.

3. Enhance the child's and family's well-being and resiliency – The focus of this element is engaging and assisting the family's ability to form and maintain healthy relationships in the aftermath of trauma.

4. Partner with families and system agencies - DCF staff facilitate strong partnerships with families and other child- and family-serving systems.

5. Enhance the well-being and resiliency of the DCF staff – The organization recognizes the impact of exposure to trauma on professionals and promotes a culture of health and wellness.

Secondary Traumatic Stress (STS) and Vicarious Trauma (VT)

Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of PTSD. Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal resources; and disruption in their perceptions of safety, trust and independence. Secondary traumatic stress is very common in child welfare workers and other professionals working with trauma victims.[9]

Vicarious Trauma (VT) refers to internal changes in worldview and perception of self and others. VT results from cumulative exposure to other people's traumatic material. A common symptom for VT is a marked change in perception or cognitive structuring that impacts how a person perceives and experiences the world and others.

DCF embraces the concept of being both a learning organization and having a trauma-informed culture that includes the capacity to support staff and the ability to realize and respond to the effects of trauma on our work. This includes:

- supporting health and wellness committees throughout DCF with the mission of supporting staff needs and promoting staff well-being;
- a reflective supervisory model that includes a component for staff support;
  promoting information about Employee Assistance Program (EAP) resources for individual and group needs;
- valuing the need to build effective work teams to carry out DCF's mission; and
- embedding a trauma-informed approach to care in policy and practice guide development.

Staff are encouraged to explore the five ways to well-being: connect, be active, take notice, keep learning

[8] Chadwick Center for Children and Families: http://www.chadwickcenter.org/CTISP/ctisp.htm.
[9] http://www.nctsn.org/resources/topics/secondary-traumatic-stress

and give. Find the way that works for you to be resilient.[10]

Practical Ways to Implement the Essential Elements of a Trauma-Informed Practice

1. Assume that every child and family who receives DCF services has been impacted by trauma in some way.

2. Interact with children and families in a manner that decreases the impact of previous trauma and prevents any future harm.

3. Establish and nurture a supportive, collaborative relationship that minimizes power imbalances by being respectful, empathetic, genuine, consistent, predictable, non-shaming and non-blaming.

4. Identify children who have been exposed to trauma so they can be assessed to determine if they need treatment to address potential trauma reactions.

5. Refer children and caregivers identified as being impacted by a traumatic event for further assessment.

6. Talk to birth parents and caregivers about their own trauma history and its potential impact on their parenting to meet the needs of their child. If necessary, refer the caregiver for an appropriate trauma-informed assessment and treatment.

7. Assure that the child's case record includes information regarding the child's and family's trauma exposure history, its impact on the child's functioning and the birth parents' ability to care for their child.

8. Assure that the case plan addresses the trauma-related needs of both the child and the family and monitor and document the progress on a consistent basis,

9. Promote family involvement in decision-making.

10. Promote stable, positive and permanent relationships in the lives of children.

11. Provide education and assistance to caregivers and any other significant people interacting with children in order to help them identify potential trauma triggers or coping mechanisms. Identify techniques to respond to the child's trauma reactions.

12. As a professional, develop a personal plan and supportive relationships to maintain wellness and resolve any job-related stress.

13. A trauma-informed system ensures that there is ongoing training in trauma to expand self-awareness, trauma knowledge and skills.

[10] http://www.neweconomics.org/projects/entry/five-ways-to-well-being.

Practice Guidelines for Working with Traumatized Children and Families

1. Be prepared to listen and talk about the traumatic events that have happened to the child.

   A traumatized child cannot begin to heal when DCF staff avoid discussion. The child senses that the trauma would be too upsetting for the staff to hear Listen to what the child wishes to share.

   When talking about a child's trauma exposure or history, social workers may encounter new information and have to decide or consult with supervisory and management staff about reporting the new incident. If the disclosure requires a report, then discussion about the incident with the child should be limited to minimal facts.

   Remember that it is not your responsibility or role to fix the hurt or minimize the events so that it doesn't feel so bad for the child in the moment. It is important to validate the child's experience, including the potential for a range of strong emotions (sadness, terror, anger, anxiety, and confusion) and promote the child's sense of safety. Do not assume that every event or situation is automatically traumatic to every child.

   Make sure that the child has accurate information, provided in an environment where the child feels safe and supported (with family if possible). The information needs to be appropriate for the child's age and developmental level. Make sure that the child does not have incorrect information. Factual information prevents the child from imagining or redefining the events. It also helps the child understand that they are not responsible.

   Discuss the traumatic events with the child in his or her preferred language.

2. Obtain an understanding of the birth parent's or other caregiver's trauma history and identify how this history impacts the care of the child.

   Viewing birth parents through a trauma lens helps DCF staff see how traumatic experiences have influenced their perceptions, feelings and behaviors and assists DCF staff in developing effective plans for changing course and moving forward.

   Helping a birth parent or other caregiver who is experiencing his or her own traumatic stress to receive treatment for him- or herself can have significant benefits on the child's functioning and recovery.

3. Provide clear and honest information to the child and primary caregivers.

   A sense of uncertainty and unpredictability is very likely to make a traumatized child feel more anxious, fearful and perhaps more symptomatic.

   Anticipate questions that a child might ask. For example: "Why can't I stay with my family? When can I see my family? How long will I be living here?" For those children remaining in their own homes, it is important to specify how the child will remain safe and protected.

   If you do not know the answer to a question, tell the child and indicate that you will try to obtain an answer if it is possible to do so. Honesty and openness will help the child develop trust, as will supportive nurturing relationships.

4. For children who have strong stress reactions to trauma reminders, create a behavior management plan that keeps them safe.

   Document trauma reminders and reactions so other caregivers and staff are informed.

Discuss ways the child can help him- or herself feel better when he or she is re- experiencing trauma or suffering from traumatic symptoms or is otherwise upset.

Resources

Child Trauma

Adverse Childhood Experiences Study (ACES) (http://www.acestudy.org/)

Chadwick Center (www.ChadwickCenter.org)

National Center for PTSD Veteran Administration (http://www.ptsd.va.gov)

National Center for Trauma Informed Care (http://www.samhsa.gov/nctic)

National Child Traumatic Stress Network (http://www.nctsn.org/)

SAMHSA link to Tip 57 (a book on trauma-informed care and behavioral health services)
http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Evidence-Based Treatment

http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
(Once the website opens, scroll down to find treatments)

Additional Resources on Best Practice

http://nctsn.org/sites/default/files/assets/pdfs/understanding_child_traumatic_stress_brochure_9-29-05.pdf

www.nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_history_fact_sheet_final.pdf

www.nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_history_birth_parents.pdf