Policy Brief

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Rees-Jones Center for Foster Care Excellence

Trauma Treatment for Children in the Child Welfare System

Highlights:

- Children involved in the child welfare system almost universally have experienced trauma, and many have experienced complex trauma.
- Research has shown that early intervention, treatment, and positive caregiving can reduce damage to the brain caused by trauma.
- Children coming into care should be screened to determine their trauma histories and related symptoms.
- Based on the outcomes of screenings and assessments, trauma-specific, evidence-based treatments or interventions should be provided.

In 2017, approximately 443,000 children were in the foster care system in the United States (U.S. Department of Health and Human Services [DHHS], 2018). In the same year, Texas had approximately 50,000 children in its care (Department of Family and Protective Services, n.d.). Children involved in the child welfare system almost universally have experienced *trauma*, defined as a frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity, or the witnessing of an event that threatens the life or physical security of a loved one (National Child Traumatic Stress Network [NCTSN], 2014). Most children who entered foster care in 2017 experienced maltreatment, defined as neglect, physical abuse, sexual abuse, and/or emotional abuse (DHHS, 2018). The most common factor in children's removal from their homes was neglect (62%), followed by parental substance use (36%; DHHS, 2018). Exposure to intimate partner violence is another potentially traumatic experience affecting many children in the child welfare system. Indeed, studies indicate that of families that experience child maltreatment or intimate partner violence, 30%-60% experience both (Hamby, Finkelhor, Turner, & Ormrod, 2011). Further, in a national study involving 2,200 children in out-of-home care, more than 70% were found to have experienced *complex trauma* (Greeson et al., 2011). Complex trauma entails chronic or repeated, typically early-onset, exposure to two or more of the following forms of trauma: sexual, physical, or emotional abuse; domestic violence; neglect; severe caregiver impairment; and school/community violence (Kisiel, Fehrenbach, Small, & Lyons, 2009).

> A traumatic event is a frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity, or the witnessing of an event that threatens the life or physical security of a loved one.
>
> NCTSN (2014)

The experience of trauma by children in foster care is not limited to their circumstances prior to entry. The process of being removed from one's home can itself be traumatic. Even when separation from a parent is in the best interest of the child, children often view it as a traumatic loss (Herrick & Piccus, 2009). Placement changes can also be traumatic, and the longer children are in care, the more likely it is that they will experience placement changes. In 2017, more than half of the children in care had been there longer than a year (DHHS, 2018). One study found that nearly one-third of foster care alumni reported being re-traumatized while in foster care (Jackson, O'Brien, & Pecora, 2011). Children with disruptive behavior problems (which may result from their trauma) can be at especially high risk for the potentially

traumatic experience of placement breakdown (Koh, Rolock, Cross, & Eblen-Manning, 2014; Rock, Michelson, Thomson, & Day, 2015).

Effects and Costs of Trauma

A growing body of evidence has associated childhood trauma with significant mental (Copeland et al., 2018; D'Andrea, Ford, Stolback, Spinazzola, & van der Kolk, 2012; Karr-Morse & Weiley, 2012) and physical (Felitti et al., 1998; Sledjeski, Speisman, & Dierker, 2008) health consequences. Posttraumatic stress disorder (PTSD) rates have been reported as high as 25%, and over 80% of children aging out of foster care have received at least one psychiatric diagnosis (Greeson et al., 2011; Salazar, Keller, Gowen, & Courtney, 2013). In addition, complex trauma can interfere with healthy formation of trust, self-concept, and development across domains (Cook et al., 2005).

In addition to the significant health consequences of trauma, the cost, especially for complex trauma, is considerable. Fang et al. (2012) conservatively estimated the cost to be more than $200,000 per child. His estimate included such factors as productivity losses and expenses associated with childhood and adult health care, child welfare, criminal justice, and special education.

Addressing Trauma

Research conducted during the last two decades has greatly increased our understanding of the effect trauma has on the brain and nervous system. Trauma exposure can result in the brain developing in "survival mode," whereby the child is on constant alert and is producing stress hormones, which can hinder progress toward higher-level brain functioning (Teicher, Andersen, Polcari, Anderson, & Navalta, 2002). Studies of the brain in adults who had been maltreated and those who had not found that those experiencing maltreatment had differing brain structures, specifically in the parts of the brain responsible for learning and memory, behavior, cognition, impulse control, and emotion regulation (Bick & Nelson, 2016; McCrory, DeBrito, & Viding, 2010; National Scientific Council on the Developing Child, 2012, 2014; Shonkoff, 2012; Wilson, Hansen, & Li, 2011).

Screening for Exposure

Research has also suggested that early intervention, treatment, and positive caregiving can change neurobiology (Blaustein & Kinniburgh, 2007). Thus, children coming into care should be screened, with the involvement and input of their caregivers when possible, to determine their trauma histories and related symptoms by professionals trained to identify trauma symptoms across developmental stages and knowledgeable about traumatic separation and loss. A positive screen should result in a comprehensive assessment for trauma conducted by a mental health provider. Examples of validated assessment measures include UCLA PTSD Reaction Index for DSM-5 (potentially traumatic event exposure and symptoms), Child and Adolescent Trauma Screen (exposure and symptoms), or the Harborview Trauma Screen (event exposure) paired with the Child PTSD Symptom Scale for DSM-V (symptoms) or Trauma Symptom Checklist for Children and Trauma Symptom Checklist for Young Children (symptoms).

Treating Trauma Exposure

Depending on the findings of the assessment, trauma-focused, evidence-based treatments (EBTs) or interventions should be provided. In particular, Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is one of the most empirically supported treatments for children ages 3 to 18 with PTSD and other trauma-related psychological problems. There have been more than 20 randomized controlled trials and multiple peer-reviewed articles on its implementation across populations and geography (Ramirez de Arellano et al., 2014), including with children in foster care (Dorsey et al., 2014). TF-CBT also has the highest rating from the California Evidence-Based Clearinghouse for Child Welfare (CEBCCW; http://www.cebc4cw.org) and is included in the National Child Traumatic Stress Network's (NCTSN; http://www.nctsn.org) list of evidence-based and evidence-supported interventions. Additional evidence-based, trauma-focused treatments include Eye Movement Desensitization and Reprocessing (EMDR; Adler-Tapia & Settle, 2008), Prolonged Exposure Therapy for Adolescents (PE-A; Foa, Chrestman, & Gilboa-Schechtman, 2009), and Child-Parent Psychotherapy[1] (CPP; Lieberman, Ghosh Ippen, & Van Horn, 2006). Establishing safety, educating about trauma, developing healthy coping, integrating the trauma story with the therapist's support, and strengthening healthy relationships are evidence-based components of trauma treatments.

Texas-Specific Recommendations

- Require that child and adolescent trauma histories are available at all entry points to the care delivery system and that individualized care planning address the child and family needs in a trauma-informed manner.
- Offer universal screening for exposure to potentially traumatic events and traumatic stress responses. Some children have great resilience and may not require clinical intervention while others exposed to similar events are devastated and require skillful intervention.
- Ensure trauma assessments are administered by trained mental health providers to children in foster care. The assessment should include caregiver involvement and should use developmentally appropriate and validated measures of exposure to potentially traumatic events and trauma-related symptoms to guide intervention.
- Provide interventions to children in care that are evidence-based, developmentally and culturally appropriate, and administered by therapists with appropriate credentials. To that end:
    - If an agency or the Legislature chooses to endorse a particular treatment modality, it should have a strong evidence base. (For help with identifying EBTs, see the resources section of this brief.)
    - Increase the number of therapists who accept the foster care health plan and who are trained in EBTs for trauma exposure.
    - Denote therapists trained in EBTs in provider directories so that caregivers can make informed decisions regarding to whom they send their children.
    - Reimburse at a higher rate for the administration of EBTs by therapists who have received appropriate training in the treatment used.
    - Provide child-placing agencies with training on trauma and various treatment options, with a focus on treatments with a strong evidence base (e.g., TF-CBT).

[1] Although CPP is an evidence-based trauma treatment, it is probably best for children in longer-term placements, as the recommended duration is 52 weeks.

  - Increase access to trauma-informed caregiver trainings that are based on research evidence and teach about evidence-based treatments (e.g., NCTSN's Resource Parent Curriculum) for foster and kinship caregivers.
- Reduce reimbursement barriers for integrated care models that allow families to access care for both physical and behavioral health problems in the same setting, with care coordination among providers. Reimburse for inter-professional care coordination among providers who are not co-located.

Conclusion

The use of EBTs for trauma exposure with children in out-of-home care has the potential to improve safety, permanency and well-being. Indeed, addressing effects of trauma on the child can significantly minimize subsequent effects on health and functioning (Child Welfare Collaboration Group, 2008). Systematic implementation of EBTs for trauma exposure is desperately needed to address different levels of need and risk in foster care.

Resources

California Evidence-Based Clearinghouse. http://www.cebc4cw.org
National Child Traumatic Stress Network. http://www.nctsn.org
Trauma Focused-Cognitive Behavioral Therapy – http://www.tfcbt.org
Eye Movement Desensitization and Reprocessing - http://www.emdr.com
Prolonged Exposure Therapy for Adolescents - https://www.med.upenn.edu/ctsa/workshops_pet.html
Child-Parent Psychotherapy - https://childtrauma.ucsf.edu/child-parent-psychotherapy-resources

About Us

The Rees-Jones Center for Foster Care Excellence is the first integrated medical home in Texas dedicated to treating the unique medical needs of children in foster care. The Center is a collaboration among child welfare, primary and specialty care physicians, mental health professionals, and nurse coordinators. The Center cares for 1,800 children in foster care each year across two dedicated clinics at Children's Medical Center Dallas and Children's Medical Center Plano. Learn more at https://www.childrens.com/specialties-services/specialty-centers-and-programs/foster-care.

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