Edited Notes from a Reflective Seminar for Supervisors in the Child Welfare System

What is This Shift to Trauma-Informed Practice?

March 15, 2011

Context

What is the origin of considering "trauma" as a defining concept for the Child Welfare system?

Was it the arrival of immigrant families, with their accounts of terror rooted in war, violence, rape, and mass killing? Some thought the idea of trauma, leaving victims helpless and vulnerable, was rooted in 9/11, with the knowledge that our borders were no longer safe. Others noted that accounts of domestic violence shattered the ideal of *home*, as a safe base for family life. Others proposed that the crack and meth epidemics of the 80's and '90's produced a dimension of disaster in its wake that left families struggling with traumatic effects that lasted a generation.

A broad definition of trauma emerged: exposure to events that are extreme in their life-threatening impact, somewhat unexpected, and uncontrollable. Common sequelae are reactions including post-traumatic stress and related symptoms.

Now comes the struggle to grasp the meaning of trauma for the Child Welfare system.

Perhaps, a brief account of the environment—"doing more with less"—that currently surrounds the Child Welfare system is in order: it is resource poor; services must be specific, time-limited, and measured for outcomes. The goal is safety, stabilization, and well-being for the child, and these outcomes are to be managed with the fewest risks to safety.

The Child Welfare system has a dual mandate, which is secured in federal and state law: families, once they are reported for maltreatment of their children, will be supported and encouraged to provide adequate care for their children; but when a child is in harm's way, intervention to protect the child will occur, with the court system as a partner.

There is a long history to the development of interventions to respond to the complexity of intergenerational, multi-problem families, with co-occurring disorders of substance abuse and mental health, trapped in poverty. Family preservation, kinship care, family strength-based partnership, and Signs of Safety are among the more recent initiatives.

Now, we have the opportunity to think, reflect, and consider what kind of contributions a "trauma-informed" shift can make that will provide a sense of hope and an optimistic outcome for children and parents.

Discussion: Reflecting on the Shift to Trauma-Informed Child Welfare Practice

Introductions

Abigail Gewirtz, Ph.D., L.P., assistant professor in the University of Minnesota's Department of Family Social Science and the Institute of Child Development, is the project director for the Ambit Network. Formerly Director of Operations for the National Center for Children Exposed to Violence at Yale University's Child Study Center, Dr. Gewirtz has extensive experience in clinical and policy work with traumatized children and families.

Dawn Reckinger, MPH, Ph.D., is the associate director of Ambit Network. Her focus is on evaluating community coalitions working on public health issues. She is also the lead evaluator on a University of Minnesota School of Nursing grant, Culture of Excellence. Dr. Reckinger has been engaged in building a capacity in Minnesota for mental health practitioners to acquire the competence to provide trauma therapy.

The Ambit Network is a Substance Abuse and Mental Health Services Administration (SAMHSA)/National Child Traumatic Stress Network (NCTSN) Community Services and Treatment Center established in Minnesota in 2005. This community-university partnership is in the early stages of collaborating with the Minnesota Department of Human Services to develop the Minnesota Continuum of Care for Child Trauma in order to raise the standard of care for traumatized children. Other partnerships include Veterans Affairs, which focuses on children traumatized by parental military deployment, community mental health clinics, Native American populations, and refugee and immigrant organizations.

In partnership with Children's Mental Health, Minnesota Department of Human Services, it has instituted extensive training on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Training has been delivered to a wide network of mental health clinicians and residential treatment centers.

Notes on Exchanges

There is often a failure to understand the realities of working with seriously troubled families in a Child Welfare context in which law enforcement (in Minnesota only police can physically remove a child from home), the court system, and community agencies are vital partners. Further, the system is highly regulated, with mandates from federal and state law.

To fully understand the current Child Welfare context, it should be noted that of families reported for maltreatment, 60-70 % will be diverted to "Family Assessment." This response will be shaped by a partnership with families, guided by a "strengths" perspective, attention to basic human needs, reliance on a kinship network, and services to improve parenting. Families participate on a voluntary basis.

Moreover, for case planning purposes, supervisors must first help front-line workers create a plausible narrative out of the maltreatment reports, in order to respond to this urgent question: will the case plan assure the safety of the child? If there is any doubt (guided by the responses to

the Structured Decision-Making tool), the case will be opened in Child Protection. Most families consider this an unwelcome investigation and would consider themselves as "involuntary."

Supervisors have a complicated task: reviewing, with staff, cases in which families are involved with multiple agencies; reviewing the brokering and monitoring of services; and assuring that documentation is in order for reimbursement purposes.

Now we are to consider the introduction of trauma-informed Child Welfare practice.

We are all "learners" in this context.

Selected Responses

Question: Is a trauma-informed system compatible with Family Assessment, with its emphasis on partnership with the family?

Response: Partnering with families is absolutely related to a trauma-informed Child Welfare system. One of the defining questions, in this framework, is "what happened to you?" This elicits the parent's traumatic experience. This interest from caseworkers may change the view of Child Protection as a punitive system.

Comment: In Child Protection, we have an emphasis on interventions that modify current behavior. What happened to a child in the past is not as urgent as the need to respond to the immediate concern of a child's safety.

Response:
At some point in case planning, an assessment of the impact of a traumatic incident on a child's behavior is relevant. A question to the parent on the child's experience in a traumatic incident is in order: "How do you think your child understood this event?" How the parent responds to this question may lead to an understanding of the parent-child relationship.

For a link between the traumatic event and a child's behavior, referral to a clinician trained in trauma treatment is in order.

Question: We are concerned with the instability of some of our children in long-term foster care placement. Would trauma-informed practice improve stability for a child in foster home placement?

Response: The research is inconclusive. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) reduces posttraumatic stress disorder (PTSD) symptoms, as well as other related problems, such as depression and acting out behavior, but research on whether this increases placement stability is not available, as yet.

Comments: As funding diminishes, we focus on safety as physical safety. Children are physically safe, but emotionally damaged. Children in "neglect" situations are usually screened out. That is how the system calibrates what it can do with diminished resources.

Responses: Juvenile Justice sees children with serious and persistent mental health issues. We want to learn how children's mental health is driven by trauma.

There must be a shift in focus from bad behavior to the question: "What happened to these kids?"

Question: Traditional child- and family-based supportive psychotherapy has been in use for many years. What is different in trauma-focused therapy?

Response: Trauma-focused therapy modalities aim to reduce trauma symptoms through structured approaches. For example, trauma-focused cognitive behavioral therapy (TF-CBT) provides children with a variety of skills to learn about and cope with traumatic stress, including exposure to the feared event via a narrative that is created with the therapist, anxiety management, and "cognitive restructuring" to address anxiety-driven thoughts and behaviors.

Comment: The children in our Child Protection caseloads may be involved with multiple systems: juvenile court; school; mental health. Each has its own focus. For us in Child Protection, safety is prime. We don't have time or resources for well-being. Accessibility to trauma-informed therapists is very limited.

Response: There is a need to blend funding streams and pool resources when we are working with children and families who are clients of several systems.

Summary Response: In multi-system collaborative work, we must feel supported by the system we work in. Moreover, we have the responsibility, in collaborative work, to protect the integrity of our system's function, while acknowledging its limitations.

Questions Raised for Further Discussion

- Does a trauma-informed Child Welfare system narrow the intervention, distracting us from the complexity of the lives we encounter in which poverty is a driving force?

- Can front-line workers be trained to administer assessment checklists, when a referral for assessment to an Ambit-trained clinician is not available?

- Is it of value to have further discussions on the definition of trauma, from the "acute uncontrollable event of a horrific nature, with the dread of helplessness" to the complex trauma of cumulative stresses in life. For example, does the circumstance of a child living with an impoverished, mentally ill mother meet the definition of trauma?

- Should we pay special attention to the largest age group in our present caseloads, infants and toddlers, with a discussion on the long-term consequences of early childhood trauma? The introduction of early brain development and memory systems has alerted us to the sources of behavior difficulties rooted in attachment disorders and witnessing domestic violence, at a young age. What do we know about adult survivors of childhood trauma?

- The training implications for front-line workers and supervisors are yet to be fully developed: among the topics to be explored are "first aid" responses to respond to the grief stage, as used by the school system when a tragedy has occurred; stages of recovery for a trauma survivor; cultural implications and a response to the disparities in victims of trauma.

Secondary Trauma: An Impact on Front-Line Child Protection Staff

Presenter: Patricia Shannon

Patricia Shannon, MSW, Ph.D., during her 10-year tenure at the Center for Victims of Torture, provided psychological evaluation and treatment services for clients and managed capacity-building projects and training requests.

Dr. Shannon is currently an Assistant Professor at the School of Social Work at the University of Minnesota. In addition to her teaching, advising, and consulting activities, Dr. Shannon collaborates with the Department of Health on developing mental health screening tools and treatment resources for Minnesota's newly arriving refugees.

Selected Notes

"Empathic engagement" is a valued practice skill for a caseworker in Child Protection. This opens up a supportive relationship in which a wide range of feelings will be touched on in listening to the details of a traumatic event. The account of the traumatic incident, with details of threat, violence, injury, and death, elicits responses which are, in fact, normative. The extent to which these accounts reverberate in both the professional and private lives of caseworks is uncertain. For some, the account of horror and helplessness raises questions, perhaps about their own capacity to cope under acute stress.

In the work place, evidence of stress is exposed in impatience with co-workers; negative self-assessment in carrying on routine work; a depletion of energy.

The stress may be carried over into private life. There may be impatience with minor stresses of domestic life; dreams about client stories; distress with cases involving familiar circumstances (violence perpetrated on a small child, when you have a small child at home).

Coping strategies of front-line staff may range from drinking to excessive absences.

Further, Child Protection work is inherently socially isolating. Work life is usually "off limits." One cannot use casework experiences in casual, social exchanges.

In sum, there are a full range of responses to the traumatic episodes suffered by parents and children: these are normative. These responses do not resemble those of "compassion fatigue."

In a profound sense, however, the accounts of traumatic experiences may shake one's view of the world: the possibility of terror and atrocities suggest the world is not necessarily a safe place.
Responses

- Supervisors hearing accounts of trauma all day long are also being traumatized.
- Certainly, while supervisors are not immune to stress, they are responsible for protecting their staff. It may be useful to create meetings with special agendas: case planning; "venting"; support for complex and difficult cases. In an annual review, discuss and support a "self-care" plan.
- In one county, the supervisor had a "trauma team" come in to address the toll that violence had taken on his staff: four deaths in a 35-day span and a shooting in front of the building. The response, initially, to the trauma team was not altogether positive. The staff felt uneasy with the exchange.

Two situations are reported as especially worrisome for front-line staff:

- Personal safety coming from indirect threats from a dangerous client; and
- A newspaper headline identifying their "inattentive" behavior as the cause of death of a child on their caseload. "A secret prayer is uttered every night that nothing goes wrong with a child in our caseload."

Responses:

The public charge of errors of judgment in predicting the child's safety, or indifference to the acute needs of the child, does raise the question, "Who should stand with the worker in a public expose?" In one case that was recalled, the worker did not stand alone. The Director and a Commissioner came forward with an explanation of the circumstances of an over-burdened staff, meager resources, and a case of accumulated family crises, unrelated to Child Welfare.

Comment: Supervisors in a rural county: B.S. workers are not prepared for child protection work.

Response: There are a few ways to support young workers in the field: mentoring; group supervision; collaborative decision-making with Mental Health and HeadStart.
The training system in DHS is engaged in supporting young workers in the field.

Comments:

Finally, at least two recent initiatives are intended to strengthen responses to high-risk families:

- The Family Asset Builder (FAB) model, Carver and Stearns Counties, with formal and informal community supports: 18 months of intensive work to assure safety, stability, and well-being; a long-time commitment to the family; building their assets. Funded by American Humane Association and Casey Family Programs. Evaluation by Wilder Research.

- Signs of Safety: particularly valued by front-line staff in Carver and Scott Counties for the positive engagement, case planning, and partnering directives.

A Few Concluding Observations

This reflective seminar raised a profound question: How will a trauma-informed system enhance the responses of a Child Welfare system?

- Will the construct of the parent as a victim of trauma inform the case plan in helping the parent to develop coping skills that will improve parenting?

- Does a trauma-informed Child Welfare system narrow the consideration of the complexity of family life in child protection caseloads in which poverty is a pervasive factor?

- Will specialized training be available for the staff on assessment issues? Will we share insights on how traumatic events shape coping behavior?

- Will there be a clear referral procedure for children who are experiencing emotional and behavioral difficulties that may be related to traumatic life events?

- Will there be timely access to an array of cultural trauma-informed services for immigrant families?

In sum, this reflective seminar on a trauma-informed Child Welfare system outlines a formidable agenda.

Note: These notes were prepared by Esther Wattenberg, Professor, School of Social Work, Center for Advanced Studies in Child Welfare (CASCW) and Associate, Center for Urban and Regional Affairs (CURA), University of Minnesota. She can be reached at ewattenb@umn.edu.

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