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## Exploring trauma-informed practice in public child welfare through qualitative data-mining of case records

Sarah Taylor<sup>a</sup>, Claire Battis<sup>b</sup>, Sarah Carnochan<sup>b</sup>, Colleen Henry<sup>c</sup>, Margaret Balk<sup>b</sup>, and Michael J. Austin<sup>b</sup>

<sup>a</sup>Department of Social Work, California State University, East Bay, California, USA; <sup>b</sup>School of Social Welfare, University of California, Berkeley, California, USA; <sup>c</sup>Silberman School of Social Work, Hunter College, City University of New York, New York, USA

### ABSTRACT

The overwhelming majority of youth in the child welfare system (CWS) have experienced trauma. This qualitative data-mining study of case records explores how trauma manifests in child welfare and how child welfare workers engage youth who have experienced trauma. Case records revealed that youth exhibit many signs and symptoms of complex trauma, however, most did not have a trauma-related mental health diagnosis. The records included examples of how child welfare workers utilized elements of trauma-informed practice. Findings support universal application of trauma-informed approaches in child welfare. Future research should explore these issues in case-matched child welfare and mental health records.

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Trauma; child welfare practice; practice-based research; case record review; qualitative data-mining

The overwhelming majority of youth in the child welfare system (CWS) have experienced trauma, and many have experienced multiple traumas (Lau et al., 2005; Salazar, Keller, Gowen, & Courtney, 2013; Stein et al., 2001). Youth who have experienced trauma are more likely to exhibit a variety of behavioral health symptoms related to affect, attention, behavior, and daily functioning (Kisiel et al., 2014). As part of the 2011 resolution of a California class-action lawsuit related to mental health care for youth in the CWS, the courts mandated improved coordination between child welfare and mental health, as well as the development and implementation of a core practice model (CPM) to guide child welfare and mental health practitioners working with youth in the system (Katie A. v. Bonta, 2006).

The CPM identifies specific service components, values, theoretical frameworks, and practice behaviors that professionals in child welfare and mental health are encouraged to use across both systems to ensure quality and consistency (California Department of Social Services [CA DSS], California Department of Health Care Services, & University of California, Davis Center for Human Services, 2013). The service components of the CPM

include: prevention, engagement, assessment, planning and service delivery, monitoring and adapting, and transition.

In recognition that most youth in the CWS have experienced trauma, as well as the impact of adverse experiences on multiple domains of development, trauma-informed practice is identified as being “foundational to the implementation of the CPM” (CA DSS et al., 2013, p. 16). The CPM specifically recommends that child welfare and mental health practitioners utilize the essential elements of trauma-informed practice as defined by National Child Trauma Stress Network (NCTSN) (Ko & Sprague, 2007). These essential elements include: 1) maximizing the child’s sense of safety; 2) helping them to reduce overwhelming emotions; 3) helping children make meaning of their trauma history; 4) addressing the impact of trauma on the child’s behavior, development, and relationships; 5) supporting positive and stable relationships in the child’s life; and 6) providing guidance to the child’s caregivers (Ko & Sprague, 2007).

Despite the prevalence of traumatic experiences among children and youth receiving child welfare services, and the increasing emphasis on trauma-informed practice in child welfare services, we found few studies documenting daily child welfare practice related to this issue. In this study, we utilize qualitative data-mining techniques (Henry, Carnochan, & Austin, 2014) to examine how trauma manifests itself among youth involved in CWS, and how child welfare workers (CWW) engage youth who have had traumatic experiences. Our research questions include:

- What kinds of trauma have the children experienced, and what mental health signs and symptoms do they exhibit?
- How does complex trauma, as described in child welfare case records, manifest in youth involved in child welfare, and how do the manifestations of complex trauma in youth correspond to trauma-related diagnoses as described in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA), 2013?
- How do CWWs identify and address youth trauma in daily practice?

## **Background and literature**

### ***Trauma in youth***

Trauma can be described both as exposure to traumatic events and a response to the exposure. Youth involved in the CWS experience higher rates of trauma compared with their non-child welfare-involved peers. Prevalence rates of post-traumatic stress disorder (PTSD) among child welfare-involved youth vary, and some studies have reported that approximately 55% of foster youth have PTSD (Grasso et al., 2009). Additionally,

Greeson and colleagues (2011) reported that 70.4% of foster youth have had at least two traumatic experiences involving complex trauma (i.e. physical abuse, sexual abuse, emotional abuse, neglect, and/or domestic violence), and that 11.7% of these youth have experienced all major types of trauma.

Trauma expresses itself in numerous ways in children and youth. The DSM is used to diagnose mental health conditions, including those resulting from trauma. Symptoms of PTSD include persistent re-experiencing of the trauma, avoidance of stimuli related to the trauma, negative emotions or thoughts that appear after or are exacerbated by the event, and trauma-related arousal that begins or worsens after the event (APA, 2013). While most youth do not meet DSM criteria for PTSD after exposure to a single traumatic event (Copeland, Keeler, Angold, & Costello, 2007), exposure to multiple traumatic events can contribute to long-lasting impairments (Cook et al., 2005).

Risk of the development of PTSD peaks during adolescence, with the prevalence of PTSD diagnosis among adolescents averaging 14% and ranging from 3 to 57% among the 80% of adolescents who experience a traumatic incident (Nooner et al., 2012). The factors that contribute to the variation in PTSD diagnosis include the type of trauma experienced, gender, and access to social support. However, the wide range in prevalence also suggests that the diagnosis of PTSD may not capture the array of trauma symptoms and responses that a young person may experience. Yeomans and Forman (2009) argue that though a diagnosis can be identified in a population, diagnosis may not be the most accurate way to describe the experiences of the people in that group.

The estimated prevalence of PTSD in youth also varies so widely in part due to the multiple methods used to diagnose PTSD in youth. Using a self-report instrument may result in higher estimates of rates of PTSD in comparison with clinician assessment of symptoms (Alisic et al., 2014). In addition, self-report measures administered to parents assessing their child's symptoms of PTSD rarely agree with the child's own assessment of their symptoms (Alisic et al., 2014).

Rates of PTSD are often underreported, as symptoms of trauma may be mistaken for other psychiatric diagnoses, such as depression, disruptive behavior disorders, or Attention Deficit Hyperactivity Disorder, among others (Grasso et al., 2009). Carrion, Weems, Ray, and Reiss (2002) suggested that the criteria for PTSD as defined in the DSM may not be appropriate for children. In their study, children who had some symptoms of PTSD, but did not meet full diagnostic criteria, did not differ significantly in degree of impairment and distress when compared with children who displayed clinical levels of PTSD symptoms (Carrion et al., 2002).

Given the often recurrent and severe exposure to trauma experienced by children involved in child welfare, and the limitations in PTSD diagnosis,

some child welfare scholars have conceptualized child trauma in terms of exposure to Adverse Childhood Experiences (ACEs) and complex trauma responses (Griffin et al., 2011; Kisiel et al., 2014). ACEs are a broad and evidence-based framework for conceptualizing exposure to trauma. They include experiences of abuse, neglect, and household dysfunction (e.g. such as domestic violence and parental divorce or separation). ACEs can negatively impact social, emotional, and cognitive development and may contribute to risky behaviors that can lead to disease, disability, and social problems (Felitti et al., 1998). In children who experience multiple ACEs, the relationship between trauma and long-term negative consequences is even more profound (Felitti et al., 1998).

Complex trauma refers to the exposure of children to multiple traumatic events as well as the long-term impact of these events on developmental outcomes (Cook et al., 2005). Complex trauma consists of seven domains, with each one composed of one or more symptoms: 1) attachment (e.g. interpersonal difficulties); 2) biology (e.g. sensorimotor and developmental problems); 3) affect regulation (e.g. problems knowing and describing internal states); 4) dissociation (e.g. depersonalization and derealization); 5) behavioral regulation (e.g. poor impulse modulation); 6) cognition (e.g. problems focusing on and completing tasks); and 7) self-concept (e.g. low self-esteem). Assessing youth who have been exposed to trauma across these areas is recommended for case formulation and treatment planning (Cook et al., 2005).

### ***Trauma-informed child welfare practice***

Given that children who do not meet diagnostic criteria for PTSD may experience significant post-traumatic distress, practitioners are encouraged to be aware of a child's history of trauma so that interventions can be tailored to their needs, including minimizing exposure to situations that may evoke traumatic memories and trigger disruptive behavior (Grasso et al., 2009). Child welfare practitioners have also been charged with incorporating the essential elements of trauma-informed practice into their work. These essential elements include: 1) maximizing the child's sense of safety; 2) helping them to reduce overwhelming emotions; 3) helping children make meaning of their trauma history; 4) addressing the impact of trauma on the child's behavior, development, and relationships; 5) supporting positive and stable relationships in the child's life; and 6) providing guidance to the child's caregivers (Ko & Sprague, 2007).

To facilitate trauma-informed care, it has been suggested that all children in the CWS undergo trauma screenings and that treatment be offered to address the impact of trauma before diagnosing a child with a mental illness (Griffin et al., 2011). A variety of screening tools have been developed and piloted in multiple child welfare agencies across the country (Akin, Strolin-Goltzman, & Collins-

Camargo, 2017; Lang et al., 2017). Considerations in implementing trauma screening include cost of using the instruments, training needed to administer them, and protocol for follow-up after screening is completed. In addition to screening, creating a trauma-informed system involves educating direct service providers and agency managers about how trauma affects the child and their family, especially given the high prevalence of traumatic experiences among their clients. A deeper understanding of the types of traumas youth experience and the ways trauma impacts youth can guide practice, regardless of whether universal screening is implemented.

In summary, ACEs and complex trauma represent useful frameworks to categorize, quantify, and understand the lasting health and well-being impacts of potentially traumatizing events among youth in the CWS. Although the literature suggests that ACEs contribute to negative outcomes in later life, not all individuals who experience ACEs exhibit signs of trauma. Children who have experienced multiple traumatic experiences (i.e. ACEs) may have signs and symptoms of complex trauma as described by Cook et al. (2005) that do not meet the clinical criteria for PTSD or trauma-related DSM diagnosis. Given that virtually all youth referred to child welfare have had exposure to one or more ACEs, and that children may not necessarily meet the criteria for a DSM diagnosis, the CPM encourages child welfare and mental health professionals to adopt trauma-informed practices universally.

In reviewing the existing literature, we found very few concrete examples that illustrated how these concepts appear in daily child welfare practice. Our study seeks to link existing theoretical models with the experiences of front-line CWWs by exploring how trauma manifests itself in the youth served by CWWs and how CWWs engage in practice that embodies the NCTSN practice elements.

## Methods

Qualitative data-mining techniques (Henry et al., 2014), the extraction and analysis of the narrative text contained in child welfare case records, were used to understand how complex trauma manifests in child welfare populations and how child welfare workers attend to this trauma in their daily practice. This technique offered a means of accessing rich, and often sensitive, practice data without disrupting daily child welfare practice or diverting child welfare workers' attention from client needs.

The research project was conducted under the auspices of a long-standing university-community partnership composed of 12 county social service agencies, five university social work departments, and a private foundation. Given the sensitivity of the data being extracted, the county used in this study was selected based on their interest in the research topic, willingness to

participate, and ability to provide the technical assistance required to allow for data extraction.

In July 2016, the research team, consisting of two lead researchers with extensive experience in qualitative research, a researcher who developed the qualitative data-mining technique, and several trained Master of Social Work student research assistants, extracted child welfare documents from the electronic county child welfare case records system. Prior to data extraction, the team participated in two half-day training sessions covering topics such as child welfare and mental health, confidentiality, qualitative data-mining, and coding. Team members also completed an online human subject course. Throughout the study period, the team met frequently to discuss and conduct data collection and analysis. The senior researchers on the project worked alongside the student researchers and were accessible at all times either in-person or via e-mail or phone.

The small county we partnered with served 30 youths who received a Katie A. determination, indicating a need for mental health services. Katie A. determination is based on several conditions, including being under age 21, eligible for full scope Medi-Cal (California's version of Medicaid), meeting medical necessity criteria for a mental health disorder, and currently receiving, or being considered for, treatment in services such as wraparound services, therapeutic behavioral services, crisis stabilization, therapeutic foster care, or group home placement (California Department of Health Care Services, 2013). In the study county, CWWs refer a youth to mental health practitioners employed by the child welfare agency to make the Katie A. determination. Of these 30 youths who received a Katie A. determination, a senior program manager at the county selected 21 cases for the team to review based on the goals of 1) representing variation with respect to case complexity; 2) capturing a variety of demographic and service characteristics of the youth; and 3) including case opening dates that reflected earlier versus later implementation of the Katie A. mandate.

The final sample of 16 cases used in the study were purposively selected by the research team for maximum variation in age, sex, race/ethnicity, in-county and out-of-county placement experiences, mental health needs, and immigration background (Miles, Huberman, & Saldaña, 2013). The sample size is consistent with qualitative research involving collection of rich data and can be considered adequate to reach data saturation (Guest, Bunce, & Johnson, 2006).

This study was reviewed and approved by the Institutional Review Boards of the two universities at which the lead researchers were employed. Documents were extracted on-site at the child welfare agency and uploaded into Dedoose, a secure qualitative analysis software program. Our team reviewed an average of 48 documents for each case, with a range of 6–77 documents. All available documents were extracted for each case, thus the



documents for many cases spanned several years. These documents contained narrative data and included:

- Emergency response reports: Descriptions of the incident leading to CWS involvement and the initial assessment and plan.
- Case contact notes: A log of each case contact, including collaterals.
- Case plans: Formal plans outlining the services to be provided and requirements for each member of the family, updated every six months.
- Court documents: Reports and other communications to the court, including recommendations about children's placements, services, and progress.

### ***Sample characteristics***

The sample represented in this study was diverse with respect to age, sex, race/ethnicity, and immigration experience. The sample included young children aged 4–8 ( $n = 6$ ), older children aged 9–12 ( $n = 3$ ), and teenagers ( $n = 7$ ). Nine of the children were female and seven were male. The races/ethnicities represented in the sample include Black ( $n = 4$ ), European American/White ( $n = 3$ ), and Latinx ( $n = 4$ ). Two children identified with two or more races/ethnicities and the race/ethnicity of two children was unclear from the records. Five children were from families with recent immigration experience, and most of these children were born outside of the USA. In addition, all youth in the final sample had experienced multiple traumas as described in the first section of our findings.

### ***Analysis***

The analysis process was guided by a pragmatic and step-wise approach (Miles et al., 2013; Saldaña, 2013) consisting of iterative cycles of analysis to organize the data and identify themes. The initial phase of qualitative data analysis involved the development of descriptive codes (Saldaña, 2013) based on the literature review and feedback from county staff collaborators that was designed to capture the range of client characteristics and experiences, child welfare practices, and child welfare outcomes related to child mental health.

Multiple team-based coding sessions by the researchers were used to clarify and refine the application of these descriptive codes; through these team coding sessions, we reached agreement about how and when to apply the codes. The resulting 60-item codebook included broad categories such as assessment; child welfare service policies and resources; child health and behavioral health signs and symptoms; trauma; and outcomes/key events; as well as sub-codes for most of these broad categories. For example, sub-



codes of the outcomes/key events category included adoption/permanency, improvements or declines in child mental health, major educational change, major family changes, placement change, reunification, successful family maintenance, and termination of parental rights. The purpose of using these descriptive codes was to organize and index the very large, complex, and detailed dataset (Saldaña, 2013).

Research assistants reviewed the entire set of documents for each case and applied the finalized codes to the relevant narrative text in each case. This code-based analysis allowed us to gain a better understanding of the patterns related to various types of phenomena captured in the child welfare data. While coding these data, the research team also created a pre-structured, de-identified analytical memo to summarize key aspects of each case. Each of these memos included an overview of: 1) child and family characteristics; 2) child mental health issues; 3) major case events; and, 4) analytical observations. This within-case analysis allowed us to “describe, understand, and explain what has happened in a single, bounded context” (Miles et al., 2013, p. 100).

The initial phase of analysis revealed the prevalence of trauma within the sample, as well as the complex practice dynamics involved in responding to trauma. The second phase of the analysis involved a review of the analytical memos and coded narrative material to identify themes related to the manifestations of trauma and trauma-informed practice. Case records reflected the breadth, severity, and frequency of traumatic experiences and provided extensive detail about trauma-informed practice in the records, leading the team to pursue the analysis presented in this paper. The team then reviewed and discussed the literature on trauma and mental health disorders in youth to develop the analysis plan. Behavioral health disorder codes were applied whenever there was mention of a specific disorder in the case records as stated by a professional or provider involved in the case. For example, if a CWW noted in the case records that a therapist believed the child had a certain disorder, we coded the disorder for that child. Formally diagnosed disorders were most often cited by CWWs in court documents and subsequently documented by research assistants in the analytical memos. Child health and behavioral health signs and symptoms were coded throughout case contact notes, including communications with the youth, caregivers, and other providers, and frequently summarized in court documents. Behavioral health symptoms were further reviewed in the context of the case and analytical memos, which presented an overall picture of each youth’s most salient needs.

The analysis of manifestations of trauma consisted of reviewing analytical memos and excerpts tagged with the behavioral health signs and symptoms code. Symptoms were based on provider, caregiver, and youth perspectives as noted in the records and categorized according to the seven domains (attachment, biology, affect regulation, dissociation, behavioral regulation, cognition, and self-concept) identified by Cook et al. (2005). Cases were then

compared by demographics, mental health severity, trauma history, and presence of a trauma or stressor-related diagnoses. For the analysis of the trauma-informed practice dimension of the study, the researchers analyzed narrative text coded as CWW Engagement (a sub-code of CWW perspective, voice, and strategies), promising practices, and assessment. After the initial review and team discussion, the research team drew on the NCTSN (2013) Essential Practice Elements to categorize trauma-informed practice.

After some discussion, the team decided to retain the CWW's exact language in all quotations, except for removing names of people and places, and we did not edit the writing. We feel this captured daily child welfare practice most accurately and that important aspects of practice, including documentation, would be lost if we changed acronyms or edited the text of the notes. Commonly used acronyms include: *CH* or *MI*, both referring to the child client; *SW* or *u/s*, a third-person reference to the CWW writing the note, and *MO* for the child's mother.

## Findings

### *Experiences of trauma and mental health signs and symptoms*

The youth in this study experienced a range of ACEs and exhibited an array of mental health disorders. All cases involved multiple traumas as defined by exposure to ACEs. Nearly all the children had experienced neglect ( $n = 14$ ). Other ACEs experienced by more than 10 youth in the sample included household substance abuse ( $n = 13$ ), household mental illness ( $n = 13$ ), psychological abuse ( $n = 11$ ), and the incarceration of a household member ( $n = 11$ ). Most cases ( $n = 11$ ) depicted verbal or emotional abuse from caregivers, and seven described physical abuse. In six cases, emotional and physical abuse were identified as co-occurring. In some instances, children reported that caregivers were abusive periodically, when intoxicated or using physical discipline, while other cases depicted more chronic abuse, especially emotional abuse (e.g. yelling, insulting, threatening, and ignoring youth). Eight case records reported suspicions that sexual abuse had occurred, and two records included speculation that the youth were involved in sex work. In one case, sexual abuse was perpetrated by a caregiver, while other children had been victimized by peers, an adult at school, siblings, another youth in foster care, or relatives. The majority of cases (13) involved neglect, often tied to caregiver incapacity, mental health, and/or substance abuse issues.

Youth also experienced an array of other potential sources of trauma that went beyond the ACEs framework that included homelessness, separation from family related to immigration, and the death of loved ones. One sibling group had been trapped in an apartment fire while another girl expressed concerns about a traumatic earthquake that killed friends and family

members. One boy witnessed his father's shooting outside their home, and another girl entered the USA alone with the help of a coyote, a person who helps smuggle undocumented immigrants across the border.

Most youth exhibited symptoms of mental health disorders or had been diagnosed with disorders not exclusively linked to trauma. The most common mental health issues experienced by the youth were depression ( $n = 10$ ), aggressive and/or emotional outbursts ( $n = 10$ ), and difficulties with attention or impulse control ( $n = 9$ ). Specific signs and symptoms of trauma included nightmares ( $n = 5$ ), flashbacks ( $n = 2$ ), and intrusive thoughts ( $n = 2$ ). Trauma and stressor-related disorders such as PTSD and adjustment disorder were mentioned in seven cases, although records indicated that only four youth had a formal DSM diagnosis at some point during their case. Two of these youth were re-diagnosed with other disorders later in the case.

Several symptoms of PTSD as defined in the DSM were rarely discussed or even mentioned in the case records. These symptoms included the inability to recall key features of the trauma, exaggerated blame of self or others for causing the trauma, decreased interest in activities, hypervigilance, and heightened startle reaction. It was unclear if these symptoms were absent, or simply not observed by the child welfare staff.

In many instances, providers and caregivers acknowledged the enduring impact of trauma on the child's present mental health conditions. For example, the potential connection between trauma and a child's Non-Verbal Learning Disorder (NVLD) can be seen in the following case record notation made by a CWW about the perspective of another provider:

She cannot say if the NVLD would have manifested itself without the trauma. She said that children who are neglected have sensory processing issues. Attachment is a reaction to a history of trauma that the brain develops differently.

### ***How does trauma manifest in youth involved in child welfare?***

Given the relatively low rate of documented PTSD diagnoses despite the widespread prevalence of exposure to trauma observed in the sample, we applied the Cook et al. (2005) framework to organize our findings related to a child's response to complex trauma as illustrated in Table 1.

### ***How do child welfare workers identify and address youth trauma in daily practice?***

As noted in the methods section, the National Child Traumatic Stress Network (2013) essential elements of trauma-informed practice were used

**Table 1.** Youth in sample experiencing challenges in Cook et al. (2005) Domains.

Cook et al. (2005) domain	Manifestations in this Domain
Attachment	Difficulties in this area were observed in three-quarters of cases. Younger children tended to exhibit anxious attachment, while older youth were more likely to be withdrawn, yet show signs of wanting to connect with adults.
Biology	A few youth exhibited developmental issues, specifically related to fine and gross motor skills. Several youth had chronic health conditions, as well as problems with sleep and eating habits.
Affect Regulation and Behavioral Control	Aggression and affect regulation appeared strongly intertwined, and so are discussed in one section in our analysis. Nearly all youth exhibited problems in affect and/or behavior, with a majority having some issues with aggression, anxiety, and/or depression.
Dissociation	Dissociation was noted in half of the cases, but the descriptions were often vague, simply noting that the youth “dissociated.”
Cognition	A majority of the children in this sample had difficulties with concentration and learning.
Self-Concept	About half of the youth had poor self-esteem as expressed through statements describing themselves as “stupid,” “a bad kid,” “ugly,” or saying that no one loved them.

to frame the findings and the analysis of practice. [Table 2](#) lists these elements and examples of practice behaviors. Two NCTSN practice elements are not included in [Table 2](#). Examples of *helping children make new meaning of their trauma history* were only minimally present in the data; we believe this may be because this practice element is more within the scope of mental health

**Table 2.** NCTSN practice elements and example child welfare worker efforts.

Practice Element	Example(s)
Maximize the child’s sense of safety	Safety planning, respecting youth’s wishes around how much to disclose, being thoughtful about how and when to re-connect youth with their families of origin given traumatic experiences.
Assist children in reducing overwhelming emotion	Validating feelings, supporting youth in interpreting challenging situations
Address the impact of trauma and subsequent changes in the child’s behavior, development, and relationships	Most evident in court documents linking the child’s trauma experiences to their current behaviors and needs, sometimes using research literature to inform their recommendations.
Coordinate services with other agencies	Collaboration with mental health providers, court-appointed special advocates, school staff, and providers at other community-based organizations was prevalent in all case.
Utilize comprehensive assessment of the child’s trauma experiences and their impact on development and behavior to guide services	Use of solution-focused questions, such as the magic wand and scaling.
Support and promote positive and stable relationships in the life of the child AND provide support and guidance to the child’s family and caregivers	Helping parents/guardians to problem-solve around barriers to re-connecting with their children; giving parents suggestions related to visitation; serving as a mediator in caregiver-child conflicts; providing empathic support and encouragement to parents/guardians as well as direct suggestions and referrals.

practitioners. *Manage professional and personal stress* were not described in this data given that child welfare records are not intended to document worker self-care.

### ***Maximize the child's sense of safety***

Every case record contained examples of staff efforts to maximize the child's sense of safety. These efforts included: 1) explicit safety planning when youth were at risk of self-harm; 2) giving the youth a sense of control over when, how, and with whom to share their experiences; 3) supporting youth when they chose to disclose sensitive information; and 4) reflecting on when and how to re-connect youth with members of their families of origin given past experiences of trauma involving those members. Child welfare workers also conveyed a sense of safety by advocating for a youth to change therapists based on a poor match and supporting youth for being courageous and reassuring them that they would not be "in trouble" for disclosing their experiences.

### ***Assist children in reducing overwhelming emotion***

While dealing with overwhelming emotions may fall more directly within the scope of mental health providers, the case records did include examples of CWWs validating the feelings of children and supporting them in interpreting challenging situations (e.g. observing a conflict between a youth and her mother and helping the youth by reframing the mother's message and thereby reducing the yelling).

### ***Address the impact of trauma and subsequent changes in the child's behavior, development, and relationships***

This practice behavior was most often evident in court documents that linked the child's trauma experiences with their current behaviors and needs, sometimes using research literature to inform their recommendations. An excerpt from a court document shows how the worker was able to articulate the impact of abuse on the child as well as how treatment addressed the child's symptoms:

The research documents that after suffering from child abuse "outward behavior" can be "an expression of inward security and safety" Odhayani A., Watson W., Watson L., (2013) Behavioral Consequences of Child Abuse. Canadian Family Physician vol. 59, 8831-836. Specifically children with anxiety can be disruptive at school and act out aggressively or in an intimidating way to their peers. However, after having struggled with behavioral and emotional dysregulation, at this time [child] seems to be thriving. He seems to be at a safe, stable and predictable place in his life. He himself shows insight and is able to articulate feeling less anxiety about his mother. In the past he worried about her drinking and possible consequences around this. However, being able to process this with his mother, observing that she is engaged in supports and that she continues to lead a sober lifestyle has allowed [child's] anxiety and worry to decrease. This has

had remarkable results. Since he is feeling better, his behavior has improved at home and at school. This means that he is less impulsive and aggressive with his peers. This has allowed him to make friends and spend more time safely with his friends.

A court document for another case also linked the child's past experiences to her current behaviors. This excerpt highlights the worker's understanding of the child's developmental needs as well as cultural sensitivity in describing the child's immigration experiences:

In her short life [Child] has had experiences that are well beyond her years. She has worked away from her home and her family since she was a young girl, has undergone the arduous process of immigration, worked to pay back the coyote while figuring out her living arrangements, paying for bills and arranging for her needs to be met. She has suffered through many losses including leaving behind her family, country, culture and language. She has then had to adapt to a new country, new culture and a new language. Throughout these experiences [Child] has demonstrated many strengths including tremendous resiliency, resourcefulness, and motivation. However after all the experiences [Child] has navigated, she has significant needs that have not been met. She never received medical or dental attention and as a result has extensive dental needs. She has also missed out on many years of school and is just now learning how to read and write. [Child] has as well struggled with loneliness, sadness and longs to feel connected to a family. In an effort to cope with these feelings at times she has turned to alcohol. In addition, [Child] also has to work on tasks related to her developmental stage that include exploring her identity, exploring career goals and working towards independence. However, the undersigned looks forward to supporting [Child] throughout this process. [Child] is driven and maintains a positive attitude. She has high aspirations for herself. Therefore the undersigned believes that she will take full advantage of the support afforded to her as a dependent of the court.

Although case plans identified services that were likely intended to address the impact of trauma, case plans tended to contain less narrative that would explain the rationale for specific interventions and referrals.

### ***Coordinate services with other agencies***

Case record documentation revealed extensive and persistent collaborative efforts with community partners, including multiple phone calls, e-mails, and meetings with other professionals, most frequently with mental health agencies and schools. For example, in the case of a Black teen, the records provided extensive documentation of the close collaboration between the CWW, community mental health provider, and school, including information about the perspectives and efforts of these various players. In another case involving a Latino elementary school-aged child, the case records provided evidence of collaboration among the CWW, the mother's substance abuse treatment provider, the

child's school, and the family therapist who appeared to play a significant role in helping the mother to develop an understanding of her child's needs.

***Utilize comprehensive assessment of the child's trauma experiences and their impact on development and behavior to guide services***

In case contact notes as well as court documents, CWWs demonstrated their use of a biopsychosocial framework in assessing trauma experiences. They inquired about and noted child emotions, expressed wishes, social supports, education, physical well-being, preferred language, and more. Often, their assessment was evident through the very detailed and highly sensitive child and family experiences described in the case contact note documenting the CWW's meeting with a child, family member, or other provider. In many cases, the specific questions the CWW posed to the individual they were meeting with are not clearly stated.

A few case contact notes described the use of assessment questions grounded in solution-focused therapy (Macdonald, 2011) as in the following examples from two different cases:

On a scale of 1-10, 1 feeling the most sad 10 the happiest, how does she feel at home when MO is drinking. [Child] said 1. When MO isn't drinking, [Child] said 3. She said that she always feels depressed when she is in the home. She said that sometime she feels happy when she's out of the home, but she always feels depressed inside.

This worker then drove [Child] home. [Child] was much more talkative. We did a lot of scaling questions. It was clear by [Child's] answers that he understood the concept. [Child] said on a scale of 1-10 he wanted to stay in his current placement at a 40. He also talked about them being his forever family. He said he wants to be adopted and wants to grow older in their home.

There was also one use of another type of solution-focused question, the "magic wand," as in this example:

The Undersigned asked MI what made him happy in his life, and he answered, "Having a puppy; everything is better when you have a puppy." The Undersigned asked MI what he would change in his life if he had a magic wand, and he replied that he would, "change the situation [he was] in right now." He said he would be with his mother and they would live in a big house.

***Support and promote positive and stable relationships in the life of the child and provide support and guidance to the child's family and caregivers***

Nearly, every case described the vigorous efforts that CWWs made to support the relationships between children and their caregivers. For example,



these activities included: collaborating with parents, guardians, and extended family members to problem-solve around barriers to re-connecting with their children; giving parents suggestions related to visitation; serving as a mediator in caregiver-child conflicts; providing empathetic support and encouragement to parents and guardians; and offering direct suggestions and referrals. Other examples related to the different ways that workers provided family-focused supports included:

- In a case involving an immigrant youth, the worker spent significant time locating a family therapist who spoke the father's language, one not commonly spoken in the region. In this same case, the worker connected the youth with a mentor from the child's home country.
- The worker spoke frequently with the two separated parents about how their conflicts with one another were contributing to their daughter's mental health symptoms and their ability to parent her in a voluntary case.
- A worker offered a mother the option of writing weekly letters to her children to show commitment and consistency to support reconsideration of visitation. She gave the mother letter writing materials and stamps.

## Discussion

The cases in this exploratory study involved youth with exposure to one or more ACEs, and most youth exhibited signs and symptoms consistent with complex trauma. However, only four youth in the sample had a trauma or stressor-related diagnosis, and most cases described a range of other mental health diagnoses. This difference is also reflected in the literature, which highlights the level of potentially overlooked trauma in youth who do not meet criteria for PTSD and underscores the need to view trauma symptoms beyond a PTSD diagnosis (Kisiel, Fehrenbach, Small, & Lyons, 2009). Most youth exhibited multiple post-traumatic stress symptoms, and in failing to meet the full criteria for PTSD, clinicians may have attributed such symptoms to other psychiatric disorders. The case records of the CWWs in this sample illustrated the application of most of the NCTSN's essential elements of trauma-informed practice as part of their daily interactions with and on behalf of youth.

## *Strengths and limitations*

The strength of our data is in its richness and longitudinal nature; the cases begin with the opening incident and continue until closure or the most recently available event at time of data extraction. Several cases span multiple

years. Nearly, all members of our research team were impressed by the richness of the case record data in describing the experiences of children, their families, and the professionals involved in their lives. We shared our observations as we collected and analyzed this data, including some of our impressions about what we were learning. The strength of our research is a team-based approach that provided a space for processing research perspectives on the data, as well as an opportunity to address any biases that may have informed any one researcher's work.

These data share the limitations of all administrative secondary data in that it was created by practitioners in the course of their work and not initially intended to be used for research. As such, some information that may be irrelevant for practice, but helpful for research, was not present. For example, a case contact note may indicate that the CWW left a message for someone, but it does not necessarily describe the content of the message. As is typical among direct practice staff, CWWs vary in their note-taking practices, both across and within individuals. Some workers write more than others, and a given worker may write a shorter note on a day that they have less time to provide details.

A few other limitations are important to note. Given that the Katie A. decision and the subsequently developed CPM call for close collaboration between child welfare and mental health, access only to child welfare data and not mental health case records is an important limitation. In addition, while the child welfare records are longitudinal and comprehensive, they do not fully capture the subjective experiences of any of the participants involved. Though workers sometimes quote children, family members, or other professionals, we have no way to assess the accuracy and completeness of these quotations, so everything we reviewed was filtered through the worker's lens. Finally, though our data are rich, and the sample is diverse, it is a small number of cases from one county in California. It is likely that CWW practice experiences related to trauma varies across different CWS agencies and regions.

## **Conclusion**

### ***Implications for practice***

Given that many more youth exhibited signs and symptoms of complex trauma than were diagnosed with PTSD, the diagnosis of PTSD should not be used as a primary indicator of whether a child has behavioral health needs associated with traumatic experiences. ACEs and the Cook et al. (2005) domains of responses to complex trauma capture a wider range of potentially traumatic experiences and subsequent signs and symptoms of exposure than child welfare allegations of abuse or neglect and DSM diagnoses. A broader understanding of trauma and how it manifests in youth has implications for

screening, assessment, case conceptualization, and intervention. For example, if child welfare and mental health professionals view a youth's behaviors as resulting from a diagnosis of ADHD, they may respond differently than if these same behaviors are seen as a manifestation of complex trauma.

The need to consider trauma across child welfare cases suggests that all youth in the system should be screened for trauma. Two recent studies describe efforts to implement trauma screening in child welfare (Akin et al., 2017; Lang et al., 2017). Though both studies show progress in moving toward trauma screening, challenges to implementation, such as training, costs, and unclear impact on child and family outcomes, make universal trauma screening "an elusive goal" (Lang et al., 2017, p. 414).

From a policy perspective, the wider lens of ACEs, broader understanding of how children respond to trauma, and challenges to implementation of trauma screening suggest that resources be allocated appropriately to meet the needs of a potentially much larger group of children than simply those who have PTSD diagnoses. Moreover, CWWs in the study county carry caseloads that are relatively low in comparison with other jurisdictions, further highlighting the need for adequate resources to ensure that all those who have been impacted by trauma are served.

Providing sufficient resources to child welfare agencies would promote and facilitate the capacity of CWWs to engage in the multiple forms of skillful, trauma-responsive practice that we observed in the cases reviewed, including mediating conflicts and facilitating communication between parents and youth; writing court reports that integrate relevant research to inform and support recommendations; conducting comprehensive and ongoing assessments grounded in a biopsychosocial framework; and engaging with clients in developmentally appropriate activities to build trust and rapport.

It should also be noted that the NCTSN framework is grounded in a common elements approach and was derived in part through review and analysis of manualized trauma-based treatments in an effort to focus on those elements that were shared across varying intervention models (Strand, Hansen, & Courtney, 2013). Our research similarly echoes the principles of the common factors (Duncan, Miller, Wampold, & Hubble, 2010) and common elements approaches (Barth, Kolivoski, Lindsey, Lee, & Collins, 2014). The common elements approach has been shown to be effective in working with youth with a range of complex and overlapping needs and is designed to be applied across a range of settings that may not specialize in providing mental health treatment (Barth et al., 2014). The findings in our study suggest that CWWs are successfully applying the NCTSN essential elements in their work. This is in contrast to more specific and manualized approaches that may not be a fit for child welfare work and/or may not be as readily implemented in practice (Barth et al., 2014).

### **Implications for future research**

Given that our data were limited to child welfare records, and that the CPM calls for consistent application of the essential practice elements across child welfare and mental health, data-mining with matched mental health and child welfare case records would provide a valuable perspective. Matched records would allow us to explore coordination of trauma-based care and illuminate those areas of practice less readily observed in the child welfare records, such as how to help children make meaning of their traumatic experiences. Research questions in a matched child welfare and mental health study could explore such issues as: a) Whether and how child welfare and mental health collaboration and case coordination has changed since the Katie A. ruling in *Katie A. v. Bonta* (2006); b) How the daily practice of mental health and child welfare professionals reflects a differentiation in roles and duties with regard to integrating the essential elements of trauma-informed practice; and, c) How any changes in collaboration and implementation of the essential elements of trauma-informed practice have impacted youth and families. The prevalence and severity of trauma experienced by children, youth, and families involved in child welfare services make it essential that we increase both our understanding of how to provide effective services and the resources need to implement the services.

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### **Notes on contributors**

**Sarah Taylor**, MSW, PhD is an Associate Professor in the Department of Social Work at California State University, East Bay.

**Claire Battis**, MSW served as a Graduate Student Researcher on this project.

**Sarah Carnochan**, MSW, JD, PhD is the Research Director for the Mack Center on Nonprofit and Public Sector Management in the Human Services at the University of California, Berkeley.

**Colleen Henry**, MSW, PhD is an Assistant Professor at the Silberman School of Social Work at Hunter College, City University of New York.

**Margaret Balk**, MSW served as a Graduate Student Researcher on this project.

**Michael J. Austin**, MSW, PhD is a Professor of the Graduate School and former Director of the Mack Center on Nonprofit and Public Sector Management in the Human Services at the University of California, Berkeley.

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