Trauma-Informed Care

FINAL REPORT

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Executive Summary

The philosophical foundation, key assumptions, and principles that comprise the Substance Abuse and Mental Health Services Administration's (SAMHSA) trauma-informed care approach aligns with those of other leading behavioral health and health care organizations. However, there is no consensus on a single definition of "trauma-informed care." This ambiguity has resulted in variations in how trauma-informed care is operationalized nationally and statewide and risks this designation having little or no meaning. The Meadows Mental Health Policy Institute (MMHPI) examined prevalence estimates, reviewed literature and national best practices, and talked with key informants in Texas to describe how the state's major child serving agencies have operationalized trauma-informed care for children and youth involved with the child welfare system.

Prevalence estimates of Adverse Childhood Experiences (ACE) among children and youth in the major child-serving systems in Texas underscore the need for these systems to be adept at identifying, understanding, and treating trauma.

- Statewide, approximately 730,000 children and youth, or 1 in 10 children/youth overall, have experienced three or more ACEs.
- For children and youth age 0–17, nearly 90,000 have been exposed to 10 or more episodes of violence.
- Among youth involved within the juvenile justice system in Texas, 5,900 have experienced four or more ACEs.
- Among all children and youth living in foster care in the state of Texas, approximately 24,300 have experienced one or more ACEs.
- Among children and youth enrolled in services with the LMHA, 7,700 (or 19%) children and youth have experienced a traumatic life event; nearly half of these individuals showed evidence that the traumatic experience was impacting one or more life domains.

In recognition of this need, Texas lawmakers and major child-serving agencies have taken initial steps towards transforming the state's systems. Legislative mandates require child welfare, juvenile justice, and state hospital staff to train professionals, staff, and caregivers in understanding the effects of trauma. Child welfare and juvenile justice have developed and are implementing system-wide training. Additional legislation requires that all children and youth entering the child welfare system are screened for trauma. Likewise, efforts in mental health have kept pace with those in juvenile justice and child welfare, ensuring children and youth are screened and agency staff are trained to recognize, understand, and treat trauma. In addition to training and screening, most organizations serving children and youth provide at least some trauma-focused, evidence-based therapeutic approaches.

A review of the trauma-informed landscape in Texas revealed grassroots and formal efforts to shape trauma-informed care at agency and community levels. These efforts, to varying degrees, use SAMHSA's six guiding principles and implementation domains to drive organizational and systematic change. The two community efforts with the largest reach use trauma-focused, evidence-informed approaches to promote common language. Key stakeholders attribute their success to wide-spread cross-system training on trauma and trauma-informed care approaches, support from leadership, an identified trauma-champion, and external resources and philanthropic support. These same individuals identified limited resources, regulatory standards, and staff trauma as being major barriers to developing a trauma-informed system.

Key informants stressed that providing trauma-informed care requires organizational change at multiple levels and funding structures that support the principles underlying this approach. Traditional state funding structures allow for the provision of evidence-based trauma screening, assessment, treatment, and recovery supports. However, they do not support the development of appropriate and safe facilities; the provision of peer support for professionals, staff, and care givers; the development and implementation of organization-wide trauma training; the training and implementation of trauma-informed communication strategies and care giver models; the development of cross-agency collaborations; and the evaluation of trauma-informed programs and services.

The following is a summary of the findings that resulted from this look at trauma-informed care for children, youth, and families in the child welfare, juvenile justice, and mental health systems.

- Child-serving systems are training staff on trauma-informed care.
- Despite the availability of training that addresses understanding and treating trauma, there is still an expressed need to train child welfare staff and foster parents.
- The main child-serving systems in the state of Texas have taken some steps towards becoming trauma-informed.
- The primary cross-system trauma-informed approaches being implemented in Texas are based on the "Adverse Childhood Experience" research and are grounded in the same trauma-informed framework.
- Reaching Teens© and Trust-Based Relational Intervention (TBRI®) provide a philosophical framework, shared language, and common set of approaches that allow providers in a community to operationalize the concept of trauma-informed care. These two approaches are easy to understand and can be implemented by a large cross-section of professionals, parents, and foster parents.
- In addition to a shared approach, successful trauma-informed cross-system efforts in Texas all have an external funder and a community champion.

- The local mental health authorities (LMHAs) are constrained to a core set of trauma-focused interventions that limit LMHA ability to select an intervention based on the child's or youth's trauma history, needs, or brain development.
- Medicaid (Star Health) pays for traditional office-based trauma-informed services and supports, and STAR Health provides training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Parent Child Interaction Therapy (PCIT). However, providers still identified funding as a barrier to expanding Trauma-Focused Evidence-Based Treatment (TF-EBT) capacity.

Purpose

Most children and youth in the child welfare system are impacted by trauma. For many, these experiences lead to behaviors that are misunderstood and misdiagnosed, resulting in disruptions in care, suspension or expulsion from school, or juvenile justice involvement. To better support these children and youth, it is necessary to understand trauma, its manifestations, and how to deliver care in a way that builds relationships, fosters hope, and promotes resilience and success. As a step toward this goal, the Meadows Mental Health Policy Institute (MMHPI) partnered with the Supreme Court of Texas Children's Commission to support the Child Welfare Trauma Consortium in understanding and addressing the needs of children in foster care with mental health conditions, particularly in relation to exposure to trauma and in understanding trauma-informed care (TIC).

Organization of the Report

In the first sections of this report, we examine the national TIC landscape to provide context for understanding TIC efforts in Texas. We review commonly cited definitions of TIC and highlight shared core components. We provide an overview of national trauma-informed best practices for a variety of individuals who interact with children and youth in the child welfare system. In addition, we provide a review of several successful statewide system-level TIC initiatives.

The later sections of this report describe trauma-informed initiatives and efforts in the state of Texas. First, we identify key trauma-informed players in Texas and discuss their approaches, reach, and implementation efforts. Our research utilized information gained from 75 key informant interviews to understand how providers define and operationalize TIC in Texas and to discuss the barriers they have encountered. We also focus on the local mental health authorities (LMHAs) and their role in serving children and youth who have experienced trauma. Finally, we provide an overview of Texas Medicaid and discuss funding barriers related to the delivery of TIC.

In the final section of this report, we summarize our findings and highlight areas for the Children's Commission Planning Work Group to consider when supporting TIC efforts in Texas.

Brief Overview of Trauma-Informed Care Literature and Research

Introduction

Understanding and recognizing the prevalence of Adverse Childhood Experiences (ACE)s helps to recognize and treat trauma. ACEs are traumatic or stressful events that take place in childhood and can potentially have enduring and damaging effects on a child's health and well-being. They can affect children and youth of all backgrounds, economic classes, and geographic locations.[1] Furthermore, ACEs come in many forms, including economic hardship, abuse and neglect, neighborhood violence or domestic violence, growing up with a parent who has a mental illness or a substance use disorder, incarceration of a parent, or parental divorce. Nationally, economic hardship is the most commonly reported ACE.[2] A child who has experienced ACEs is more likely to experience learning or behavioral issues and to develop a wide range of health problems including obesity, alcoholism, and drug use.

The original study on ACEs was conducted by Kaiser Permanente and the Centers for Disease Control and Prevention (CDC) from 1995 to 1997. Over 17,000 health maintenance organization (HMO) members completed surveys on their childhood experiences and current health status and behaviors. The study found that ACEs are common, and it identified an association between the number of ACEs an individuals experienced and social and health problems they reported having later in life.[3]

What Is Trauma-Informed Care?

A trauma-informed approach acknowledges the prevalence and impact of trauma and attempts to create a sense of safety for all persons, whether or not they have experienced trauma. Becoming trauma-informed requires a re-examination of policies and procedures that may result in participants feeling a loss of control, training staff to be welcoming and non-judgmental, and modifying physical environments. Becoming trauma-informed also involves minimizing perceived threats, avoiding re-traumatization, and supporting recovery.

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[1] American Academy of Pediatrics (2014). *Adverse childhood experiences and the lifelong consequences of trauma.* https://www.aap.org/en-us/Documents/ttb_aces_consequences.pdf

[2] Sacks, V., Murphy, D., & Moore, K. (2014). Research Brief-Adverse childhood experiences: National and state level prevalence. Child Trends. Publication #2014-28

[3] Centers for Disease Control and Prevention. (2016, March). *Adverse childhood experiences (ACEs*). Retrieved from https://www.cdc.gov/violenceprevention/acestudy/.

The History of Trauma-Informed Care

The National Association of Social Workers (NASW) provides an overview of the events that formed the foundation for and influenced the framework of what is now known as trauma-informed care (TIC).[4] These events include the following:

- The domestic violence and rape crisis movement of the 1970s and child advocacy centers and multidisciplinary team response to child abuse in the 1980s gave a voice to victims of interpersonal violence.
- The formation of the International Society of Traumatic Stress Studies (ISTSS) in 1985 served as a resource for professionals treating highly traumatized populations.
- The investigation of the high prevalence of physical and sexual abuse among women served by the public mental health system highlighted the victimization many women experienced when seeking mental health services.
- The 1998 Women and Co-Occurring Disorders and Violence Study encouraged providers to deliver services in a manner that did not add trauma, unnecessarily trigger memories of past traumatic events, or place a woman in a physically or psychologically dangerous situation.
- The National Child Traumatic Stress Network (NCTSN) was established by Congress in 2000 as part of the Children's Health Act to identify and promote the use of evidence-based, trauma-specific mental health interventions with children and their families.
- The NCTSN created the System Integration Committee in 2005 in recognition of the fact that system issues undermine the effectiveness of trauma-specific interventions.

How Is "Trauma-Informed Care" Defined?

"Trauma" is defined somewhat differently across disciplines. However, the most commonly referenced definition comes from the Substance Abuse and Mental Health Services Administration (SAMHSA):

> Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (p.7)[5]

[4] National Association of Social Workers and Oxford University Press (2013). Encyclopedia of Social Work: Trauma Informed Care. Retrieved from http://socialwork.oxfordre.com/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1063

[5] Substance Abuse and Mental Health Services Administration. (2014, July). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf

The terms "trauma-informed care", "trauma-informed approach," and "trauma-informed system" are often used interchangeably to describe how care is delivered at an organizational or system level. TIC can be implemented in any service setting or organization and differs from a trauma-specific intervention or trauma-focused treatment that is designed specifically to address the consequences of trauma.

A review of the literature reveals several definitions for TIC and little consensus on a single one. This ambiguity leaves providers, organizations, and systems to interpret how to operationalize the concept. In general, there is a fairly low bar for something to be considered "trauma-informed," and definitions center on a philosophical foundation that TIC is present when the awareness that trauma exists is combined with an understanding of trauma. As a result, there is often little meaning behind an organization's designation as "trauma-informed."

Hopper, Bassuk, and Olivet[6] summarized the basic principles of TIC definitions and identified four cross-cutting themes:

- **Trauma awareness:** Staff training, consultation, and modifications in organizational practices reflect an understanding of trauma and the various behaviors and symptoms that represent adaptations to trauma.
- **Emphasis on safety:** Organizational operations ensure that consumers are physically and emotionally safe, potential triggers and re-traumatization are avoided, and clear roles and boundaries are defined.
- **Opportunities to rebuild control:** Trauma-informed services emphasize the importance of choice and build a sense of efficacy and personal control.
- **Strength-based approach:** TIC is strength-based and future-oriented; it utilizes skill-building to develop resiliency.

Based on these combined principles, Hopper et al. offer the following consensus-based definition of TIC:

> Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. (p. 82)[7]

The NCTSN defines a trauma-informed child and family services system as follows:

> A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact

[6] Hopper, E. K., Bassuk, E. L., & Olivet, J., (2010). Shelter from the storm: Trauma-informed care in homeless service settings. *The Open Health Services and Policy Journal,* 3, 80-100.
[7] Hopper, E. K., Bassuk, E. L., & Olivet, J., (2010). Shelter from the storm: Trauma-informed care in homeless service settings. *The Open Health Services and Policy Journal,* 3, 82.

> with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive.[8]

SAMHSA defines TIC as an approach to the delivery of behavioral health services that

> includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. (p. xix)[9]

SAMHSA utilizes the "Four Rs" to describe the four elements that are necessary in a trauma-informed approach:

> A program, organization, or system that is trauma-informed… realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization. (p. 33)[10]

In addition, SAMHSA states that a trauma-informed approach adheres to a key set of six principles rather than a set of policies and procedures.[11] These principles appear to build on Hopper, Bassuk, and Olivet's work:

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender issues

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[8] The National Child Traumatic Stress Network. (n.d.) Creating trauma-informed systems. Retrieved from http://www.nctsn.org/resources/topics/creating-trauma-informed-systems

[9] Substance Abuse and Mental Health Services Administration. (2014). *Trauma-Informed Care in Behavioral Health Services.* Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816.pdf

[10] Flatow, R. B., Blake, M., & Huang, L. N., (2015). SAMHSA's concept of trauma and guidance for a trauma-informed approach in youth settings. Focal Point: Youth, Young Adults, & Mental Health. *Trauma-Informed Care*, 29–35. Retrieved from https://www.pathwaysrtc.pdx.edu/pdf/fpS1510.pdf

[11] Substance Abuse and Mental Health Services Administration. (n.d.) Trauma-informed approach and trauma-specific interventions. Retrieved from https://www.samhsa.gov/nctic/trauma-interventions

The Center for Health Care Strategies (CHCS) states that TIC must involve organizational and clinical practices that recognize the impact of trauma on both the provider and the patient.[12] CHCS stresses that, in order to be trauma-informed, an organization must initiate widespread trauma-informed organizational change that includes changes to culture and policy. These changes form the foundation for the delivery of trauma-specific treatment.

Evidence-Based Trauma-Informed Practices

Despite the fact that there is no single definition for trauma or TIC, there are many evidence-based, trauma-specific or trauma-focused approaches available to work with when providing services to children, youth, and their families in the various child-serving systems. Several of these approaches and interventions are listed in this report. This is not an exhaustive list. Further information on the approaches mentioned below and on additional evidence-based practices can be found by accessing the websites for the NCTSN,[13] the National Registry of Evidence-Based Programs and Practices (NREPP),[14] and the California Evidence-Based Clearinghouse for Child Welfare (CEBC).[15] See Appendix One for an overview NREPP and CEBC.

Trauma-Focused Training

Trauma-focused interventions are most effective when they are implemented within and throughout an organization so that approaches become ingrained in the culture of an organization and that *every* person who comes in contact with a child or youth understands the impact of trauma and can respond to traumatic stress symptoms in a supportive manner. Below is a sample of curricula developed by the NCTSN as well as additional promising trauma models and tools.[16]

Child Welfare Caseworkers

- Child Welfare Trauma Training Toolkit (Child Welfare Collaborative Group, NCTSN, and the California Social Work Education Center, 2013)[17]

[12] Menschner, C., & Maul, A., (2016). Issue brief: Key ingredients for successful trauma-informed care implementation. Advancing Trauma-Informed Care. Center for Health Care Strategies, Inc. Retrieved from www.chcs.org

[13] National Children's Traumatic Stress Network (NCTSN). http://www.nctsn.org/

[14] National Registry of Evidence-based Programs and Practices (NREPP). https://www.samhsa.gov/nrepp.

[15] California Evidence-Based Clearinghouse for Child Welfare (CEBC). http://www.cebc4cw.org/

[16] Olafson, E., Halladay Goldman, J., Gonzalez, C. (2016). Trauma-informed collaborations among juvenile justice and other child-serving systems: An update. *OJJDP Journal of Juvenile Justice.* (5)1. Retrieved from http://www.journalofjuvjustice.org/JOJJ0501/article01.htm

[17] Child Welfare Collaborative Group, National Child Traumatic Stress Network, California Social Work Education Center. (2013). *Child welfare trauma training toolkit: Trainer's guide* (2nd ed.). Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

Residential Treatment Staff, Probation Officers, Court Personnel

- Think Trauma: A Four-Module Trauma Milieu Training (Marrow, Benamati, Decker, Griffing, & Lott, 2012)[18]
- Cops, Kids, and Domestic Violence (NCTSN, 2006)[19]
- Ten Things Every Juvenile Court Judge Should Know About Trauma and Delinquency (Buffington, Dierkhising, & Marsh, 2010)[20]
- NCTSN Bench Card for the Trauma-Informed Judge (NCTSN Justice Consortium and National Council of Juvenile and Family Court Judges, 2013)[21]

Foster Families

- Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents (NCTSN, 2010).[22] This training was co-created by NCTSN experts and experienced foster parents. It combines trauma knowledge and peer support with opportunities to apply that knowledge to a child in the caregiver's home.

Educators

- Child Trauma Toolkit for Educators (NCTSN Schools Committee, 2008)[23]

Trauma-Specific Interventions in Mental Health[24, 25, 26]

The trauma-specific, evidence-based or evidence-informed therapeutic approaches most commonly mentioned in the literature for treating children, youth, and their families are the following:

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[18] Marrow, M., Benamati, J., Decker, K., Griffin, D., Lott, D.A. (2012). *Thinking trauma: A training for staff in juvenile justice residential settings.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.
[19] National Child Traumatic Stress Network (2006). *Cops, Kids & Domestic violence: Protecting our future* (DVD). Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.
[20] Buffington, K., Dierkhising, C. B., Marsh, S. C. (2010). *Ten things every juvenile court judge should know about trauma and delinquency.* Retrieved from http://www.ncjfcj.org/sites/default/files/trauma%20bulletin_1.pdf
[21] National Child Traumatic Stress Network, Justice Consortium & National Council for Juvenile and Family Court Judges. (2013). *NCTSN bench card for the trauma-informed judge.* Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/judge_bench_cards_final.pdf
[22] National Child Traumatic Stress Network. (2010). *Caring for children who have experienced trauma: A workshop for resource parents.* Retrieved from http://nctsn.org/nctsn_assets/pdfs/rpc/RPC Participant Handbook FINAL.pdf
[23] National Child Traumatic Stress Network Schools Committee. (2008). *Child trauma toolkit for educators.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress. Retrieved from https://wmich.edu/sites/default/files/attachments/u57/2013/child-trauma-toolkit.pdf
[24] De Arellano, M. A., Ko, S. J., & Sprague, C. M. (2008). *Trauma-informed interventions: Clinical and research evidence and culture-specific information project.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.
[25] National Child Traumatic Stress Network. *Treatments that Work.* Retrieved from http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices#q4
[26] Child Trauma Academy. (n.d.). NMT. Retrieved from http://childtrauma.org/nmt-model/

- Attachment, Self-Regulation, and Competency (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth
- Cognitive Behavioral Therapy Approaches (CBT)
  - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
  - Combined Parent Child Cognitive Behavioral Approach for Children and Families At-Risk for Child Physical Abuse (CPC-CBT)
  - Alternatives for Families-Cognitive Behavioral Therapy (AF-CBT)
- Dialectical Behavioral Therapy (DBT)
  - Adapted Dialectical Behavioral Therapy for Special Populations (DBT-SP)
- Eye Movement Desensitization and Reprocessing (EMDR)-Child and Adolescent
- Parent-Child Interaction Therapy (PCIT)
- Prolonged Exposure Therapy for Adolescents (PE-A)
- Neurosequential Model of Therapy (NMT)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Trauma Affect Regulation Guideline for Education and Therapy for Adolescents (TARGET-A)
- Trauma and Grief Component Therapy for Adolescents (TGCT)

Trauma-Specific Interventions in Juvenile Justice

Probation officers and juvenile justice staff are not mental health professionals. They do not need to know how to implement trauma-specific treatment approaches. However, it is important that they understand how trauma impacts behaviors, are trained to determine the needs of a youth, and identify the services and supports required to meet these needs. Probation officers and juvenile justice staff must have access to a comprehensive continuum of care that includes evidence-based, trauma-specific treatments effective with youth in the juvenile justice system.[27]

Ford, Kerig, Desai, and Feirman identified four evidence-based psychosocial interventions that have been proven to be effective with the juvenile justice population.[28]

- Cognitive Processing Therapy (CPT)
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma and Grief Components Therapy for Adolescents (TGCTA)
- Trauma-Adapted Multidimensional Treatment Foster Care (TA-MTFC)

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[27] National Center for Mental Health and Juvenile Justice Policy Research Associates. (2015). Strengthening our future: Key elements to developing a trauma-informed juvenile justice diversion program for youth with behavioral health conditions. Retrieved from https://www.ncmhjj.com/wp-content/uploads/2015/12/Strengthening-Our-Future.pdf

[28] Ford, J. D., Kerig, P. K., Desai, N., & Feierman, J. (2016). Psychosocial interventions for traumatized youth in the juvenile justice system: Research, evidence base, and clinical/legal challenges. *OJJDP Journal of Juvenile Justices.* (5),1.

Two additional models that support a trauma-informed care environment in juvenile justice diversion and supervision practices are identified in *Strengthening Our Future*.[29] T4 (TARGET 1, 2, 3, 4) is a four-step shortcut to the TARGET training. It provides concrete tools that help youth and staff achieve optimal personal control. The Sanctuary Model is a whole-organizational model of service and care. It was originally designed for an acute inpatient psychiatric population of adults who had been traumatized as children. It has been adapted to cover a variety of populations, including children and youth.

Trauma-Specific Interventions in Child Welfare [30, 31, 32, 33]

Many people touch the lives of children and youth who are involved in the child welfare system. These include judges, lawyers, child protective service (CPS) workers, Court Appointed Special Advocates (CASAs), mental health and primary care providers, biological parents, relatives, and foster parents. These individuals need to understand what trauma is, recognize signs and symptoms, know how to treat it, and create opportunities for children and youth who have experienced trauma to feel safe and empowered. There are several evidence-based interventions, evidence-informed approaches, tools, and sources of information to help individuals who provide services and supports to children and youth involved in the child welfare system and their families.

Therapeutic Interventions for Mental Health Professionals

The following approaches were found to be effective, specifically with children and youth involved in the child welfare system, and supplement the therapeutic approaches mentioned above.

- Attachment and Biobehavioral Catch-Up (ABC)
- Child and Family Traumatic Stress Intervention
- Real Life Heroes: Resiliency-Focused Treatment for Children with Traumatic Stress (RLH)
- Treatment Foster Care Oregon (TFCO-A) Educational Intervention for Children in Foster Care

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[29] Strengthening Our Future. (2015). Strengthening our future: Key elements to developing a trauma-informed juvenile justice diversion program for youth with behavioral health conditions. Retrieved from https://www.ncmhjj.com/wp-content/uploads/2016/01/traumadoc012216-reduced-003.pdf

[30] National Child Traumatic Stress Network. (n.d.). *Treatments that work.* Retrieved from http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices#q4

[31] California Evidence-Based Clearinghouse for Child Welfare. (n.d.). Treatment Foster Care Oregon. Retrieved from http://www.cebc4cw.org/program/

[32] Circle of Security International. For Parents. Retrieved from https://www.circleofsecurityinternational.com/for-parents

[33] Fostering Resilience: Preparing children and teens to thrive through both good and challenging times. (n.d.). Retrieved from http://www.fosteringresilience.com/professionals/

Interventions for Foster, Kinship, and Biological Parents

- Trauma-Informed PS MAPP (TIPS-MAPP)
- Trust-based Relational Intervention (TBRI®)
- KEEP (Keeping Foster and Kin Parents Supported and Trained)
- Circle of Security-Parents (COS-P)
- Reaching Teens©: Strength-Based Communication Strategies to Build Resilience and Support Healthy Adolescent Development

Intervention for Caseworkers

The following approaches are in addition to the interventions listed for parents.

- Child-Adult Relationship Enhancement (CARE): Adaptation of Parent Child Interaction Therapy (PCIT)
- Wraparound

Trauma-Informed Resources Information for Judges, Attorneys, and CASAs

There are no specific trauma-focused interventions or approaches for judges. However, the NCTSN recommends that courts become trauma-informed at all levels. The intent is to make the court a safe environment that does not increase the trauma experienced by the child, youth, or parents and that does provide opportunities to learn tools to cope with traumatic stress reactions. In addition, courts can screen for trauma, refer for necessary trauma assessments, and refer to providers that use trauma-focused approaches. Courts are encouraged to take a leadership role in increasing system-wide awareness of trauma, developing community capacity to deliver trauma-focused approaches, and fostering partnerships among youth, families, professionals, and stakeholders.

The following tool was identified as effective in assisting attorneys and other court-appointed advocates in incorporating trauma knowledge into their daily practices. It is not intended to be a screening tool. It is designed to help advocates identify trauma experiences and symptoms of trauma and identify beneficial services.[34]

- Identifying Polyvictimization and Trauma Among Court-Involved Children and Youth: A Checklist and Resource Guide for Attorneys and Other Court-Appointed Advocates.[35]

[34] Klain, E. J., & White, A. R., (2013). Implementing trauma-informed practices in child welfare. Retrieved from http://www.centerforchildwelfare.org/kb/TraumaInformedCare/ImplementingTraumaInformedPracticesNov13.pdf

[35] Pilnik, L., & Kendall, J. R. (2012). Identifying polyvictimization and trauma among court-involved children and youth: A checklist for attorneys and other court-appointed advocates. North Bethesda, MD: Safe Start Center, Office of Juvenile Justice and Delinquency Prevention, Programs, U.S. Department of Justice. Retrieved from https://www.ojjdp.gov/programs/safestart/IdentifyingPolyvictimization.pdf

Klain and White identify five trauma-informed practice recommendations for child welfare systems, courts, advocates, and staff:[36]

- Educate stakeholders about the effects of trauma on children and families as well as effective trauma-specific treatments.
- Ensure children entering the child welfare system are screened and assessed for trauma.
- Refer children to appropriate evidence-based, trauma-specific treatment.
- Provide information and trauma-related services to birth families and caregivers.
- Encourage stakeholders to collaborate to form a cohesive, integrated community approach to addressing trauma.

Trauma-Specific Interventions in Schools[37, 38, 39]

Social and emotional learning (SEL) is a process through which a student acquires and applies the knowledge and skills necessary to understand and manage emotions, set and achieve goals, feel and show empathy, and develop positive relationships.[40] TIC and SEL share interrelated characteristics that, when used in tandem, help children and youth who have experienced trauma succeed in school. Blodgett and Dorado believe that the social and emotional skills of a child or youth who has experienced trauma will develop naturally when trauma-sensitive educational practices are utilized. Despite this alignment, there are no standard practices for integrating trauma-informed or trauma-sensitive care and SEL in schools.

There are several evidence-based and evidenced-informed school-based interventions identified in the literature. These interventions are effective with children and youth who have experienced abuse and neglect, except for Psychological First Aid (PFA). PFA for schools is designed to assist children, youth, and their families in the aftermath of disaster or terrorism.

Structured, Mental Health-Focused, Student-Centered, and Trauma-Specific

- Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a school-based program designed to reduce the symptoms of post-traumatic stress disorder, depression, and general anxiety among children exposed to multiple forms of trauma
- Multimodality Trauma Treatment (MMTT), also known as Trauma-Focused Coping in Schools

[36] Klain, E. J., & White, A. R., (2013). Implementing trauma-informed practices in child welfare. Retrieved from http://www.centerforchildwelfare.org/kb/TraumaInformedCare/ImplementingTraumaInformedPracticesNov13.pdf
[37] National Child Traumatic Stress Network. *Treatments that Work.*
[38] Child Trauma Academy. NME.
[39] Blodgett, C., & Dorado, J. (n.d.). CLEAR trauma-informed schools white paper: A select review of trauma-informed school practice and alignment with educational practices. Retrieved from http://ext100.wsu.edu/cafru/wp-content/uploads/sites/65/2015/02/CLEAR-Trauma-Informed-Schools-White-Paper.pdf
[40] CASEL: Educating Hearts. Inspiring Minds. (n.d.). *What is SEL.* Retrieved from http://www.casel.org/what-is-sel/

Structured, Population-Focused, Trauma-informed, System-Centered

- Collaborative Learning for Educational Achievement and Resilience (CLEAR)
- Healthy Environments and Response to Trauma in Schools (HEARTS)
- Neurosequential Model in Education (NME)
- Psychological First Aid (PFA)-Schools

School-Wide, Teacher Centered, Trauma-Informed

- FuelEd: Fueling Schools with the Power of Relationships

Trauma-Informed, Cross-System Collaboration Models

Olafson, Halladay Goldman, and Gonzalez[41] identified four themes that are essential to fostering trauma-informed cross-system collaborations. They are (1) effective cross-system, multi-level leadership; (2) formalized stakeholder engagement through memoranda of understanding (MOUs) and multi-disciplinary teams; (3) collaborative identification of shared outcomes by key stakeholders and community members; and (4) evaluation of the impact in order to inform future planning and support sustainability. Using these themes, they identified several examples of trauma-informed cross-system collaboration.

- **Georgetown University Crossover Youth Practice Model**[42]
  This model is a collaboration between Casey Family Programs and the Center for Juvenile Justice Reform (CJJR). It focuses on youth who are known to be in both the child welfare and juvenile justice systems.
- **Trauma-Systems Therapy (TST)**[43]
  This is a promising cross-system comprehensive approach for youth who have experienced trauma. It has been used with various populations including youth involved in the child welfare and juvenile justice systems.
- **Positive Student Engagement Model for School Policing**[44]
  Initially known as the Multi-Integrated Systems Approach, this model was developed in response to the school-to-prison pipeline. It encourages the use of restorative rather than punitive practices.

[41] Olafson, E., Halladay Goldman, J., & Gonzalez, C., (2016). Trauma-informed collaborations among juvenile justice and other child-serving systems: An update. *OJJDP Journal of Juvenile Justice*, (5)1.
[42] Georgetown University Crossover Youth Practice Model. (n.d.). Retrieved from http://cjjr.georgetown.edu/our-work/crossover-youth-practice-model/
[43] Trauma-Systems Therapy. (n.d.). Retrieved from https://med.nyu.edu/child-adolescent-psychiatry/research/institutes-and-programs/trauma-and-resilience-research-program/trauma-systems-therapy
[44] Multi-Integrated Systems Approach. (n.d.). Retrieved from http://www.ncjfcj.org/sites/default/files/Zero%20Tolerance%20Policies%20in%20Schools%20%282%29.pdf

- **Child Development Community Policing Program (CDCP)**[45]
  Developed by the Yale Child Study Center in collaboration with the New Haven Police Department, CDCP supports the work of mental health providers and police officers attending to the needs of children and youth exposed to traumatic events, responding immediately to calls involving children or youth who are witnesses or victims to violent events, including domestic violence.
- **Court and Mental Health Collaboration*s***[46]
  Olafson et al. provide numerous examples of proactive collaborations between the court system and mental health system that have shown promise in the areas of prevention and treatment.

A Look at State Consortiums and Councils

Successful states have collaborated across service systems to develop their workforces, screen for trauma, change practices, and increase access to evidence-based practices. Connecticut, Iowa, Ohio, and Oregon have developed statewide or regional cross-system collaboratives, steering committees, and learning communities. Iowa's steering committee has developed a five-year vision and common legislative agenda. Connecticut and Oregon have expanded their collaborative efforts to include training primary health care providers, with Connecticut developing a trauma screening for physicians. Ohio's initiative provides training to expand opportunities for practitioners to become competent in trauma-informed approaches. In addition, Washington, Pennsylvania, and California have passed statewide resolutions that support trauma-informed care. The following are examples of states' collaborative efforts. This list is not exhaustive.

Connecticut

The Child Health and Development Institute of Connecticut, Inc. (CHDI) has been working to implement a trauma-informed system of care in Connecticut since 2007. CHDI has worked with state agencies, provider organizations, and families to improve access for children to services that address trauma. Their strategies include workforce development, trauma screening, practice change and access to evidence-based practices, and cross-system collaboration.[47]

With funding from the Department of Children and Families and the Federal Administration for Children and Families, CHDI has developed and implemented trauma-informed policies, systems, and practices in the child welfare, juvenile justice, and children's mental health

[45] Child Development Community Policing Program (CDCP). https://medicine.yale.edu/childstudycenter/cvtc/programs/cdcp.aspx.
[46] Olafson, E., Halladay Goldman, J., & Gonzalez, C., (2016). Trauma-informed collaborations among juvenile justice and other child-serving systems: An update. *OJJDP Journal of Juvenile Justice*, (5)1.
[47] Lang, J., Campbell, K., & Vanderploeg, J. (2015) Advancing trauma-informed systems for children. Farmington, CT: Child Health and Development Institute of Connecticut.

systems. They have also trained pediatric health providers to identify trauma and link children and families to services, developed a screening tool for childhood trauma (The Child Trauma Screen), and developed a website to increase public awareness for parents and caregivers.

Another statewide TIC consortium is the Connecticut Women's Consortium, which expanded statewide in 1998. The consortium has worked with the Department of Mental Health and Addiction Services to train providers on evidence-based practices and to promote a recovery-oriented system that is trauma-informed and gender-responsive. The consortium's partnership, the Trauma and Gender Initiative, will be moving towards a regional collaborative model in 2017.

Iowa

Central Iowa Adverse Childhood Experiences Steering Committee focuses on collective community efforts to prevent or lessen the impact of ACEs and is a coalition of business, education, non-profit, and philanthropic entities.[48] The structure of the coalition includes a learning community with open membership that convenes at least twice a year to share information and opportunities for engagement, a steering committee, and action groups. The Iowa ACEs Steering Committee started in 2011 after learning about the ACEs study findings.[49]

The group's past efforts include developing a standard presentation to over 1,000 people in the state, adding child neglect questions to the Behavioral Risk Factor Surveillance System (BRFSS) questionnaire, and hosting a summit to engage education and juvenile justice sectors on ACEs. In collaboration with other Iowa groups, the policy committee has developed a five-year vision along with a common legislative agenda regarding ACEs.

Ohio

Ohio's Trauma-Informed Care Initiative[50] is organized through six regional collaboratives. The Ohio Department of Mental Health and Addiction Services (OhioMHAS) and Department of Developmental Disabilities (DODD) collaborate on a statewide Trauma-Informed Care Initiative. The initiative's intent is to promote a sense of safety, security, and equality among clients. The initiative expands opportunities for people to receive trauma-informed interventions by

[48] Iowa ACEs 360. (n.d.). About us. Retrieved from http://www.iowaaces360.org/uploads/1/0/9/2/10925571/central_iowa_aces_360_steering_committee_timeline.pdf

[49] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*. 14 (4), 245–258. DOI: http://dx.doi.org/10.1016/S0749-3797(98)00017-8

[50] Ohio Mental Health and Addiction Services. (n.d.). Ohio's Trauma Informed Care Initiative. Retrieved from http://mha.ohio.gov/traumacare

improving opportunities for practitioners, facilities, and agencies to become competent in trauma-informed practices.

An annual Trauma-Informed Summit that promotes knowledge about the impact of trauma, implementation of trauma-informed practice, sustainability, and collaboration among agencies has been held for four years. The National Center for Trauma-Informed Care (NCTIC) has provided consultation and training to different sectors.

The TIC Initiative has provided training to all Regional Psychiatric Hospitals and the DODD Developmental Centers, created a train-the-trainer model for trauma-informed approaches, developed an educational and communication campaign on trauma, initiated a reduction of seclusion and restraint initiative, supported a trauma-informed initiative across social service systems, and created a statewide TIC Advisory Committee.

Oregon

Trauma Informed Oregon (TIO)[51] reflects the state's commitment to promote trauma prevention and to better align policies and practice with the principles of TIC. The statewide collaboration was initiated in 2014 when the Oregon Health Authority's Health Systems Division contracted with Portland State University in partnership with Oregon Health and Science University (OHSU) and the Oregon Pediatric Society to promote and sustain TIC across child- and family-serving systems. In 2015, the collaborative was expanded to include adult behavioral health-serving systems.

TIO coordinates and provides training and serves as a source of information and resources. It also works with state agencies, state and local providers, communities, family and youth organizations, and other stakeholders to bring perspectives together so that they may learn from each other and to advocate for trauma-informed policies and practices.

State Resolutions

The following states passed resolutions to promote expansion of trauma-informed practices and policies.

California

In 2014, the California Senate passed Assembly Concurrent Resolution 155 (ACR 155), which encourages statewide policies to reduce children's exposure to stress and ACEs.[52] The

[51] Trauma Informed Oregon. (n.d.). About trauma-informed Oregon. Retrieved from http://traumainformedoregon.org/about

[52] Trauma Informed Oregon. (n.d.). About trauma-informed Oregon. Retrieved from http://traumainformedoregon.org/about

resolution encourages officials to support research-based solutions, invest in preventive health care, and promote mental health and wellness interventions.

Pennsylvania

In April 2013, Pennsylvania House Resolution 191, which declares support for a public health approach to violence and statewide trauma-informed education, was passed.[53] The resolution acknowledges the impact of trauma and esblishes a framework for dialogue on the issue. It also secured approval by the National Conference of State Legislatures an action which is communicated to Congress and the President, moving the issue to a national stage. The resolution did not authorize or fund new mandates or programs, and the Senate did not issue a similar resolution.

Washington

In 2011, House Resolution 1965, which was intended to identify and promote innovative strategies to prevent or reduce ACEs, was passed. It also developed a public-private partnership to support effective strategies which formed the Washington State ACEs Public-Private Initiative (APPI). APPI examines effective community-based approaches to reducing ACEs and documenting public savings resulting from this work.[54] The APPI conducted a two-and-a-half-year evaluation that studied how five communities in the state implemented community-based approaches.

[53] Prewitt, E. (2014, April 30). State, federal lawmakers take action on trauma-informed policies, programs. Retrieved from http://acestoohigh.com/2014/04/30/state-federal-lawmakers-take-action/

[54] Prewitt, E. (2014, April 30). State, federal lawmakers take action on trauma-informed policies, programs. Retrieved from http://acestoohigh.com/2014/04/30/state-federal-lawmakers-take-action/

What Does Trauma-Informed Care Look Like in Texas?

To understand how TIC is delivered to children, youth, and families in the child welfare, juvenile justice, and mental health systems in Texas, we needed to explore the following actions:

- Estimate how many children and adolescents in Texas have experienced trauma
- Review statewide legislation that addresses trauma and TIC
- Identify and review TIC training available to professionals and caregivers throughout the state
- Review the primary models of TIC utilized in Texas
- Meet with key informants in the state's child-serving systems to find out how TIC is being operationalized and delivered in communities across the state, which trauma-focused models are being used, and what organizational- and system-level successes and barriers they have experienced
- Identify successful cross-system TIC collaboratives
- Review the funding streams that are available to fund TIC and trauma-focused approaches

How Many Children in Texas Have Been Affected by Trauma?

An adverse childhood experience is a potentially traumatic event that can have a lasting, negative effect on a child or youth's physical and emotional wellbeing.[55] The prevalence of ACEs is measured by whether a child has been a victim of violence, experienced economic hardship "somewhat often" or "often," lived with a parent who divorced or separated, lived with a parent who died or was incarcerated, witnessed violence at home or in his or her neighborhood, or lived with a parent who had a mental illness or struggled with a substance abuse problem. Children and youth who have experienced multiple ACEs are at highest risk for negative outcomes, including health and behavioral problems.[56]

Just under half of children in the United States have experienced one traumatic life event or ACE.[57] A review of national prevalence estimates and state-level data indicates that approximately 10% of Texas children have experienced three or more ACEs in their lifetime.[58] Many have experienced eight or more episodes of violence. In addition, children and youth who are involved in the child welfare and juvenile justice systems are significantly more likely than

[55] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*. 14 (4), 245–258. DOI: http://dx.doi.org/10.1016/S0749-3797(98)00017-8
[56] Sacks, V., Murphy, D., & Moore., K. (2014). Adverse childhood experiences: National and state-level prevalence. *Research Brief: Child Trends.* Publication #2014-28.
[57] American Psychological Association. (n.d.). Children and trauma: Update for mental health professionals. Retrieved from http://www.apa.org/pi/families/resources/children-trauma-update.aspx
[58] Sacks, V., Murphy, D., & Moore., K. (2014). Adverse childhood experiences: National and state-level prevalence. *Research Brief: Child Trends.* Publication #2014-28.

the general population to have experienced an ACE. Taking these factors into consideration, child-serving systems in Texas need to be able to identify, understand, and treat trauma.

Methodology for Estimating Prevalence

Measuring the prevalence of child and youth trauma is difficult and imprecise. National- and state-level data must be triangulated to estimate how many children and youth have been exposed to trauma. The following estimates for Texas children and youth draw on the National Survey of Children's Exposure to Violence and the National Survey of Children's Health. Other data include the number of youth who have been identified with mental health needs within the social services and juvenile justice system.

Findings on Child and Youth Trauma Exposure (TE) in Texas

- **Finding 1: Statewide, approximately 730,000 children and youth, or 1 in 10 children/youth overall, have experienced three or more ACEs.** The most prevalent ACEs among Texas children and youth are exposure to economic hardship, living with a divorced parent or guardian, living with someone who has a substance use problem, and living with someone with a mental illness.

Table 1: Children and Youth Who Have Experienced Three or More Adverse Childhood Experiences[59,60]

Adverse Childhood Experiences (ACEs)	Texas Prevalence Proportion (Age 0–17)	Texas Prevalence Count (Age 0–17)
Three or more adverse childhood experiences	**10.0%**	**728,289**
Lived with a parent or guardian who got divorced or separated	20.0%	1,456,577
Lived with a parent or guardian who died	2.6%	189,355
Lived with a parent or guardian who served time in jail or prison	6.9%	502,519
Lived with anyone who was mentally ill or suicidal, or severely depressed for more than a couple of weeks; lived with anyone who had a problem with alcohol or drugs	8.0%	582,631
Lived with anyone who had a problem with alcohol or drugs	10%	728,289
Witnessed a parent, guardian, or other adult in the household behaving violently toward another (e.g.,	7.9%	575,348

[59] Sacks, V., Murphey, D., & Moore, K. (2014). Adverse childhood experiences: National and state-level prevalence. Child Trends: Research Brief, Publication #2014-28. Retrieved from: https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

[60] Additional data not found in Sacks et al. (2014) was retrieved from the Data Resource Center for Child & Adolescent Health: http://www.childhealthdata.org/browse/survey.

Adverse Childhood Experiences (ACEs)	Texas Prevalence Proportion (Age 0–17)	Texas Prevalence Count (Age 0–17)
slapping, hitting, kicking, punching, or beating each other up)		
Was ever the victim of violence or witnessed any violence in his or her neighborhood	7.3%	531,651
Experienced economic hardship "somewhat often" or "very often" (i.e., the family found it hard to cover costs of food and housing)	29.0%	2,112,037

- **Finding 2: For children and youth age 0–17, nearly 90,000 have been exposed to 10 or more episodes of violence.** According to The National Survey of Children's Exposure to Violence, approximately 90,000 Texas children and youth may have been regularly exposed to any form of violence. The table below summarizes the estimated prevalence of child and youth exposure to violence in Texas based on national prevalence estimates by the type of violence and the general frequency of multiple exposures within a 12-month period.

Table 2: Children and Youth Annual Exposure to Violence[61]

Violent Experience	National 12-Month Prevalence (Age 0–17)	Texas State Count (Age 0–17)
Direct Exposure to One or More Episodes of Violence (Low)	60.8%	4,427,995
Direct Exposure to Six or More Episodes of Violence (Moderate)	10.1%	735,572
Direct Exposure to 10 or More Episodes of Violence (High)	1.2%	87,395
Direct, Indirect or Witnessed Exposure to One or More Episodes of Violence	67.5%	4,915,949
Any Physical Assault	37.3%	2,716,517
"Any Physical Assault" includes assault with a weapon, assault with injury, assault with no weapon, attempted assault, attempted or completed kidnapping, assault by adult, assault by juvenile sibling, assault by non-sibling peer, assault by gang or group, genital assault, dating violence, bias attack, threatened assault, physical intimidation, relational aggression, internet or cell phone harassment		
Any Sexual Offence	5.0%	364,144

[61] Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of childhood exposure to violence, crime, and abuse: Results from the National Survey of Children's Exposure to Violence. *JAMA Pediatrics*, 169(8). These data have applied national prevalence rates to the 0–17 age Texas population.

Violent Experience	National 12-Month Prevalence (Age 0–17)	Texas State Count (Age 0–17)
"Any Sexual Offence" includes sexual assault, completed rape, attempted rape, sexual assault by known adult, sexual assault by adult stranger, sexual assault by peer, flashed by peer, flashed by adult, sexual harassment, internet sex talk, statutory sex offense		
Any Maltreatment	15.2%	1,106,999
"Any Maltreatment" includes physical abuse, emotional abuse, sexual abuse, neglect, custodial interference or family abduction		
Any Property Crime	27.1%	1,973,662
"Any Property Crime" includes robbery by non-sibling, vandalized by non-sibling, theft by non-sibling		
Witnessed Any Violence	24.5%	1,784,307
"Witnessed Any Violence" includes family assault, partner assault, physical abuse, assault in community, exposure to shooting, exposure to war, exposure to household theft, indirect exposure to school threat, bomb, or attack		

- **Finding 3: Among youth within the juvenile justice system in Texas, 5,900 have experienced four or more ACEs.** Youth involved in the juvenile justice system are more likely to have experienced multiple types of trauma, are 13 times less likely to report zero ACEs, and experience 3 times the prevalence of ACEs as the general population.[62] Among juvenile offenders, the most prevalent ACEs are family violence, parental separation/divorce, and household member incarceration. Based on a study by Baglivio and Epps examining the prevalence of ACEs among 64,000 juvenile offenders, 25% of juvenile offenders reported four or more ACEs.[63] Among the 23,963 youth on probation in the state of Texas, an estimated 5,900 youth have experienced an ACE of some kind. The Texas Juvenile Justice Department (TJJD) does not use a formal screen for capturing trauma exposure. However, it currently screens for mental health treatment needs. In FY 2015, more than 11,500 juvenile offenders were identified with a mental health need upon entering the TJJD system.[64]

[62] Baglivio, M. T., Epps, N., Swartz, K., Huq, M. S., & Hardt, N. S. (2014). The prevalence of Adverse Childhood Experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice*, 3, 1–23.
[63] Baglivio, M. T., Epps, N., Swartz, K., Huq, M. S., & Hardt, N. S. (2014). The prevalence of Adverse Childhood Experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice*, 3, 1–23.
[64] TJJD. (2016). FY 2015. Department-identified mental health needs and services provided to youth on probation. Dataset provided to MMHPI by Pernilla Johansson of TJJD on March 9, 2016.

Table 3: Characteristics of Youth Admitted to the Texas Department of Juvenile Justice in FY 2015[65]

Other Youth Characteristics (New Admissions)	High MH Need	Moderate MH Need	Low MH Need	No MH Need
Parents Unmarried, Divorced, Separated, or at Least One Deceased	16 (93%)	117 (86%)	223 (89%)	351 (87%)
On Probation at Commitment	13 (76%)	94 (69%)	203 (81%)	283 (70%)
Prior out of Home Placement	11 (65%)	94 (69%)	195 (78%)	238 (59%)
Family History of Criminal Involvement	10 (59%)	82 (60%)	125 (50%)	218 (54%)
Suspected History of Abuse or Neglect	14 (82%)	80 (59%)	95 (38%)	117 (29%)
Special Education Eligible	14 (82%)	45 (33%)	105 (42%)	81 (20%)

- **Finding 4: Among all children and youth living in foster care in the state of Texas, approximately 24,300 have experienced one or more ACEs.** Relatively little research has examined the prevalence rates of ACEs among youth in substitute care. Child welfare research estimates that 6% of all U.S. children and youth will experience entry into a foster care system before age 18.[66] African Americans and Native Americans are much more likely to enter a foster care system (12% and 15% respectively).[67] Based on the 2011–2012 National Survey of Children's Health (NSCH), 76% of all youth in foster care (or previously in foster care) experienced one or more ACEs, compared to 33% among children without exposure to the foster care system.[68] In 2016, there were 31,943 total foster care placements statewide. Based on current research, as many as 24,300 children and youth in foster care in Texas may have experienced an ACE. The 2011–2012 NSCH is based on a representative sample of parents in the United States. There is likely to be some unknown degree of misclassification of ACE status as some guardians and parents of foster care dependents may not know the complete history of their child or youth. For this reason, some child welfare experts suspect ACE prevalence among children with exposure to the foster care system to be greater than reported.

- **Finding 5: Among children and youth enrolled in services with the LMHA,7,700 (or 19%) children and youth who were assessed for trauma have experienced a traumatic**

[65] TJJD. (2016). Residential mental health services provided to youth on probation in FY2015. Dataset provided to MMHPI by Pernilla Johansson of TJJD on March 9, 2016.
[66] Turney, K., & Wildeman, C. (2016). Adverse childhood experiences among children placed in and adopted from foster care: Evidence from a nationally representative survey. *Child Abuse & Neglect*, 64: 117–129.
[67] Wildeman, C., & Emanuel, N. (2014). Cumulative risks of foster care placement by age 18 for U.S. children, 2000–2011. *Public Library of Science*, 9(3), 1–7.
[68] Turney, K., & Wildeman, C. (2016). Adverse childhood experiences among children placed in and adopted from foster care: Evidence from a nationally representative survey. *Child Abuse & Neglect*, 64: 117–129.

life event; nearly half of these individuals showed evidence that the traumatic experience was impacting one or more life domains. The LMHA completed the trauma item on the CANS assessment for more than 41,000 children and youth in FY 2016. Approximately 7,700 or 19% children and youth assessed had experienced a traumatic life event, of whom, nearly half showed evidence that the traumatic experience was impacting one or more life domains. Among children and youth who were assessed for trauma through the CANS assessment, 1% (566 children and youth) reported features consistent with one or more PTSD systems in the past 30 days.

Table 4: Child and Youth Trauma Exposure Assessed Through CANS FY 2016[69]

CANS Assessment Findings	Number of Youth	Percent of Total
CANS Assessment - Total	**49,275**	**100%**
Trauma History not recorded by the LMHA	8,040	16%
Total Completed CANS Trauma Section	**41,221**	**100%**
No History of Trauma in past 30 days	29,674	80%
History of Traumatic Life Event	7,698	19%
Trauma impacts ≥ 1 life domain	3,297	8%
Experiencing ≥ 1 PTSD symptoms in past 30 days	566	1%

Trauma-Informed Care Legislation in Texas

Texas lawmakers have begun to lay a foundation to address trauma statewide. Between the 82nd and 84th legislative sessions, seven bills containing mandates related to TIC were passed (see Table 5, below). There were no bills passed during the 85th legislative session that required statewide systematic changes to address trauma, specific to children and youth. Six of seven past mandates focused on training the child welfare, juvenile justice, state hospital, and state supportive living center workforce as well as foster care families and caregivers. The intensity and frequency of training varies by legislative mandate. At minimum, those agencies are required to provide new employees, foster care families, and caregivers with web-based or face-to-face introductory training on TIC. The mandates around juvenile justice training requirements are the most stringent. They require face-to-face training that includes best practices in behavior management and seclusion and restraints.

[69] Lynch, C. (June 16, 2017). Email. Texas CANS Aggregate Data. Health and Human Services Commission-Office of General Counsel

During the 84th legislative session, lawmakers took steps to ensure that children and youth entering the child welfare system are screened for trauma. Senate Bill (SB) 125 required the Department of Family and Protective Services (DFPS) to implement a statewide, developmentally appropriate comprehensive assessment that includes a screening for trauma and mental health needs within 45 days of a child or youth entering the system. DFPS began implementing the Child and Adolescent Needs and Strengths (CANS) Assessment statewide in September 2016. In preparation for CANS implementation, the state was required to train staff on trauma and how to use this tool to make trauma-informed decisions for children, youth, and families.

The following table offers an overview of legislation related to trauma and trauma-informed care in Texas, dating back to the 82nd Legislative Session. Legislation covers training requirements and assessments used for children and youth.

Table 5: Trauma-Informed Care Legislation in Texas

Legislative Session	Bill Number	Description
82nd	SB219	Mandates the DFPS to include training in trauma-informed programs and services in any training the department provides to foster parents, adoptive parents, kinship caregivers, department caseworkers, and department supervisors. Also requires all DFPS caseworkers to complete an initial, in-person training on trauma-informed care during their basic skills development training and complete an online refresher course annually.[70]
83rd	SB1356	Related to human trafficking and care of juveniles who have experienced trauma. Requires trauma-informed training for probation officers, juvenile supervision officers, correctional officers, and court-supervised community-based personnel. The training must include best practices in behavior management as well as appropriate restraint techniques, which should only be used in emergencies as a last resort.[71]
83rd	SB7	The Department of Aging and Disability Services (DADS) must ensure that professionals working on a behavioral intervention team that is supporting an individual with a developmental disability and a behavioral health need who is at risk for institutionalization have training on TIC practices.[72]

[70] Codified at Texas Family Code §264.015. Retrieved from http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.264.htm
[71] Codified at Human Resources Code Section 221.002. Retrieved from http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.221.htm
[72] Portal to Texas History. *83rd Texas Legislature, Regular Session, Senate Bill 7, Chapter 1310.* Retrieved from https://texashistory.unt.edu/ark:/67531/metapth438730/m1/71/

Legislative Session	Bill Number	Description
83rd	SB152	Related to the protection and care of persons who are elderly or disabled or who are children. Ensures that direct staff at state hospitals have training in trauma-informed care.[73]
84th	HB2789	Requires web-based TIC training for new employees hired at state supported living centers (SSLCs) and intermediate care facilities (ICFs) for people with intellectual disabilities. Requires DADS to develop or adopt TIC training for employees who work with individuals with IDD in SSLCs and ICFs.
84th	SB125	Requires that children who are entering into DFPS conservatorship receive a "developmentally appropriate comprehensive assessment" that includes a screening for trauma and mental health needs within 45 days of the child's entrance into DFPS care. The tool must include a trauma assessment and an interview with at least one individual who has knowledge about the child's ongoing mental health needs. Also requires child welfare system stakeholder training on trauma and on the assessment tool, including how to employ the tool and to make trauma-informed decisions on behalf of children and families.
84th	HB781	Requires DFPS to determine and evaluate the home screening, assessment, and pre-service training requirements used by substitute care providers before the verification and approval of caregivers. Requires DFPS to adopt certain policies to ensure certain caregivers receive at least 35 hours of pre-service training before being verified as a foster care or adoptive home.

Federal legislation on TIC has been proposed in current and previous legislative sessions but no legislation has been enacted to-date.

Trauma-Informed Training in Texas

The first step in delivering TIC is to ensure that every individual who encounters a child or youth can recognize and understand trauma. Most child-serving agencies in the state offer some workforce training on trauma and TIC. A review of training opportunities throughout the state indicates that there is a variety of training available in various formats (see Appendix Two). TIC training is offered through community-wide faith-based initiatives, online training, small groups, and large conferences and trainings (TIC of Central Texas, Reaching Teens©-El Paso, TBRI® Summer Seminar, Fostering Connections-Teleconference, Bouncing Forward). They vary in length, quality, target audience, and cost. All discuss the impact of trauma on the brain, the

[73] Portal to Texas History. *83rd Texas Legislative, Regular Session, Senate Bill 152, Chapter 395.* Retrieved from https://texashistory.unt.edu/ark:/67531/metapth438186/m1/3/?q=children

need to understand how trauma impacts behaviors, and the use of accepted definitions and research.

Legislative mandates require all child welfare personnel, juvenile justice staff, caregivers, and foster families to receive training on TIC. In addition, most mental health professionals are introduced to the ACE study[74] and TIC. School personnel such as teachers and other community providers, depending on the community and district, have much less exposure or access to TIC training. Despite the availability of training and current training requirements, respondents to the Texas CASA 2015[75] survey on TIC selected "increasing mandated training requirements for foster parents and CPS workers" as their top recommendations for policy makers.

The table in Appendix Two offers an overview of TIC training in Texas. As noted above, some trainings have resulted from legislation referenced in the prior section. This list is not exhaustive.

Trauma-Informed Approaches in Texas

Three approaches permeate the TIC landscape in Texas. Two of them, Neurosequential Model Therapeutics/Neurosequential Model of Education and Trust-Based Relational Intervention (TBRI®), originated in Texas. The third, Reaching Teens©, originated in Pennsylvania but was adopted by Mental Health Connections in Fort Worth, Texas and has become the foundation for their TIC efforts. All three models share a common understanding of how trauma impacts the brain and a focus on safety, attachment, control, and self-regulation. An overview of each approach, training requirements, and how the approach is being implemented in Texas is provided below.

Child Trauma Academy – Neurosequential Model of Therapeutics (NMT) and Neurosequential Model of Education (NME)

Child Trauma Academy (CTA) is a not-for-profit organization in Houston, Texas. Dr. Bruce Perry is its founder and Senior Fellow. Jana Rosenfelt is the Executive Director. CTA was founded in 1990 as a "center for excellence" at the University of Chicago and later Baylor College of Medicine. In 2001, it became a not-for-profit that functions as a "community practice" that promotes social change. CTA's work focuses on the development of non-medical models of care and cross-agency collaboration within therapeutic, child protection, and education systems. CTA's stated mission is "to help improve the lives of traumatized and maltreated children… by

[74] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Koss, M. P. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: Adverse Childhood Experiences (ACE) Study. *American journal of Preventive Medicine*, 14(4), 245–258.
[75] Texas CASA (2015). Understanding trauma-informed care in the Texas child welfare system: Data and recommendations from the field. Retrieved from https://texascasa.org/understanding-trauma-informed-care-in-texas/

improving the systems that educate, nurture, protect and enrich these children. [They focus their] efforts on service delivery, program consultation, research and innovations in clinical assessment/treatment."[76]

NMT integrates the core principles of neurodevelopment and traumatology. It is grounded in the awareness that the brain develops sequentially and can be negatively impacted by neglect, chaos, attachment disruption, and traumatic stress. NMT is not a therapeutic approach. It is a multidimensional assessment "lens" that guides clinical problem-solving and outcome monitoring by providing a picture of a child's current strengths and vulnerabilities in the context of his or her developmental history. It is a way to organize a child's history and current functioning. The model has been widely used with children and youth presenting the most complex cases of maltreatment and psychological trauma.

The NMT process gathers information on a child's past and current experiences and functioning including trauma and relationship history. This information creates an estimate of the severity and timing of risk and resiliency factors that may have influenced a child's brain development. This estimate is paired with a review of a child's current functioning. The information is then organized into a functional map of the brain that identifies which parts of the brain appear to have functional or developmental problems. The functional brain map is used to guide the selection and sequencing of interventions that are developmentally sensitive. NMT is listed as evidence-based.

Neurosequential Model for Education (NME),[77] a spin-off of NMT, is designed to help educators create optimal learning by acting on the principles of development and brain functioning. NME is a multifaceted approach that provides a "picture" of the child's brain in relation to same-grade peers. The mini-map looks at reading/verbal skills, math skills, reactivity/impulsivity, communication/language skills, relational skills, self-regulation, threat response, coordination, fine motor skills, and attention/distractibility. NME offers teachers classroom management tools including taking brain/regulation breaks, having students monitor their heart rate during a fight or flight state, and daily journaling. Teachers are also taught to manage challenging behaviors by first providing regulating opportunities, relating to the student, and, finally, reasoning with the student.

[76] Child Trauma Academy. (n.d.). Retrieved from http://childtrauma.org/about-childtrauma-academy/mission/

[77] Walters, S. (2016). Early experiences in the neurosequential model in education. *The Canadian Journal for Teacher Research: Teachers leading Transformations.* Retrieved from http://www.teacherresearch.ca/blog/article/2016/10/30/314-early-experiences-in-the-neurosequential-model-in-education

Training Requirements

NMT is designed to be delivered by licensed social services professionals who are currently working with children, youth, or families. It features multi-media training that requires participants to view online materials, read assigned articles, and complete reports that are written to fidelity. CTA staff estimate that it takes approximately 15 months (a total of 90–120 hours) to complete all required training. All certified NMT practitioners are required to complete bi-annual fidelity exercises.

Texas Implementation of NMT and NME

CTA has one flagship organization, Cal Farley's Boy's Ranch in Texas. This organization has 19 certified sites in the nation, and 3 of them are in Texas: the Center for Child Protection, the Dallas Children's Advocacy Center, and the Regional Casey Family Programs Headquarters. The Center for Child Protection and Casey Family Programs are also NMT Trainers. There are two NME sites in Texas: Austin Texas Area Schools and Talitha Koum Institute.

The CTA describes its footprint in Texas as "quietly" growing over time. Because both NMT and NME require a significant time commitment, and both stress fidelity to the model, CTA is careful to work only with organizations that have a strong organizational commitment to implementation. They also are in the process of developing a Neurosequential Model for Caregivers (NMC). CTA staff indicate that it will be a year or two before the formalized training for this new model is complete.

Fostering Resilience – Reaching Teens© – Dr. Kenneth Ginsburg

Reaching Teens© is a textbook/video project published by the American Academy of Pediatrics for non-physician professionals. Dr. Kenneth Ginsburg is a pediatrician specializing in adolescent medicine at the Children's Hospital of Philadelphia and a professor of pediatrics at the University of Pennsylvania School of Medicine. He is also the Director of Health Services at Covenant House Pennsylvania. The theme that ties together Dr. Ginsburg's clinical practice, teaching, research, and advocacy efforts is that of building on the strength of youth by fostering their internal resilience. Fostering Resilience translates what is known from research and practices into practical approaches that parents, professionals, and communities can use to prepare children and youth to thrive.[78]

Dr. Ginsburg works with communities to develop a foundational framework to promote resilience in youth. This framework draws from positive youth development and TIC practices to help care providers integrate an understanding of what a youth has been through with high expectations for the youth. Dr. Ginsburg believes that understanding trauma is critical.

[78] Fostering Resilience: Preparing children and teen to THRIVE through both good and challenging times. Retrieved from http://www.fosteringresilience.com/professionals/about.php

However, Dr. Ginsburg argues, TIC alone can be too flexible and does not hold youth accountable. The positive youth development approach sees youth as the experts in their life, considers them excellent role models for other youth, encourages independence, understands the importance of a caring and trusted adult in the healing process, and provides alternative coping strategies.[79]

Reaching Teens©[80]

Reaching Teens© is a comprehensive, interdisciplinary, evidence-informed and expert-driven approach to addressing risk by building on a youth's strengths. It is theoretically grounded in positive youth development and resilience approaches and TIC. The curriculum consists of a textbook, 445 videos, live links to resources, and downloads for youth, parents, and professionals. It provides strategies for paraprofessionals and professionals to engage youth in trusting relationships, promote positive behaviors, engage and inform parents, and address specific emotional and behavioral concerns. Reaching Teens© is published by the American Academy of Pediatrics.

Training Requirements

There are no specific training requirements for this curriculum. The 69 chapters, videos, and additional resources can be navigated by individuals or with a group. Chapters and additional content can be selected and prioritized based on relevance and population. The Reaching Teens© website provides tips for individual learners and groups of learners. The American Academy of Pediatrics and the National Association of Social Workers offer 65 hours of continuing professional education credits for professionals.

Texas Implementation

It is difficult to determine the scope or impact of Reaching Teens© in Texas because all or part of the curriculum can be used by individuals or agencies without training or certification by Dr. Ginsburg or the National Academy of Pediatrics. However, two community-wide implementation efforts were identified: El Paso, which is in the initial stages of community engagement and implementation, and Fort Worth, which has led the country in piloting Reaching Teens© at a community level.

In 2014, with the support of the Rees-Jones Foundation, Mental Health Connections (MHC) and Dr. Ken Ginsburg launched a three-year pilot project of Reaching Teens© in the Fort Worth community. The goal of the project was that "[a]ll people who work with teens–from parents to mental health providers to pediatricians to law enforcement–could speak the same language

[79] Excerpts from "Our Kids are not Broken: Recognizing and Building on the Strength of Marginalized and Traumatized Youth" a presentation given by Dr. Ginsburg in El Paso, Texas on May 7, 2017.
[80] Fostering Resilience. http://www.fosteringresilience.com/professionals/

and provide consistent trauma-informed and strength-based approaches to teens across multiple systems."[81]

Thirteen MHC partners agreed to participate in the pilot, which trained 250 community members during its kick-off workshop. The project concluded in June of 2017.

Karyn Purvis Institute of Child Development – Trust-Based Relational Intervention (TBRI®) – Dr. Karyn Purvis and Dr. David Cross

The Karyn Purvis Institute of Child Development is housed in the college of Science and Engineering at Texas Christian University (TCU). David Cross, Ph.D. is the Rees-Jones Foundation Director. TBRI® is described as a caregiving model, not a clinical model. It can be used in all environments with children and youth from "hard places."[82] It is a trauma-informed, whole-child, ecologically valid model. TBRI® is rooted in the work of Bessel van der Kolk, M.D. and aligns with the three factors he identified as being necessary in any program designed to treat complex trauma-development: safety, promotion of healing relationships, and teaching of self-management and coping skills. The overarching goals of TBRI® are to help caregivers "see" (compassionate understanding) the needs of children who have experienced relational trauma and "do" (knowledge and skills) what is necessary to meet these needs.[83]

Trust-Based Relational Intervention (TBRI®)[84,85]

The TBRI® model comprises a clear set of developmental principles that are designed to bring healing to at-risk children and youth. TBRI® encompasses three interacting and synergistic sets of principles and practices: empowering, connecting, and correcting. Each principle has two sets of strategies.

- **Empowering Principles:** Caregivers can enhance a child's capacity for self-regulation, decrease the likelihood of disruptive behaviors, and increase the likelihood of successfully connecting and correcting if they attend to external (ecological) and internal (physiological) strategies. This principle sets the stage for positive change by creating healthy conditions and an environment that fosters "felt safety." Ecological strategies include recognizing and managing transitions and establishing rituals. Physiological strategies include regular physical exercise and sensory experiences and meeting nutritional needs.

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[81] Mental Health Connections of Tarrant County. Resiliency Committee. (n.d.). Retrieved from http://www.mentalhealthconnection.org/committees/resiliency-committee

[82] Purvis, K. B., Cross, D. R., Dansereau, D. F., & Parris, S. R. (2013). Trust-based relational intervention (TBRI®): A systematic approach to complex developmental trauma. *Child & Youth Services,* 34:360–386.

[83] Purvis, K., Call, C., & Cross, D. (2014). TBRI® and the TCCC.

[84] Purvis, K. B., Cross, D. R., Dansereau, D. F., & Parris, S. R. (2013). Trust-based relational intervention (TBRI®): A systematic approach to complex developmental trauma. *Child & Youth Services,* 34:360–386.

[85] Purvis, K., Call, C., & Cross, D. (2014). TBRI® and the TCCC.

- **Connecting Principles:** The TBRI® connecting principles are based on attachment theory and are the essential mechanisms for building trusting relationships and ensuring that the empowering and correcting principles work. They are considered the source of "felt safety" and self-regulation. There are two connecting principles: mindful awareness and engagement strategies. Mindfulness is a TBRI®'s core capacity. It helps a caregiver see both the child's and their own needs. Mindfulness Awareness Practice (MAP) strategies include yoga, tai chi, entering prayer, mindful walking, and mindfulness meditations. Empowerment assumes that most communication is non-verbal.
- **Correcting Principles:** The TBRI® correcting principles are used to shape behaviors. In order to be effective, these principles must have a firm foundation of connecting and empowering. The correcting principles are proactive strategies and responsive strategies. Proactive correcting principles include "Life Value Terms" and "Behavioral Scripts."

TBRI® is currently listed on the California Evidence-Based Clearinghouse (CEBC) for Child Welfare. It is rated as being "highly" relevant because it is designed to be used with children, youth, young adults, and/or families receiving child welfare services. The CEBC gave it a scientific rating of three and considers it to have promising research evidence.

Training Requirements

TBRI® is designed to prepare professionals (e.g., therapists, caseworkers, foster and adoption care specialists, occupational therapists, medical professionals, counselors, CASA workers, and early childhood development specialists) to work with children and youth who have experienced trauma and their families. Phase 1 of the training consists of five units of online course work to be completed in the 10 weeks prior to the on-site training. This initial work establishes a knowledge base for the on-site training. Phase 2 of the training requires successful completion of Phase 1 and consists of five days of intensive on-site training.

Texas Implementation

Almost 700 professionals, paraprofessionals, caregivers, and faith-based leaders are identified as TBRI® camp alumni. More than 75 have completed the training requirements to become educators. Child-placing agencies, emergency shelters, general residential operations, and treatment facilities throughout the state have chosen to implement TBRI®. In addition to agency-wide implementation, there are two community-based system efforts to implement TBRI®, one in Travis County and one in Fort Worth. Mental Health Connections (MHC) is examining the feasibility of a TBRI® collaboration with Tarrant County and Texas Christian University (TCU) and the Karen Purvis Institute of Child Development (KP-ICD). The Travis County Collaborative for Children (TCCC) was launched in 2014 to improve outcomes for foster children through the power of collective impact.

Summary of Key Informant Interviews

MMHPI conducted 75 key informant interviews from February 2017 to June 2017 to gain a better understanding of organizational and system efforts to implement TIC in Texas. Key informants were asked to define TIC, to discuss how they were operationalizing their definition, to identify the key components required to be a trauma-informed agency, to discuss the barriers they had experienced when implementing TIC, and to describe their successes.

We engaged a wide array of organizations and systems that work with children in foster care, including state agencies, child welfare agencies, foster care agencies, Court Appointed Special Advocates (CASAs), judges, researchers and trainers from TIC models and approaches, and other community agencies. The organizational diversity of these interviews was intended to incorporate the experiences and perspective of multiple child welfare entities into a common understanding of TIC in Texas and to align priorities for implementing TIC in Texas when appropriate. Below is a summary of their responses. A list of all key informants can be found in Appendix Three.

How Texas Defines Trauma-Informed Care (TIC)

We asked key informants how they define and implement TIC. All respondents easily defined this concept and demonstrated a solid understanding of the prevalence and impact of trauma on the children and youth they served. Their responses aligned with the core components of the primary definitions provided above and included references to various national and regional definitions and models, including those by the Substance Abuse Mental Health Services Administration (SAMHSA), the National Child Traumatic Stress Network (NCTSN), the Center for Health Care Strategies (CHCS), the Three Pillars for TraumaWise Care,[86] Dan Siegel's Whole Brain Child,[87] the National Coalition for Trauma-Informed Care, the Trauma-Informed Care Consortium (TICC) of Central Texas, and the Travis County Collaborative for Children (TCCC). The following core components were identified consistently across the majority of key informants.

- **TIC starts with the awareness that trauma exists and an understanding of the impact trauma has on children, youth, and their families.**

  Trauma-informed care "starts with a deep understanding of ACEs and the impact of trauma, including how trauma impacts a child's ability to cope."

  Dallas Child Advocacy Center key informant

[86] Bath, H. (2015). Three pillars of traumawise care: Healing in the other 23 Hours. *Reclaiming Children and Youth.* 23(4). Retrieved from http://traumebevisst.no/kompetanseutvikling/filer/23_4_Bath3pillars.pdf

[87] Dr. Dan Siegel. *Inspire to rewire*. Retrieved from http://www.drdansiegel.com/about/biography/

All individuals interviewed were knowledgeable of the effect trauma has on the developing brain and how trauma can result in coping behaviors that can be misunderstood as defiance or a result of attention problems. The work of Dr. Dan Siegel, founder and co-director of the Mindful Awareness Research Institute at UCLA, was mentioned several times to underscore the importance of this awareness. Key informants stressed how important it was for everyone in a child's sphere—including parents, foster families, caseworkers, advocates, attorneys, mental health and foster care providers, and probation officers—to understand trauma and the impacts of trauma. In addition, several discussed the intergenerational impact of trauma and the importance of working with the whole family to eliminate the negative impacts of trauma and set the stage for healing.

Once there is an understanding of trauma and its impact, assessing for trauma and recognizing related behaviors and symptoms is needed to implement TIC. This can be done through formal assessments or conversations with the child and family. A few key informants suggested that universal screenings and assessments are necessary to implement TIC.

- **TIC must be a core organizational value and an integral part of the culture.**

  "You [organization/agency] cannot go through one training and think you are trauma-informed. It is a shift in culture."

  The Village Network-Ohio key informant

The majority of respondents stressed that TIC has to be part of the foundation an organization is built on. It needs to be at the core of everything an organization or agency does. This requires a shift in organizational culture and operations. TIC should be woven through its policies, procedures, training, and service delivery. Every decision an organization makes should be intentional and trauma-informed. All staff in the organization, from the front desk to leadership, should recognize the widespread impact of trauma. Integrating TIC into all levels of an organization improves the organization's ability to effectively respond to the impacts of trauma on its workforce and on the children, youth, and families it serves.

- **Organizations must provide services and supports in a way that is transparent, instills trust, and ensures that children, youth, their families, and the staff that serve them feel safe.**

  Trauma-informed care "starts at the front door and continues through multiple levels."

  Austin Travis County Integral Care key informant

The majority of key informants mentioned safety, transparency, and trust when defining TIC. Many indicated that they achieve these aspects of TIC by providing services in a safe and

confidential environment, using clear language to communicate expectations and next steps, and treating people with dignity and respect. Respondents underscored the importance of ensuring that staff and clients felt physically and emotionally safe when entering the building, seeking services, or being provided support. There was a general consensus that in order to achieve this, all staff members who interact with a child or youth, including front-line staff, needed to be trained in TIC. Several key informants describe this as viewing all children, youth, and their families through a "trauma-informed lens."

- **Relationships are integral to trauma-informed care.**

  "The members of the court consider trust and attachment as critical to having positive relationships with children and their families."

  The 321st Court of Smith County key informant

Developing and maintaining relationships was identified by many of the key informants as the foundation for treating trauma. Several respondents described relationships as healing and reparative. Others noted that a strong connection or attachment to an adult caregiver was necessary to developing feelings of safety and trust. Still others stressed that in order to connect with a child or youth, they first had to understand that their behaviors were not personally directed to caregivers and staff; rather, these informants noted the need to be mindful of their own ability to connect.

- **Providing trauma-informed care means providing individualized care.**

Key informants said that TIC requires meeting children and youth "where they are." Each child is unique, including the trauma they have experienced, the impact it has had on them, and the needs that result from it. A trauma-informed treatment plan takes into consideration a child's history of trauma, is holistic, and accounts for the emotional, educational, physical, and behavioral needs of the child. Selected interventions need to take into consideration a child's brain development and should address the trauma the child has experienced. This approach requires individualized care and treatment options. No single intervention will meet the needs of every child.

- **Services and supports should not re-traumatize a child or youth.**

  When providing services, providers "want to prevent trauma and prevent re-traumatization."

  Texas Children Recovering from Trauma key Informant

Finally, a few key informants discussed the importance of avoiding re-traumatization when providing services and supports to children, youth, and their families. Several relayed concerns that the child-serving systems in Texas often minimize the importance of attachment and community, thereby re-traumatizing the children they serve.

A Shared Community Definition

Key informants from Travis County use the TIC definition that was created by the Travis County Collaborative for Children (TCCC). This collaborative, cross-disciplinary definition provides a common understanding of TIC across multiple disciplines, child-serving agencies, and community members. The TCCC definition of trauma-informed care is contained in Appendix Six.

How Trauma-Informed Care Is Operationalized

When key informants were asked how they operationalized or implemented TIC, all respondents indicated that they trained staff in recognizing and understanding the impact of trauma; formally or informally screened and assessed for trauma; provided a safe environment; and implemented trauma-focused, evidence-based approaches. Some of the key informants discussed the need to understand how trauma impacts the workforce. However, these steps were not coordinated or integrated into some organizations' missions, strategic plans, policies, and procedures, nor were they reflected in organizational culture. Only a handful talked about taking steps to drive true organizational or system change. The majority of respondents that did take these steps were involved in a broader system-wide effort to address TIC that provided a lens to view trauma, a common language, and a set of tools to address trauma that could be used by a broad cross-section of staff and community members.

Trauma-Informed Training

Key informants emphasized that initial and ongoing training were necessary to implement TIC. All identified the need to train everyone, including support staff, front-line staff, leadership, and board members. Most respondents reported that they provide TIC training as part of their new employee orientation, and some noted that they provide annual refresher training. All key informants stressed the fact that agency-wide trauma-informed training efforts require leadership support and a commitment of resources.

Screening and Assessment

Being trauma-informed requires staff to recognize the signs and symptoms of trauma. The majority of the key informants discussed the need to screen and assess for trauma. Several key informants recognized trauma screening tools such as the Adverse Childhood Experience (ACE) Questionnaire, Child and Adolescent Trauma Screening (CATS), Child and Adolescent Needs and Strengths Assessment (CANS), or the Childhood Trust Event Survey to assess for trauma. Other

respondents noted that they informally screened and assessed for trauma by integrating questions on trauma into their current assessment.

Safety

When key informants were asked about how they operationalized TIC, their most frequent responses were related to safety. Most respondents described creating a welcoming, comforting, safe, and predictable environment for children and families. This was accomplished in a variety of ways, including adding more seating and a television to waiting areas, confirming lights in parking lots functioned, offering snacks and water, filling rooms with stuffed animals, bringing in service dogs, and ensuring children and youth had access to a private, quiet space. Organizations with residential facilities have created play rooms, regulations rooms, chill spaces, and comfort zones for children and youth.

Secondary Traumatic Stress and Compassion Fatigue

Most key informants felt strongly about the need to address secondary traumatic stress and compassion fatigue within their workforce. Described strategies include providing regular supervision, implementing breaks, adjusting caseloads, being flexible with work schedules, and encouraging self-care. Several key informants described promoting team-building activities, using a group approach to handle challenging situations, and offering staff wellness programs that promote physical activity and provide access to counseling services. However, a majority of respondents indicated that regulatory statutes, state and organizational policies, and funding constraints limited their ability to effectively address the levels of secondary traumatic stress experienced by staff.

Trauma-Informed Culture

Successful implementation of TIC requires a change in organizational culture. Key informants described TIC as a change in philosophy and culture that is fully embraced by the organization's leadership; is rooted in the organization's mission, vision, values, policies, and procedures; is driven by an organization champion; and has staff buy-in. They provided multiple examples of how their organizations' cultures and operations shifted to be more trauma-informed. These shifts included incorporating TIC training into new employee orientation, changing job titles and job descriptions to be more trauma-informed, updating agency forms, creating TIC study guides for supervisors and direct care staff, creating TIC-specific forms to problem-solve day-to-day situations, and adjusting staff caseload size and distribution. Informants from residential facilities also discussed taking measures to reduce seclusions and restraints, doing away with level systems, and promoting relationship building as a means to individualize care. Several of the key informants noted that organizational changes around TIC were not always universally accepted and could result in some initial staff turnover.

Some key informants identified TIC champions within their organization who helped spearhead TIC efforts. TIC champions help implement TIC within an organization or agency by fostering interest and growth, boosting morale, providing inspiration, and supporting and coaching staff. Some organizations have TIC newsletters or e-mails that include tips and examples, while others have designated space in their building where staff can write down TIC ideas and lessons learned. Organizations have also created core TIC internal teams that meet consistently and provide monthly peer learning activities and bi-monthly coaching sessions. These adjustments ensure that TIC continues to expand whithin an organization or agency.

Collaboration

Key informants emphasized the importantce of community collaboration to implementing TIC. The courts described the need to engage communities to support foster, kinship, and biological parents. Several child-placing agencies expressed the need to develop a supportive web of positive relationships that reached beyond the service providers and included everyone a child or family might encounter. The backbone agencies for Travis County and Fort Worth described the community collaborative's role in supporting the implementation of a single trauma-informed intervention. They described the process of selecting a single approach as a catalyst for community buy-in. This tactic provided the community with a common language that was understood across disciplines and service systems. Key informants in communities where a single approach had been identified operationalized TIC within the context of that approach.

Evidence-Based Trauma-Focused Approaches

Based on information provided by key informants, there are a reasonable number of trauma-focused approaches and interventions available in Texas. However, access to these approaches and interventions is limited by location, funding streams, reimbursement, priority populations, and provider capacity. The most common trauma-focused approach identified by key informants is TBRI®, an attachment-based, trauma-informed intervention developed by Dr. Karyn Purvis and Dr. David Cross. The Travis County Collaborative (TCCC) identified TBRI® as the framework for reaching their goal of accelerating healing and decreasing time to permanency for children in foster care. As a result, various child-placing agencies and providers who serve children and youth in foster care in Travis County shared the success they experienced through this approach.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based treatment for children and adolescents impacted by trauma, is the most commonly provided trauma-focused intervention offered throughout various parts of Texas. TF-CBT is offered by a wide variety of providers, including Local Mental Health Authorities (LMHAs), Child Advocacy Centers, mental health providers, child welfare agencies, and foster care agencies. Some providers partner TF-CBT with other evidence-based practices, such as Eye Movement Desensitization and

Reprocessing (EMDR). Other trauma-focused interventions commonly provided include Parent Child Interaction Therapy (PCIT), Seeking Safety, and Solution Focused Therapy. Many key informants shared that when choosing trauma-focused, evidence-based interventions, it is important to individually assess children and families and seek their input to develop the best treatment because no single intervention meets everyone's needs. A complete list of trauma-informed frameworks and interventions utilized by key informants can be found in Appendices Four and Five.

What Are the Benefits of TIC?

According to key informants, children and families in trauma-informed environments are gaining understanding of trauma and what has happened to them. Families are learning how to predict their own cycle of crisis, prepare for stressful times, and reduce reactions to trauma. They are also becoming more resilient and open to services. The services provided are being matched to the child and their needs. As such, children and families are feeling more secure and knowledgeable in the services they are receiving. Children are developing long-lasting relationships that will continue to support and empower them. The majority of key informants identified measurable benefits, such as a decreases in physical holds, restraints and seclusions, runaways, medication use, psychiatric hospitalizations, and no-shows. They also saw increased reunifications and chances of permanency.

There are also staff benefits from implementing TIC. Key informants stated that staff feel increased empathy for the children and families they serve. Although some agencies have experienced turnover when first implementing TIC, most key informants noted that they have higher staff retention and job satisfaction. Staff feel empowered and invested in their roles. They take pride in their work and feel they are making a difference, creating a deeper sense of value and support. TIC also impacts how staff treat each other; staff have a more relational approach and support one another in the work that they do.

Finally, key informants said that TIC helps decrease institutional trauma and reduces the chance of re-traumatizing children and families.

Barriers to Implementation

Key informants identified various barriers to implementing TIC within their organization or agency including limited resources, staffing needs, regulatory standards, and staff trauma. Additional barriers included challenges defining TIC, measuring progress toward becoming trauma-informed, and overcoming a lack of trauma-informed community providers. None of the barriers identified were related to delivering billable services and supports.

Developing and sustaining trauma-informed care requires change at multiple levels of the organization and the funding structures that support the principles underlying this approach.Traditional funding streams allow for the provision of evidence-based trauma screening, assessment, treatment, and recovery supports. Texas's Medicaid State Plan funds traditional trauma-focused office-based therapies. The local mental health authority (LMHA) provides traditional trauma-focused therapies, case management, rehabilitation skills training, and family support services. The Youth Empowerment Services (YES) Waiver covers non-traditional services and support for children at risk of psychiatric hospitalization or out-of-home placement. Community providers have access to free training on trauma-focused therapies, and general revenue covers a portion of the LMHA's cost for training and supervision. However, these funding structures do not support the development of appropriate and safe facilities; peer and supervisory support for professionals, staff, and care givers; the development and implementation of general trauma training for all staff; the development of cross-agency collaborations; and the evaluation of trauma-informed programs and services.

Key informants indicated that there are costs to developing and implementing organization-wide training on TIC. They described the staff time required to attend trainings in general TIC and in trauma-informed evidence-based practices and to participate in the supervision required for certification. They discussed the cost of training professionals, staff, caregivers, and community members in trauma-informed communication strategies (Reaching Teens©) and models of caregiving (TBRI®). Two respondents indicated that they needed a full-time position dedicated to TIC. This position would ensure that TIC is considered in all organizational decisions and is interwoven through the agencies' policies and practices.

Organizations that are trauma-informed provide a supportive work environment that recognizes, and guards against, the impacts of secondary traumatic stress and compassion fatigue on their staff members. This awareness includes ensuring that staff are fairly compensated for the work they do, caseload sizes are manageable, intensive cases are balanced, and staff are provided with adequate support and supervision. Some of the respondents indicated that this can be difficult due to limited agency resources, regulatory standards, and state service requirements.

Key informants also indicated that unresolved staff trauma and resistance to change can be barriers to implementing TIC. Attachment and attachment styles play a role in a staff person's ability to develop positive relationships with the children and families they work with. In addition, staff resistance to change, adherence to contradictory models, or belief that TIC is merely an additional job duty can make implementing TIC very difficult. Several respondents noted that TIC is most successful when all child-serving entities and stakeholders who work with children and families embrace and implement TIC. They shared that it can be challenging

to operate with other entities in the child-serving system that are not educated on TIC or do not believe in the TIC philosophy.

Successful Community-Based Cross-System Efforts

There are several noteworthy communities across Texas that have been successful in developing cross-system efforts to implement TIC. Six are highlighted below. These community efforts share a handful of characteristics that appear to have led to their success. All of the community efforts are led by an individual or organization in a leadership role in the community. All the cross-system efforts are supported by grant or foundation funding. Three of the six efforts are rooted in a trauma-focused, evidence-informed approach that is easily understood and can be utilized by professionals, families, and community members. Two were supported by the NCTSN—one at a state level and one through a university. Finally, two took an ecological or collective impact approach to community change.

Mental Health Connections (MHC) – Fort Worth, Texas[88]

MHC is unique in the state of Texas. It is a community of not-for-profit organizations that uses a collective impact model to address community need. MHC is sustained by a dues-based membership. Its long-term strategic approach to change is multifaceted and designed to ensure sustainability. Below is a brief overview of select MHC initiatives to address TIC.

- **Evidence-Based Practices:** In 2008, MHC provided training on TF-CBT to 59 practitioners from 13 agencies and three hospitals. This pilot was the result of a learning community on trauma. Anthony Marrino, PhD, co-developer of TF-CBT, provided training, and Molly Lopez, PhD, from the University of Texas at Austin conducted an evaluation of the year-long project. This project provided the foundation for MHC's goal to become a trauma-informed community.
- **Social Media Campaign on Trauma:** As a foundation for its trauma-informed efforts, MHC launched a three-year social marketing campaign in 2013 designed to educate the community about trauma. The campaign educated parents, teachers, and professionals.
- **Trauma Symposiums:** MHC conducted cross-agency trainings on evidence-based trauma practices and held three symposiums on trauma. In 2013, Kenneth Ginsburg, MD, presented information on building resilience with traumatized children. In 2014, Stuart Ablon, PhD, provided 1,000 practitioners with an overview of Collaborative Problem Solving. In 2016, Vincent Felitti, MD, founder of the Department of Preventative Medicine for Kaiser Permanente and co-principal investigator of the Adverse Childhood Experience Study, provided a presentation on ACES to over 1,000 community providers.
- **Resilience:** After hosting a Reaching Teens© training with Dr. Ken Ginsburg, MHC entered into a three-year pilot project. In 2014, the MHC Resiliency Subcommittee and

[88] Mental Health Connections of Tarrant County. Retrieved from http://www.mentalhealthconnection.org/committees

"Reaching Teens Captains" from 10 partnering agencies began meeting to coordinate implementation. Emily Spence-Almaguer, PhD, from the University of North Texas Health Science Center, developed and conducted an evaluation with the support of the Rees-Jones Foundation. A final report will be presented to the community in September 2017. These efforts have been so successful that MHC is currently working with several communities outside of Texas to implement the Reaching Teens© curriculum. In addition, MHC is completing the development of a "Tarrant County Guide" to implementing Reaching Teens©, a companion to Reaching Teens© that will be published by the American Academy of Pediatricians.

- **Trust-Based Relational Interventions (TBRI®):** The MHC Trauma Transition Committee is focused on three areas: determining the need for further community education and training, completing the analysis of a community-wide implementation of the ACEs screening tool, and determining interest in and feasibility of doing a collaborative pilot with Texas Christian University's Karyn Purvis Institute for Child Development.
- **Adverse Childhood Experiences:** MHC has a vision to make Fort Worth the first city in the United States with a comprehensive approach to addressing Adverse Childhood Experiences. It has been implementing ACE questionnaires across the county and has interns analyzing this data. MHC has brought in Dr. Vincent Felitti, of the California Institute of Preventative Medicine, and is planning a multi-stakeholder planning meeting in the summer of 2017.
- **Resilient/Trauma-Informed Community Strategic Action Plan:** In June 2017, MHC approved a strategic action plan to advance its goal to become a Resilient/Trauma-Informed Community. In addition to TBRI®implementation, the plan will focus on (1) creating a comprehensive trauma-focused social marketing and communications plan for multiple stakeholder groups; (2) creating a learning community to identify and review assessment and screening tools for resilience and trauma and make recommendations to appropriate disciplines for utilization in Tarrant County; (3) creating a learning community to study best practices for self-care and make recommendations for utilization across agencies in Tarrant County; and (4) creating a centralized repository of all resilience and trauma training options in Tarrant County.

Smith County's 321st District Court with Judge Carole Clark – Tyler, Texas

Judge Carole Clark leads the 321st District Court in Tyler, Texas, which handles family law cases. Judge Clark and her team began their trauma-informed journey about 10 years ago, after hearing the late Karen Purvis from TCU present on trauma and on TBRI. The Court's understanding of trauma is rooted in the principles of TBRI (Connecting, Correcting, and Empowering), and it is through this lens that the courtroom is run. All of the court staff and attorneys are trained in trauma and TBRI.

Judge Clark and her team recognize the impact of trauma on brain development and how it affects children and their parents. They view the family as the client and aim to provide a safe and predictable environment in the courtroom. They view attachment and trust as critical to having positive relationships with children and their families.

To make complete treatment plan and achieving reunification less overwhelming for families, the Court has modified it treatment plan into three phases. Phase 1 addresses safety, including drug treatment. Phase 2 addresses risk factors and includes a psychological assessment and enrollment in services and supports such as EMDR, trauma-informed therapy, Trauma Group, Circle of Security, parenting groups, and AA. Phase 3 is monitored return, during which the court provides in-home services and supports to parents to help them manage children's behaviors when they return home. The program tries to ensure bonding between infants and their mothers through increased visitations. The Court has also incorporated a transition period in which foster parents and biological parents can meet to discuss the routine of the child, his or her likes, triggers, and things that help soothe him or her. All service providers and foster parents utilized by the court are trained in TBRI and provide services and supports in manners that aligns with the trauma-informed values of the court. Parents and foster parents are encouraged to read *The Connected Child* and view the video series as a resource to understand trauma and ways to address it.

A core management team meets twice a month to discuss processes. The court team also holds book clubs during which members review books related to TIC. Resources are dedicated to the development of trauma-informed services and supports in the courtroom and in the community.

Texas Children Recovering from Trauma (TCRFT) – Department of State Health Services (DSHS)[89]

Through a four-year cooperative agreement from the National Child Traumatic Stress Network (NCTSN), DSHS's TCRFT established the following goals:

- Transform the public children's mental health service system into a trauma-informed system by training the workforce, enhancing trauma-informed policies and practices, increasing the use of trauma-informed screening tools, providing trauma-specific practices and treatments, and increasing access to trauma-informed services
- Create partnerships that promote access to TIC
- Evaluate outcomes of trauma-informed treatment

[89] Lopez, M. A., Borah, E., Oh., S., Patmore, J. (2016, December). *Texas children recovering from trauma: final evaluation report.* Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin.

- Increase child functioning, increase child and caregiver strengths, and decrease needs and risk behaviors through the provision of trauma-focused treatments
- Increase the number of children screened by integrating trauma screening practices into community-based mental health organizations

The TCRFT initiative officially ended in 2016. The initiative's final program evaluation by the Texas Institute for Excellence in Mental Health yielded several findings and recommendations. Notable findings relevant to trauma-informed system change included the following:

- The creation of a strong implementation team was a critical factor in trauma-informed organizational change.
- Organizations began their change initiatives by building buy-in from leadership and by training the workforce.
- Organizations could achieve moderate progress across two or three of SAMHSA's trauma-informed organizational domains.

Relevant system-level recommendations included the following:

- A modest amount of fiscal support resulted in significant gains in building a trauma-informed system. The state should consider utilizing a small amount of discretionary funding to continue supporting the implementation of trauma-informed treatment approaches and trauma-informed practices within the system.
- Texas should consider encouraging the use of high-quality, high fidelity, evidence-based treatment approaches through financial incentives such as the use of higher reimbursement rates for counseling provided by certified TF-CBT or PCIT providers.
- Opportunities for communities or regions of the state to share resources and build competency in trauma-informed approaches should be supported as these approaches are likely to maintain buy-in of key champions across the state and create efficiencies in transformational efforts.

Travis County Collaborative for Children (TCCC) – Austin, Texas[90, 91]

TCCC was launched in 2013 with the support of several community foundations. It is intended to create system-wide change to improve the outcomes of children in Travis County through training and collaboration in the delivery of trauma-informed services. The following are TCCC's objectives:[92]

- Provide intensive training and follow-up support in trauma-informed practices suitable for this population

[90] TCU Institute of Child Development (2016). Helping at-risk children: Learning to change the world…for children. Year in Review: 2015–2016.
[91] Travis County Collaborative for Children. Retrieved from https://www.tccc-tx.org
[92] Purvis, K., Call, C., & Cross, D. (2014). TBRI® and the TCCC.

- Build trauma-informed collaborative agencies and individuals that can implement and sustain a high level of TIC
- Evaluate this effort so that this project and subsequent projects are informed and improved by what is learned

The collaborative is guided by three conceptual models: authoritative community, bioecological model, and collective impact. The authoritative community model purports that the brain is primed for relationships and community, the root of human community can be found in early relationships, and relationships and community are the wellspring to well-being. Key critical features of the bioecological model are transitions, connections, and "proximal process" (interactions between an individual and environments). Finally, the collective impact model supports funding systems of care to achieve the synergy necessary to address a social problem.[93]

TCCC is led by the Karyn Purvis Institute for Child Development and Mission Capital. It is overseen by a steering committee and an advisory council representing nearly 40 different agencies. Notable accomplishments include drafting a community-wide definition of TIC, providing TBRI® training to over 1,550 professionals representing more than 350 organizations, and implementing the "Meeting the Needs of Children in Care" research study in partnership with TCU's Institute for Child Development, the Travis County Model Court for Children and Families, and CASA Travis County.

Trauma-Informed Care Consortium of Central Texas (TICC) – Austin, Texas[94]

The TICC of Central Texas was founded in 2013 with the support of the St. David's Foundation. Led by the Austin Child Guidance Center, the TICC's mission is to create a comprehensive trauma-informed community for children, families, and providers through education, outreach, and training. The goal of the TICC is to increase knowledge of trauma that affects children and families within the community. More than 60 organizations representing mental health providers, medical professionals, law enforcement, school, and child welfare are members of the TIC. The TICC has developed trauma screening standards for a variety of different settings, provides trauma training, online resources for trauma screenings and assessments, distributes a monthly newsletter, maintains a consolidated calendar of trauma-informed training, and holds quarterly meetings. In addition to these community education efforts, the consortium hosts the Cross-Discipline Trauma Conference of Central Texas. This biannual conference showcases national experts and community efforts.

[93] Purvis, K., Call, C., & Cross, D. (2014). TBRI® and the TCCC.
[94] The Trauma-Informed Care Consortium of Central Texas. Retrieved from https://www.traumatexas.com

The TICC developed and distributed a Trauma-Informed Organizational Readiness Survey in 2014, 2015, and 2016. Eighty-seven individuals from 70 agencies responded to the 2015 survey. Key findings indicated that even though more than half of the organizations that responded described themselves as trauma-informed, just over 10% had an official trauma-informed policy. Only one third of agencies screened for trauma. Cost and administrative buy-in were the biggest barriers to implementing TIC. Finally, 229 trainings were reported to train 7,553 professionals in TIC.[95]

Trauma and Grief (TAG) Center for Youth – Houston, Texas

The Texas Trauma and Grief (TAG) Center for Youth, housed within Texas Children's Hospital, is one of 25 SAMHSA-funded, Category II Treatment and Services Adaptation Centers of the National Child Traumatic Stress Network. It is the only Category II Center to specialize in child and adolescent bereavement. Its primary mission is to increase the standard of care and access to best-practice care among traumatized and bereaved children, youth, and their families. The TAG Center uses state-of-the art, empirically validated screening tools to ensure that youth receive the most appropriate and effective intervention. Their primary treatments include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Trauma and Grief Component Therapy (TGCT). They served approximately 300 children and youth between the ages 7-17 in 2016.

The TAG Center has trained the Houston Independent School District, YES Prep, and the Spring Branch Independent School District on assessment of childhoold trauma and bereavement and TGCT. They are currently talking with the Pasadena, Alief, and Humble Independent School Districts. In addition to its work with the schools, the TAG Center has initiated the Houston Child Trauma Consortium to promote networking related to trauma and to conduct a community-wide trauma needs assessment. The group has met four times over the past year. Finally, as a NCTSN Category II Center, the TAG Center is currently preparing to facilitate a learning community comprised of 10 different organizations across the United States.

Local Mental Health Authorities (LMHAs) TIC Efforts

Representatives from five Texas Local Mental Health Authorities (LMHAs) that serve children participated in key informant interviews for the MMHPI research described in this report. All the LMHAs are involved in activities, consortiums, or collaboratives to move them towards providing TIC. Their experiences in implementing TIC were like those of other key informants, but they shared additional barriers that are specific to LMHAs.

[95] Crosbie, S. (2015). TICC's Trauma-Informed Organizational Readiness Survey. Retrieved from https://www.traumatexas.com/publications-newsletter/

TIC at an Organizational Level

Three of the LMHAs that participated in key informant interviews were learning communities in the Texas Children Recovering from Trauma (TCRFT) Learning Communities initiative through the Texas DSHS. The initiative was funded by SAMHSA and included collaboration with NCTSN. The learning communities were part of a statewide transformation of behavioral health systems intended to help communities implement TIC. The communities created core implementation teams, which included people with lived experience. They selected areas within their organizations that they wanted to focus on improving. They received training, participated in networking events, and participated in monthly calls with the National Council on Behavioral Health.

The Klara's Center for Families, of the Heart of Texas Region MHMR Center, was an early grantee in this initiative. It received support to become a NCTSN Category III Community Treatment Service Center. As part of the initiative, the Klara's Center for Families provided services to children and youth who had been exposed to traumatic events or who were children of military families impacted by military transitions.

The LMHA key informants indicated that trauma awareness needed to be embedded in their organizations at all levels. They are all making or have made efforts to ensure that all staff (from administrative to leadership) are trained in TIC. They believe that it is important to understand trauma when interacting with and providing services to their clients. Informants also discussed their efforts towards becoming a trauma-informed agency, not just one that provides services that address trauma. They discussed the importance of ensuring that staff feel supported in finding a work-life balance given the demands of their contracts. Some stressed the importance of having buy-in from leadership and addressing policies and procedures as necessary components towards becoming a trauma-informed agency. LMHA representatives discussed how making changes in their agencies to be more trauma-informed impacts client outcomes and staff longevity.

LMHA Trauma-Focused Approaches

LMHAs have been trained in and are implementing several evidence-based practices. They typically provide the interventions that have been approved by the Texas DSHS, which for most LMHAs include Seeking Safety, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Parent Child Interaction Therapy (PCIT). Some are also trained in Attachment, Regulation, and Competency (ARC); Eye Movement Desensitization and Reprocessing (EMDR); and Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A). One LMHA expressed interest in having clinicians and staff trained in Trust-Based Relational Interventions (TBRI®).

LMHA-Specific Barriers

LMHAs face similar barriers as other providers in becoming trauma-informed agencies, including the cost of training and the time needed for staff to participate in training. When staff are at training, they are not available to provide services to clients, and this inavailability impacts direct service hours. Large scale or agency-wide training is also a challenge for this reason. Additionally, staff turnover affects the training investment agencies make. When staff who have been trained in specific interventions leave, agencies must invest in training for new staff. LMHAs also face challenges in getting all staff to buy into being trauma-informed. Staff may have been taught in different models or may not accept the impact of trauma on people's lives.

LMHAs also face insufficient staffing for dedicating one staff person to ensure that the agency remains focused on TIC. Some have developed a "champions" model in which one person at each location is responsible for ensuring that trauma-informed principles are infused into everything that facility does. Several have embedded trauma awareness training into their new employee orientations.

LMHAs also face barriers that are more particular to individual agencies. DSHS approves training through specific training providers, and only specific interventions are authorized for training. The approved interventions do not include all the evidence-based interventions that address trauma. LMHA representatives indicated that there should be more flexibility in the trauma-focused interventions they can provide since that flexibility would result in more individualized services. LMHA staff are trained in other interventions, but they cannot implement them through their contract with the state. LMHAs cannot be reimbursed for interventions that are beyond the scope of what they are authorized to provide. Interventions such as EMDR are not paid for through Medicaid. Other nontraditional interventions that a client may need are not reimbursable through Medicaid unless the youth is covered under the YES Waiver.

Funding TIC

Texas's Medicaid State Plan funds some of the traditional office-based therapies for children and youth who have experienced trauma. These include services such as TF-CBT, EMDR, Theraplay, and PCIT. Caregivers seeking services and support through an LMHA and a handful of child-placing agencies also have access to targeted case management, rehabilitation skills training, and family support services. As of September 2016, children in DFPS conservatorship, through the Youth Empowerment Services (YES) Waiver, have access to services and support historically not funded by Medicaid. A review of the state's Medicaid plan is provided below.

Medicaid State Plan

The basis for the Texas Medicaid program is the Medicaid State Plan, a contract between the state and the Centers for Medicare and Medicaid Services (CMS) that outlines Medicaid eligibility, benefits, provider qualifications, and reimbursements allowed by the state. The federal government matches state funding through its Federal Match Assistance Percentages (FMAP). In Texas, this means that the federal government pays $56.18 on every state dollar used for Medicaid. Under the federal plan, there are mandatory and optional Medicaid State Plan services. States must cover mandatory benefits such as inpatient and outpatient medical services and may cover alternative benefits such as rehabilitation and pharmacy services. CMS allows states to amend their state plan to modify provider qualifications and provide target populations with services not allowed for all consumers under the state plan. For example, the "1115 demonstration" waiver in Texas modifies the state plan by adding populations and services not otherwise permitted under Medicaid. There are also waivers to implement Medicaid managed care.

MCOs under Texas Medicaid Managed Care

Managed care organizations (MCOs) have the responsibility to oversee the service delivery of physical health and behavioral health care. MCOs may directly manage behavioral health care or may contract with behavioral health managed care organizations (BHOs) to oversee the utilization and quality of services. Also, MCOs and their respective BHOs (if any) may contract for different Medicaid programs that cover different populations and different health and mental health benefits for children, youth and adults. These programs are described briefly below.

- **STAR** is a Medicaid-managed care program for women and children with low incomes who receive Temporary Assistance for Needy Families (TANF) and/or for pregnant women and newborns with limited income. The program also covers young adults from ages 21 to 26 years who are eligible for Medicaid for Former Foster Care Children (FFCC).

- **STAR+PLUS** is a Medicaid-managed care program for adults with Supplemental Security Income (SSI) or disabilities, who are age 65 or older, and who are eligible for STAR+PLUS Home and Community-Based Services (HCBS) Waiver services.
- **STAR Health** is a Medicaid-managed care program for children under age 18 who are in DFPS conservatorship, young adults in DFPS extended foster care, and young adults who were previously under DFPS conservatorship and have returned to foster care through voluntary foster care agreements (ages 18 to 20). Superior Health Plan is the only MCO to offer STAR Health and covers children and youth in foster care statewide.
- **STAR Kids** is a Medicaid-managed care program for youth and young adults under the age of 21 who have SSI or disabilities; are eligible for Medically Dependent Children Program (MDCP) Home and Community-Based Services (HCBS) Waiver services or Youth Empowerment Services (YES) Waiver services; live in a community-based intermediate care facility (ICF) or a nursing facility for individuals with an intellectual or developmental disability (IDD) or related condition; receive services through a Medicaid buy-in program; or receive services through Department of Aging and Disability Services (DADS) intellectual and developmental disability (IDD) waiver programs such as Community Living Assistance and Support Services (CLASS), Deaf Blind with Disabilities (DBMD), Home and Community-Based Services (HCBS), and Texas Home Living (TXHmL).

Expanded Access to Additional Medicaid Mental Health Services

Before 2013, community-based organizations (CBOs) could only bill Medicaid for Mental Health Rehabilitative Services and Targeted Case Management (TCM) through LMHAs. In 2013, Senate Bill (SB) 58, 83rd Legislature, Regular Session, integrated Mental Health Rehabilitative Services and TCM into the state's Medicaid managed care program—reimbursed through capitated (or fixed, predetermined) rates—and enabled provider entities other than LMHAs to become credentialed and obtain reimbursement for providing these services. This was an important first step in expanding the capacity to provide these services statewide. Only LMHAs and provider entities that are organizations—not individual practitioners—can bill for TCM and Mental Health Rehabilitative Services.

Today, all Mental Health Rehabilitative Services and TCM provider entities (not independent practitioners) enrolled in Medicaid must utilize the Texas Health and Human Services Commission's (HHSC) Texas Resilience and Recovery Utilization Management Guidelines (RRUMG), which were originally designed for LMHA use. Information on how to become a Mental Health Rehabilitative Services and TCM provider and how to access the current HHSC Medicaid managed care contracts and manual is included in the Recommendations section of this report.

During the 85th Legislature, Regular Session, additional efforts were made to help increase the state's capacity to assist children living in poverty and involved in foster care who have acute

mental health needs gain access to Mental Health Rehabilitative Services and TCM. SB 74, which streamlines the Medicaid-managed care credentialing process, increasing the state's capacity to connect children and youth to the intensive treatment they require, overwhelmingly passed both houses of the legislature and now awaits Governor Abbot's signature. Key provisions of the bill include clarifying that non-LMHA providers can contract with MCOs to provide Mental Health Rehabilitative Services and TCM to children, youth, and their families. The bill also clarifies that non-LMHA providers are not required to provide crisis services such as crisis hotlines or mobile crisis teams. It also requires HHSC to update Medicaid-managed care contracts and related manuals and guidelines.

In addition, SB 74 is associated with a budget rider that makes $2 million available to establish a grant program to increase access to Mental Health Rehabilitative Services and TCM to children and youth in the child welfare system. This one-time grant program will provide funds to LMHAs and other nonprofit entities that are making investments either to become providers of Targeted Case Management and Mental Health Rehabilitative Services for children in foster care at the Intense Service Level or to expand their existing capacity to provide these services. To receive grant funds, an entity must provide local matching funds in an amount defined by HHSC, based on the entity's geographical location. Funds may only be used to pay for costs directly related to developing, implementing, and training teams to provide Targeted Case Management and Mental Health Rehabilitative Services to children in foster care at the Intense Service Level. The Health and Human Services Commission, in collaboration with the Department of Family and Protective Services (DFPS), must establish the initiative no later than November 1, 2017.

Youth Empowerment Services (YES) Medicaid Waiver[96, 97]

As noted above, most children and youth involved in the child-serving system have access to trauma-focused or trauma-specific therapeutic interventions. The most common is TF-CBT. However, many of the experts on trauma and its impact on the developing brain (Perry,[98] van der Kolk,[99] Siegel[100]) recommend interventions, services, and supports that are not traditionally paid for by Medicaid. The YES Waiver can provide access to these interventions.

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[96] Texas Department of State Health Services (2016). Youth Empowerment Services (YES) Waiver: Policy Manual. Retrieved from https://www.dshs.texas.gov/mhsa/yes/Resources-for-Families.aspx

[97] Texas Department of State Health Services YES Waiver website. (n.d.). Resources for Families. Retrieved from https://www.dshs.texas.gov/mhsa/yes/Resources-for-Families.aspx

[98] Cross, D., & Purvis, K. B. (2013). Non-pharmacological interventions for children and youth in care. *Institute of Child Development* Texas Christian University. Retrieved from http://texascasa.org/wp-content/uploads/2013/11/Non-pharmacological-Interventions-Dr.-Purvis.pdf

[99] Van der Kolk, B. (2014). *The body keeps the score: brain, mind, and body in the healing of trauma*. Penguin Books. NY, NY.

[100] Information by Dr. Siegel at the Trauma-informed Care Consortium of Central Texas. May 2017.

The YES Waiver provides comprehensive home- and community-based mental health services to children and youth aged 3–18 who have a serious emotional disturbance (SED). It also offers flexible supports and specialized service to children and youth at risk of institutionalization or out-of-home placement due to their SED. And it uses the wraparound planning process to create a plan specifically for each child or youth with services designed to identify and support the strengths of the child or youth. An overview of YES Waiver services is provided below.

- **Adaptive Aids and Supports:** Adaptive aids and supports are designed to help children improve their functioning in different settings such as home, school, and the community. These services include consumable goods (e.g., art supplies, psychoeducational materials), durable goods (e.g., exercise equipment, musical instruments), lessons, classes, seasonal activities, memberships, and camps.
- **Community Living Skills (CLS):** This group of services is designed to help a family adjust to the special challenges related to the child's mental health need. Skills training can be related to daily living skills, socialization, communication, relationship building, and integration into community activities. In addition to skills for the child or youth, CLS can provide the family caregiver with skills training, including basic parenting and other forms of guidance to assist the caregiver in coping with and managing the child's or youths' symptoms.
- **Employee Assistance and Supported Employment:** These services specifically aim to assist youth in finding employment.
- **Family Supports:** Family Supports provide peer mentoring and support to primary caregivers of a child or youth who has received services and support from a community mental health providers. The family support provider delivers peer mentoring and can model self-advocacy skills, provide information, assist in the identification of traditional and nontraditional support, and offer non-clinical skills training.
- **Minor Home Modifications:** These are modifications to help keep children or youth and their families safe. They can include alarm systems, alert systems, and other safety devices.
- **Non-Medical Transportation:** This service ensures that a child or youth enrolled in the YES Waiver has access to any non-medical YES Waiver services when there is no other available transportation.
- **Paraprofessional Services:** These are skills training and mentoring to address a child's or youth's symptoms that may interfere with functioning in his or her living and learning environment.
- **Respite Services:** In- and out-of-home respite services can be provided on a short-term basis because of the need for relief for the caregiver of a child or youth enrolled in the YES Waiver program.
- **Specialized Therapies:** These are therapies that include art, recreational, music, and animal-assisted therapy. They may also include nutritional counseling.

- **Supportive Family-Based Alternatives:** These interventions provide support and model appropriate behaviors for the caregiver of a child or youth residing in a home other than that of his or her caregiver. The objective is to enable the child or youth to successfully return home to live in the community with his or her family. Services can include guidance with daily living skills, counseling reinforcement, therapy or related activities, supervision of the child or youth for safety and security, facilitiation of inclusion in community activities, social interaction, natural supports use, and assistance with community and school resources.
- **Transitional Services:** Transitional services help with the costs associated with a young adult moving into his or her own home.

Findings

Finding 1: Child-serving systems are training staff in trauma-informed care.

As a result of multiple legislative mandates, statutes, and organizational policies, all child welfare, juvenile justice, and foster families are trained on TIC. The majority of mental health staff are introduced to the adverse childhood experience study and trauma-informed care. However, school personnel such as teachers and other community providers, depending on the community and district, have much less exposure/access to trauma-informed care training.

Finding 2: Despite the availability of training that addresses understanding and treating trauma, there remains a widely expressed need to train child welfare staff and foster parents.

The Texas Court Appointed Special Advocates (CASA) with the support of the Supreme Court of Texas Permanent Judicial Commission for Children, Youth, and Families (The Children's Commission) and the Texas Institute for Excellence in Mental Health at the University of Texas at Austin (TIEMH) developed and distributed the Texas CASA *Workforce Survey on Trauma-Informed Care Within the Child Welfare System in Texas* in 2015. A total of 1,758 professionals from across the state responded. They self-identified as CASA staff and volunteers, mental or behavioral health providers, attorneys, CPS case workers, foster parents, Child Advocacy Center staff, judges, medical health providers or psychiatrists, kinship care givers, or other. The resulting Texas CASA *Report on Understanding Trauma-Informed Care in the Texas Child Welfare System* is an analysis of the data and information gathered from the survey.

The report states that the majority of respondents believe they need more training and would recommend policy makers increase training requirements. Responses to an open-ended question regarding workforce needs stressed the need for in-person, practical, accessible training. Survey participants were also provided with a list of recommendations for policy-makers to help make the child welfare system in Texas more trauma-informed and were asked to select their top three. A review of the responses indicated that respondents believe there should be increased training for foster parents and CPS caseworkers and increased access to trauma-focused treatment for children in child welfare. Respondents placed less focus on improving or changing state-level policy and supporting communities and agencies to improve and change their policies to be more trauma-informed. Minimal emphasis was placed on creating a plan to make the child welfare system more trauma-informed. Little to no emphasis was placed by respondents on developing programs to increase self-care for child welfare staff. Participants identified need for further training, and the way they prioritized the recommendations does not recognize the need to build an organizational framework that will support staff, families, and community members in applying this information.

Finding 3: The main child-serving systems in the state of Texas have taken some steps towards becoming trauma-informed.

- **Child Welfare:** The Department of Family and Protective Services (DFPS) has adopted the CANS assessment, which screens for trauma; has added a TIC training to its preservice training requirements; has mandated residential facilities and child-placing agencies to train all staff and foster families in TIC; and is working with the Karyn Purvis Institute of Child Development (KP-ICD) at TCU to develop a training on secondary traumatic stress.
- **Juvenile Justice:** The Texas Juvenile Justice System, in response to legislation to train all staff in TIC, has developed an intensive TIC training in partnership with the NCTSN. Some departments have implemented a trauma screening, and Williamson County has trained all its staff in TBRI®.
- **Mental Health:** The Local Mental Health Authorities have added TIC training to their employee orientation. Many of the LMHAs have introduced trauma screening, and six LMHAs have participated in the state's SAMHSA grant *Texas Children Recovering from Trauma*, which provided support in becoming trauma-informed. The majority of the LMHAs have clinicians who are trained in TF-CBT. A handful have staff who are trained in EMDR, Aggression Replacement Therapy, Seeking Safety, Solution-Focused Therapy, and Parent Child Interaction Therapy. However, their ability to implement these interventions is limited by the Texas Resiliency and Recovery (TRR).

In addition to these initiatives, child welfare, juvenile justice, and mental health professionals have worked to increase the number of evidence-based, trauma-focused treatment providers available to children and youth in their systems.

Training, screening, and evidence-based practices need to be embedded in a culture of TIC in which policies and practices address the experience of the workforce along with the experience of the children and youth seeking services and supports. Most of the current training is provided during pre-service training or new employee orientation, with a shorter refresher offered annually. To be successful, this training must be supported by leadership in an environment where policies, procedures, and practices are trauma-informed.

Few organizations have developed formalized efforts to provide staff with trauma-informed approaches and continued support to implement them. These approaches and support include training on trauma-informed interventions and ongoing supervision and coaching to build staff understanding and skills. In addition, staff are faced with high caseloads; therefore, it is difficult to achieve service delivery standards. Staff also are faced with unsupportive work environments and experience secondary traumatic stress and compassion fatigue. Staff are provided information about recognizing and responding to trauma; however, given the demands placed

on them, it can be difficult to utilize this knowledge. These conditions can lead to high staff turnover and burnout, impacting the child's ability to build positive relationships with his or her providers and ultimately decreasing the quality of care.

Finding 4: The primary cross-system trauma-informed approaches being implemented in Texas are all based on the Adverse Childhood Experiences (ACEs) research and are grounded in the same trauma-informed framework.

Common themes include the following:

- **Trauma and brain development:** Childhood trauma can impact brain development, which can result in a variety of challenging behaviors and can affect a child's or youth's ability to build positive, trusting relationships with caring adults.
- **Safety:** Children and youth need to feel safe both psychologically and physically. Predictability and perceived control can provide a sense of safety.
- **Connection:** Trusting relationships/attachment are critical to healing. Children and youth can heal when they are in a loving, stable relationship with a nurturing caregiver. Adult caregivers need to be aware of their own ability to connect.
- **Control:** Children and youth who have been traumatized have had control taken away from them. Therefore, it is important to return control.
- **Self-management and correcting:** Children and youth benefit from being taught self-regulation, self-awareness, and stress management skills.
- **Developmentally appropriate Interventions:** Interventions and therapeutic approaches need to meet a child or youth at developmentally appropriate levels in order to be successful.
- **Strength-based:** All approaches are strength-based.

Finding 5: Reaching Teens© and TBRI® provide a philosophical framework, shared language, and common set of approaches that allow providers in a community to operationalize the concept of trauma-informed care. These two approaches are easy to understand and can be implemented by a large cross-section of professionals, parents, and foster parents.

The communities, systems, and organizations that have been the most successful in implementing TIC have agreed to start with a single intervention that is easily understood by all staff and families and that is embedded in a strong philosophy and culture. No community or collaborative has chosen a therapeutic approach (i.e., TF-CBT, PCIT). Foundational approaches being used across the state are Trust-Based Relational Intervention (TBRI®) and Reaching Teens©. Similar interventions being utilized outside of Texas to change philosophical approach and build a trauma-informed culture include Cooperative and Proactive Solutions (Dr. Greene, California Evidence-Based Clearinghouse) and Dan Siegel's work.

The Neurosequential Model of Therapeutics (NMT) approach aligns with the models mentioned above but is targeted specifically to professionals, requires a significant amount of training to be implemented to fidelity, and is much more expensive to implement. The Neurosequential Model in Education (NME) is easier to understand and is designed for teachers, but training and cost remain a barrier to widespread implementation. The Child Trauma Academy is working on developing a model for parents and caregivers.

Finding 6: In addition to a shared approach, successful trauma-informed cross-system efforts in Texas all have an external funder and a community champion.

All cross-system efforts in the state have utilized foundation dollars and other commitments of resources to support their efforts. Foundations that have contributed to Texas initiatives include but are not limited to St. David's Foundation, Rees-Jones Foundation, Michael and Susan Dell Foundation, and SAMHSA. In a recent Travis County Collative for Children's (TCCC) meeting, Dr. David Cross reported that the KP-ICD at TCU has donated over $2.5 million in training and technical assistance over the past five years. Each community-wide collaborative is led by a respected organization or passionate community leader with a vision for children and youth. Dr. David Cross from TCU leads the TCCC, Judge Carol Clark leads Smith County's efforts, and Austin Child Guidance has spearheaded the TCCC.

Finding 7: The local mental health authorities are limited to a core set of trauma-focused interventions that limit their ability to select an intervention based on the child's or youth's trauma history, needs, or brain development.

The Texas Resilience and Recovery (TRR) Guidelines limit the trauma-focused evidence-based treatments (TF-EBTs) through LMHAs to ART, PCIT, TF-CBT, and Seeking Safety. Several of the LMHAs indicated they have staff trained in other TF-EBTs and would like the TRR to expand the list of allowable services and support. The current limitations can cause difficulty for case managers to select the services and support necessary to effectively meet the needs of children or youth.

Verbal or cognitive therapy alone for children or youth that have experienced developmental or complex trauma is not always the best intervention.[101] Alternative interventions such as physical therapy, occupational therapy, art and music therapy, equine therapy, yoga, and martial arts have been found to effectively address the needs of children and youth who have experienced complex or developmental trauma.[102, 103] NMT was founded on the premise that therapeutic

[101] Walters, F. (2005). When treatment fails with traumatized children…Why? *Journal of Trauma & Dissociation,* 6(1). DOI: 10.1300/J229v06n01_01

[102] Perry, B. D, & Szalavitz, M. (2008). *The boy who was raised as a dog: And other stories from a child psychiatrist's notebook: What traumatized children can teach us about loss, love, and healing*. New York: Basic Books.

[103] Van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York: Viking.

interventions must follow the sequence of normal developmental milestones of brain development.[104]

In addition to the activities above, the following therapeutic activities and organizing events have been found to effective: healthy massage, EMDR, canine interactions, social play, and performing and creative arts. The only way for children and youth in the child welfare system to access these more "nontraditional" services is currently through the YES Waiver. Approximately 1,700 youth in Texas are presently enrolled in this program, and 50 of them are in CPS conservatorship.

Finding 8: Medicaid (Star Health) pays for traditional office-based trauma-informed services and supports, and STAR Health provides training in TF-CBT and PCIT. However, providers still identified funding as a barrier to expanding TF-EBT capacity.

There are several issues associated with the cost of expanding trauma-focused evidence-based treatments in Texas. First, Medicaid and free training do not negate the cost associated with the loss of a revenue stream while staff are attending training, nor do they compensate for the additional cost of coaching and supervision required to ensure staff are delivering the service to fidelity. Second, STAR Health only provides TF-CBT training and a limited amount of PCIT training. Consequently, if a provider wants to deliver additional TF-EBT, it must assume the full cost of training staff, coaching, and supervising staff. Third, Medicaid does not cover the cost of training and delivering evidence-informed approaches such as TBRI®, Reaching Teens©, and Dr. Dan Siegel's work. A number of residential facilities and child-placing agencies (CPA) train their staff, clinicians, and foster parents during their pre-service or annual training. Other organizations have used grant or philanthropic dollars to train a large number of community stakeholders, courts, providers, DFPS staff, parents, and foster parents in these interventions. Finally, as noted above, the only Medicaid funding stream available for nontraditional approaches is through the YES Waiver.

[104] Cross, D. R., & Purvis, K. B. (2013). *Non-pharmacological Interventions for children and youth in care.* Retrieved from http://texascasa.org/wp-content/uploads/2013/11/Non-pharmacological-Interventions-Dr.-Purvis.pdf

Appendix One: National Evidence-Based Practices Repositories

The National Registry for Evidence-Based Programs and Practices (NREPP) and the California Evidence-Based Clearinghouse for Child Welfare (CEBC) are registries for evidence-based practices. The overriding purpose of both is to promote the implementation of evidence-based practices. The repositories each focus on a different set of interventions and use different rating scales to distinguish effectiveness. A brief overview of the purpose and content of each database and a description of their rating scales is provided below.

The National Registry for Evidence-Based Programs and Practices (NREP) is SAMHSA's National Registry of Evidence-based Programs and Practices.[105]

Overview: NREPP is a repository and review system for mental health and substance use interventions. Its purpose is to help people identify and learn more about available evidence-based programs to determine which ones best meet their needs. It is designed to give reliable information on each program's effect on individual outcomes. All interventions are independently assessed and rated by certified NREPP reviewers.

NREPP assesses the research that evaluates the outcomes of a program or practice and provides information on effective dissemination and implementation. All ratings take into account the methodological rigor of the evaluation studies, the size of impact of the program on outcomes, the degree to which the program was implemented as intended, and the strength of the program's conceptual framework. A program profile is provided for each practice and includes a description of the intervention, its goals, its major components, and a side-bar snapshot with outcome-level ratings.

Rating Scale:[106] NREPP uses green, yellow, red, and black circles with corresponding symbols to depict the outcome evidence rating. The outcome rating levels are described below.

- **Effective:** The evaluation evidence has strong methodological rigor, the short-term effects favor the intervention group, and the size of the effect is substantial.
- **Promising:** The evaluation evidence has sufficient methodological rigor, and the short-term effect on the outcome is likely to be favorable.
- **Ineffective:** The evaluation evidence has sufficient methodological rigor, but there is little to no short-term effect.

[105] National Registry for Evidence-based Programs and Practices: SAMHSA's National Registry of Evidence-based Programs and Practices. http://nrepp.samhsa.gov/about.aspx.
[106] National Registry for Evidence-based Programs and Practices: SAMHSA's National Registry of Evidence-based Programs and Practices. http://nrepp.samhsa.gov/about.aspx

- **Inconclusive:** A program is classified as inconclusive if the evaluation evidence has insufficient methodological rigor or the size of the short-term effect cannot be classified.

The California Evidence-Based Clearinghouse for Child Welfare (CEBC)

Overview: The California Evidence-Based Clearinghouse's mission is to "advance the effective implementation of evidence-based practices for children and families involved with the child welfare system."[107] Evidence-based practices are defined by the California Clearinghouse as practices that incorporate the best research evidence and the best clinical experience and are consistent with family/client values.[108] A program is eligible to be rated on the CEBC scientific rating scale if it has been reported in a published, peer-reviewed journal; there is a book or manual that describes how it has been administered; it meets the requirements of one of CEBC's topic areas; it has outcome measures that have been determined to be reliable and valid; and the program has been administered with consistency and accuracy.

CEBC has a scientific rating scale (described below) and a Child Welfare Relevance Level.

Scientific Rating Scale:[109]

- **1-Well-supported by Research Evidence:** The program must have at least two rigorous randomized control (RCTs) trials in different usual care or practice settings and have been found to be superior to an appropriate comparison practice. At least one of the RCTs has shown a sustained effect of a year or more beyond the end of treatment when compared with the control group.
- **2-Supported by Research Evidence:** The program must have at least one rigorous RCT in a usual care or practice setting and must have been found to be superior to an appropriate comparison group.
- **3-Promising Research Evidence:** The program must have at least one study utilizing some form of control group (untreated, placebo, matched wait list) and have established the benefits of the practice over the control. or it must be found comparable to a practice rated 3 or higher on the CEBC or superior to an appropriate comparison practice.
- **4-Evidence Fails to Demonstrate Effect:** The program has not resulted in improved outcomes when compared to usual care in RCTs.
- **5-Concerning Practice:** Overall evidence from RCTs suggests the program has a negative effect on the clients it served. Or the case data suggests there is a risk of harm or there

[107] California Evidence-based Clearinghouse for Child Welfare. http://www.cebc4cw.org
[108] California Evidence-based Clearinghouse for Child Welfare. Practice-based evidence and how it is different from evidence-based practice. http://www.cebc4cw.org/files/PBEvsEBP.pdf
[109] California Evidence-based Clearinghouse for Child Welfare. Overview of the CEBC Scientific Rating Scale. http://www.cebc4cw.org/files/OverviewOfTheCEBCScientificRatingScale.pdf

is a legal or empirical basis suggesting that compared to its likely benefits, the practice constitutes a risk of harm.

- **NR-Not Able to be Rated:** The program does not have any published, peer-reviewed study utilizing some form of control group.

Child Welfare System Relevance Levels:[110]

- **High:** The program was designed or is commonly used to meet the needs of children, youth, and adults or families who are receiving child welfare services.
- **Medium:** The program was designed, or commonly used, to serve children, youth, young adults, and/or families who are similar to the children, youth, and families in the child welfare system and are likely to include current and former recipients.
- **Low:** The program is designed or commonly used, to serve children, youth, young adults and/or families with little or no apparent similarity to the child welfare population.

There are a number of organizations that have developed scales to rate the research evidence that supports the effectiveness of programs and practices. For the sake of efficiency and concision, these levels, ratings, and grading scales are not included within this document.

[110] California Evidence-based Clearinghouse for Child Welfare. Child Welfare System Relevance Levels. http://www.cebc4cw.org/home/how-are-programs-on-the-cebc-reviewed/child-welfare-relevance-levels/

Appendix Two: Trauma-Informed Care Training

Organization and Training Name	Designated Attendees	Training Description
Beyond Consequences Institute	Parents, professionals, and schools	Nationally available program that provides educational materials, training programs, and resources. Training is through books, webinars, coaching, and onsite workshops. http://www.beyondconsequences.com/about-bci
Child Trauma Academy	Anyone working with someone affected by trauma	Offers four online courses for all participants. However, the academy does not offer Certificates of Completion or CEUs for any of the online courses. Resource library is also available fromhttp://childtrauma.org. http://www.childtraumaacademy.com
Circle of Security	Parents and professionals	Circle of Security International offers training around the world focusing on the early intervention models to increase attachment and security developed by Glen Cooper, Kent Hoffman, and Bert Powell. https://www.circleofsecurityinternational.com/training
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Schools	The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based, group and individual intervention. https://cbitsprogram.org
Communities in Schools of Central Texas Trauma Training	Educators	Free online training resource designed to give information about how student learning and behavior is impacted by trauma. http://www.ciscentraltexas.org/resources/traumatraining/
Dan Siegel's No Drama Discipline	Caregivers and parents	Training is available online and through a book by Dan Siegel called *No-Drama Discipline: The Whole-Brain Way to Calm the Chaos and Nurture Your Child's Developing Mind.* Dr. Siegel also hosts training events nationally. http://www.drdansiegel.com/books/no_drama_discipline/
Department of Aging and Disability Services (DADS) and Department of State Health Services Trauma Informed Care for Individuals with Developmental Disabilities (IDD)	Anyone who supports someone with IDD.	Online training module as part of comprehensive online course, "Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities (IDD)." Resulted from HB2789, 84th Regular Legislative Session. https://tango.uthscsa.edu/mhwidd

Organization and Training Name	Designated Attendees	Training Description
Department of Family and Protective Services (DFPS) Trauma-Informed Care Training	Parents, foster parents, counselors, therapists, and shelter workers	As a result of SB 219, 82nd Regular Session, DFPS now provides this training opportunity to assist families, caregivers, and other social service providers in fostering greater understanding of trauma-informed care and child traumatic stress. This training aims to help understand the effects that trauma can have on child development, behaviors, and functioning as well as recognize, prevent, and cope with compassion fatigue. The training also does the following: Provides practical information that prepares the caregiver to put into practice what he or she has learned; Includes a component on adverse child experiences (ACEs); and Includes training and resources related to prevention and management of secondary traumatic stress and compassion fatigue. This training is online and is estimated to take two hours. https://www.dfps.state.tx.us/training/trauma_informed_care/ https://www.dfps.state.tx.us/Training/Trauma_Informed_Care/begin.asp
DFPS Caseworker Initial Training	DFPS Caseworkers	As a result of SB 219, 82nd Regular Session, DFPS caseworkers are required to complete an initial training on trauma-informed care during their basic skills development training and complete an online refresher course annually. This training is offered in-person. There is also a two-hour online refresher course for CPS program and contract staff to complete annually. Training requirements are included in Texas Family Code §264.015. http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.264.htm http://www.dfps.state.tx.us/About_DFPS/Title_IV-B_State_Plan/2010-2014_State_Plan/Health_Care_Oversight_and_Coordination_Plan.pdf
DFPS Secondary Traumatic Stress Training	DFPS Caseworkers and caregivers	Texas Christian University (TCU) developed a training specific for DFPS caseworkers and caregivers on secondary traumatic stress. The training was rolled out Summer 2017 and is called, “Building Resilience in the Face of Trauma.”

Organization and Training Name	Designated Attendees	Training Description
DFPS STAR Health Cenpatico Trauma-Informed Care Training and CenpaticoU	Foster families, caregivers, CASA workers, educators, school counselors, judges, and attorneys	STAR Health is the statewide Medicaid-managed care program for children in DFPS conservatorship and young adults in DFPS paid placements. Cenpatico manages the behavioral health benefits for STAR Health. Cenpatico trainers are regionally assigned across Texas to partner with local child welfare stakeholders to provide free in-person training to caregivers, caseworkers, teachers, therapists, judges, and others who are involved in lives of children in foster care. CenpaticoU, an online resource, also offers free training to all foster care stakeholders. Training is also available in Spanish. https://www.cenpaticointegratedcareaz.com/providers/education-training/trauma-informed-care.html https://www.envolveu.com
Education Kinesiology Foundation's Brain Gym	Primarily for educators	Training is available nationally through courses taught by local Brain Gym facilitators. http://www.braingym.org/schedule?level=1
Empowered to Connect (ETC)	Pre- and Post-adoptive and foster parents	Based heavily on TBRI®, this training is specifically for adoptive and foster parents. The training is taught from a Christian perspective. There are two courses: "Prepare" is for pre-placement parents, and "Connect" is for post-placement parents. Each course is taught in nine weekly two-hour sessions for small groups. http://empoweredtoconnect.org/training/
Eye Movement Desensitization and Reprocessing (EMDR) Institute	Mental Health Practitioners	The EMDR Therapy Basic Training (Weekend 1 and 2) is designed for licensed mental health practitioners who treat adults and children in a clinical setting. http://www.emdr.com/us-basic-training-overview/
Karen Purvis Institute of Child Development at TCU TBRI®Training	Caregivers, parents, caseworkers, medical professionals, counselors, CASA workers, and teachers	Attachment-based, trauma-informed intervention. Training is centered on children from places of abuse, neglect and/or trauma. Practitioner Training is available for caseworkers, foster and adoption care specialists, medical professionals, counselors, and CASA representatives. Parent training and resources are available online and in a book by Dr. Purvis called *The Connected Child*. https://child.tcu.edu/professionals/tbri-training/#sthash.vDnwozxB.dpbs
The National Child Traumatic Stress Network	Mental health professionals, parents, caregivers, educators, and policy makers	Online learning center that offers free webinars and continuing education certificates on various topics, including trauma-informed care. Training offered includes Child Trauma Toolkit for Educators, Child Welfare Trauma Training Toolkit, Resource Parent Curriculum Online, and Trauma-Informed Juvenile Justice System Resource Site. https://learn.nctsn.org

Organization and Training Name	Designated Attendees	Training Description
The National Child Traumatic Stress Network Psychological First Aid	First responders	Online six-hour interactive course that puts the participant in the role of a provider in a post-disaster scene. https://learn.nctsn.org/course/index.php?categoryid=11
Problematic Sexual Behavior Cognitive Behavioral Therapy (PSB-CBT)	Child advocacy centers, law enforcement, clinicians, and practitioners	Training is provided through the National Center on the Sexual Behavior of Youth (NCBY) http://www.ncsby.org/content/about-us
Satori Learning Designs Satori Alternatives to Managing Aggression (SAMA)	Schools, law enforcement, foster care providers, RTCs, and hospitals	SAMA is a 16-hour training program that focuses on risk management of aggressive behavior. Program is national; however, it is headquartered in Texas. http://www.satorilearning.com/index
Solution-Focused Therapy at the Institute for Solution-Focused Therapy	Practitioners	National program taught as an online hybrid course consisting of three in-person class days and 14 classes using a web-based program. https://solutionfocused.net/training/
Starr Commonwealth National Institute for Trauma and Loss in Children (TLC) Structured Sensory Intervention Program for Traumatized Children, Adolescents and Parents (SITCAP)	Educators, case workers, counselors, and practitioners	National online and in-person training designed to enable schools, crisis teams, child and family counselors, and private practitioners help traumatized children and families. https://www.starr.org/training/tlc/courses-training
Texas Center for the Judiciary	Texas judges	Annual Child Welfare Conference is a continuing education program for Texas judges who hear child protection cases. Past conferences included a general session on “Creating Trauma-Informed Courts.” http://www.yourhonor.com/Web/Online/Events/2016_Conferences/2016ChildWelfareConference/Event_Details.aspx?EventTabs=2&EventKey=16CWC#EventTabs%20class
Texas Health Steps training on Childhood Trauma and Toxic Stress	Health care providers	Free online continuing education training available to Texas Health Steps providers and other interested health care professionals. https://www.txhealthsteps.com/cms/?q=node/250

Organization and Training Name	Designated Attendees	Training Description
Texas Juvenile Justice Department (TJJD) Trauma Informed Care Training	Juvenile probation and supervision officers	As a result of Senate Bill 1356, 83rd Texas Legislature, which requires all juvenile probation and supervision officers to have TIC training prior to certification or renewal (for existing officers), the Juvenile Justice Training Academy (JJTA) created and implemented a TIC training. TJJD worked with National Child Traumatic Stress Network (NCTSN) to develop the training. TJJD developed two trainings: one for State Programs and Facilities and one for Community-Based Programs. Departments can submit a Training Technical Assistance Request or assist in coordinating a Regional Training effort for TIC Training. To date, all of the regional training across the state have offered the TIC training. https://www.tjjd.texas.gov/regionaltraining/training_news.aspx#trauma-informed-care
Texas Lawyers for Children	Attorneys and judges	Free online training and support resource for Texas judges and attorneys for child welfare cases. www.texaslawyersforchildren.org
Treatment Innovations Trauma-Informed Care and Seeking Safety	Clinicians and agencies	Provides training and other resources to clients, clinicians, and agencies who serve people with substance abuse and trauma-related problems. Training can be onsite, online webinar, or DVDs.
Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET)	Corrections facilities, health providers and children's service providers	Training is through Advanced Trauma Solutions. http://www.advancedtrauma.com/Services.html
The Trauma Center at Justice Resource Institute Attachment, Regulation and Competency (ARC) Training	Clinicians, schools, and RTCs	The ARC framework is built around the following core targets of intervention. These targets are addressed in client- and system-specific ways, with an overarching goal of supporting the child, family, and system's ability to engage thoughtfully in the present moment (Trauma Experience Integration). http://www.traumacenter.org/research/ascot.php
Trauma-Informed Care Consortium of Central Texas	Professionals and parents	Trauma training is offered through the Austin Child Guidance Center on a variety of topics centered on trauma. The website also has a calendar listing of all upcoming professional development opportunities and public training relate to trauma in the Central Texas region. https://www.traumatexas.com/trauma-training/
Trauma Recovery and Empowerment Model (TREM)	Clinicians	SAMHSA recommends training through Community Connections. Community Connections provides manuals, training, and ongoing consultations. https://www.samhsa.gov/nctic/trauma-interventions http://www.communityconnectionsdc.org/training-and-store/training

Organization and Training Name	Designated Attendees	Training Description
University of California Davis Children's Hospital Parent Child Interaction Therapy (PCIT)	Mental Health Agencies	The PCIT Training Center provides training and support to help agencies develop effective mental health programs. Training is available as webinars. https://pcit.ucdavis.edu/training/

Appendix Three: Key Informants

2017 Key Informant Participants

Name	Title	Organizational/Departmental Affiliation
General Residential Operation-Child Welfare		
Ray Baca	Behavioral Resource Counselor	Cal Farley's Boys Ranch
Michelle Maikoetter	Senior Vice President of Programs	Cal Farley's Boys Ranch
Jim Taylor	Assistant Administrator for Residential Services	Cal Farley's Boys Ranch
Robert Marshall	Administrator of Residential Homes	Cal Farley's Boys Ranch
Joyful and Judith Brown	House Parents	Cal Farley's Boys Ranch
Tiffany Carpenter	Director of Counseling	Cal Farley's Boys Ranch
Carol Humbert	Counselor	Cal Farley's Boys Ranch
Shanna Tipton	Neurofeedback Counselor	Cal Farley's Boys Ranch
Katherine Clay	Counselor	Cal Farley's Boys Ranch
Mike Wilhelm	Chaplin	Cal Farley's Boys Ranch
Ray Baca	School Support Specialist	Cal Farley's Boys Ranch
Josh Sprock	Trainer	Cal Farley's Boys Ranch
Suzanne Wright	Director of Training	Cal Farley's Boys Ranch
Rachel King	Trainer	Cal Farley's Boys Ranch
John Hazle	Administrator of Case Work Services	Cal Farley's Boys Ranch
Ted Keyser	Executive Director	Helping Hand Home for Children
Vanessa Davila	Director of Strategic Initiatives, Research and Grants	Helping Hand Home for Children
Dave Paxton	Chief Clinical Officer	The Village Network
Jerry Hartman	Clinical Director	The Village Network
Mark Welty, PhD	Director of Research and Innovation	The Village Network
Randy Spencer	Vice President of Organizational Impact	Presbyterian Children's Homes and Services

Name	Title	Organizational/Departmental Affiliation
Mental Health Services		
Bridget Speer	Child and Family Services Manager	Austin Travis County Integral Care
Telawana Kirbie	Director of Clinical Services	Heart of Texas Region MHMR Center
Ron Kimbell	Division Director, Klara's Center for Families	Heart of Texas Region MHMR Center
Tricia Boodhoo	Social Services Director	Ysleta del Sur Pueblo
Angel Montoya	Alcohol and Substance Abuse Program Coordinator	Ysleta del Sur Pueblo
Viridiana Sigala	Therapist	Ysleta del Sur Pueblo
Cathy Gaytan	Executive Director	El Paso Child Guidance Center
Brad Schwall, PhD	Executive Director	Pastoral Counseling Center
Seanna Crosby	Director of Service Programs	Austin Child Guidance Center
Evelyn Locklin	Program Director	Harris Center MCOT
Ross Robinson	Executive Director	Hill County MHDD Centers
Anne Taylor	Director of Behavioral Health Services	Hill Country MHDD Centers
Theresa Thompson	Children's Director	Hill Country MHDD Centers
Julie Kaplow	Associate Professor Director	Trauma and Grief Center for Youth
Kay Brotherton	Director of Special Projects and Change Initiatives	Central Plains Center
Ann Bradford	CEO	Centers for Children and Families, Inc. (CENTERS)
Kristi Edwards	Clinical Director	Centers for Children and Families, Inc. (CENTERS)
Robin Birkla	Post Adoption Director	Centers for Children and Families, Inc. (CENTERS)
Michael Gomez, PhD	Director of Child and Adolescent Mental Health	Department of Pedicatrics-Center for Superheros, Texas Tech University Health Science Center
Patti Patterson, MD	Professor	Department of Pedicatrics-Center for Superheros, Texas Tech University Center

Name	Title	Organizational/Departmental Affiliation
Department of Family and Protective Services		
Lindsey Van Buskirk	Region 7 Deputy Regional Director	Department of Family and Protective Services
Foster Care Agencies		
Jessica Kilpatrick	Director of Training and Program Development	Starry Counseling and Foster Care Program
Renee Calder Price	Director of Child Welfare Services	DePelchin Children's Center
Darcie DeSchazo	Executive Director	The Settlement Home for Children
Court Appointed Special Advocates (CASA)		
Andy Homer	Public Affairs Executive Director	Texas CASA
Sarah Crockett	Public Policy Coordinator	Texas CASA
Laura Wolf	Executive Director	CASA of Travis County
Don Binnicker	Chief Executive Officer	CASA of Tarrant County
Other Community Agencies		
Ivonne Tapia	Chief Executive Officer	Aliviane
Sandy Couder	Executive Assistant for CEO	Aliviane
Carolina Gonzalez	Divisional Director	Aliviane
Irene Silva	Methadone Clinic Supervisor	Aliviane
Julie Priego	Prevention and Intervention Services Supervisor	Aliviane
Judge Carole Clark and Core TIC Team	Presiding Judge and 30 plus community partners, providers, contract lawyers, and CPS staff	321st District Court of Smith County
Anu Partap, MD (taken from previous interviews)	Pediatrician; Medical Director	Rees-Jones Center for Foster Care Excellence at Children's Medical Center
Lena Zettler	Behavioral Health	Cook Children's Health Care System
Christine Gendron	Executive Director	Texas Network of Youth Services (TNOYS)
Julie Kouri	Founder and Executive Director	Fostering Hope Austin

Name	Title	Organizational/Departmental Affiliation
Katy Bourgeois	Senior Consultant	Mission Capital (Backbone agency Travis County Children's Coalition)
Nichole Aston	Grant Manager	Michael and Susan Dell Foundation
Marisol Acosta	Program Specialist V/Project Director	Texas Health and Human Services/Texas Children Recovering from Trauma
Candace Aylor	Owner	Candace Aylor Consulting
Ian Spechler	Regional Attorney	Disability Rights Texas
Kristen Howell	Chief Programs Officer	Dallas Children's Advocacy Center (CAC)
Gwendolyn Downing	Manager of Hope and Resilience	Oklahoma Department of Mental Health
Trauma-Informed Care Approaches		
Dr. David Cross	Reese-Jones Director	Texas Christian University (TCU)
Jana Lihn Rosenfelt	Executive Director	Child Trauma Academy
Emily Perry	Director of Training and Education	Child Trauma Academy
Ken Ginsburg, MD (Presentation)	Pediatrician	Children's Hospital of Philadelphia
Dan Siegel, MD (Presentation)	Child and Adolescent Psychiatrist and Executive Director	Mindful Awareness Research Center at UCLA and the Mindsight Institute.
Sarah Mercado	Training Specialist	Karyn Purvis Institute of Child Development
Behavioral Health Management Company		
Roy Van Tassel	Director of Trauma and EBP Interventions	Cenpatico
David Allen	Senior Director of Training and Education	Cenpatico
Cheryl Fisher	Senior Director for Foster Care and Specialty Population	Cenpatico
Karen Rogers	Director of Foster Care	Cenpatico
Court System		
The Honorable Aurora Martinez Jones	Associate Court Judge	Travis County District Courts
The Honorable Darlene Byrne	Judge	Travis County District Courts 126th Civil District Court
Juvenile Justice		
Kristy Almager	Director of Training	Texas Juvenile Justice Department (TJJD)

Name	Title	Organizational/Departmental Affiliation
Matt Smith	Assistant Executive Director Director of Mental Health Services	Williamson County Juvenile Detention Center
Lynn Kessel	Assistant Director Mental Health Services	Williamson County Juvenile Detention Center

Appendix Four: Trauma-Focused Approaches Utilized by Key Informants

Child and Adolescent Evidence-Based and Evidence-Informed Practices Across Key Informants

Trauma-Informed Practice	Agencies/Organizations
Trauma-Informed Foundational Frameworks	
Neurosequential Model of Therapeutics (NMT) The Child Trauma Academy reports that it meets the evidence-based criteria Level III (Opinions of respected authorities, based on clinical experience, descriptive studies, or reports fo expert committees), Level II (Evidence obtained from well-designed cohort or case-controled analytic studies), and Level I (Evidence obtained from well-designed controlled trial).	Cal Farley's Boys Ranch; Helping Hands Home for Children
Neurosequential Model of Education (NME) NME is not an intervention; it is a way to educate school staff.	Cal Farley's Boys Ranch
Trust-Based Relational Intervention (TBRI®) CEBC Ratings TBRI On-line Caregiver Training: Scientific Rating (SR)-3, Child Welfare System Relevance Level (CWL)-High TBRI Caregiver Training: SR-3, CWL-High TBRI Therapuetic Camp: SR-NR, CWL-High	Karen Purvis Institute of Child Development-Texas; Christian University; 321st District Court of Smith County-Judge Carole Clark; Associate Judge Aurora Martinez Jones; Austin Travis County Integral Care; Cal Farley's Boys Ranch; CASA of Tarrant County; CASA of Travis County; Centers for Children and Families; DePelchin Children's Center; Helping Hands Home for Children; Presbyterian Children's Home and Services; Settlement Home; STARRY; Williamson County Juvenile Detention Center
Trauma-Specific Interventions	
Aggression Replacement Therapy (ART) CEBC Ratings ART: SR-3, CWL-Medium	Austin Travis County Integral Care; Williamson County Juvenile Detention Center
Attachment, Regulation, and Competency (ARC) CEBC Ratings ARC Client-Level Intervention: SR-NR, CWL-High	Centers for Children and Families; Heart of Texas Regional MHMR

Trauma-Informed Practice	Agencies/Organizations
Circle of Security CECB Rating CS Parenting: SR-NR, CWL-Medium CS Home-visiting: SR-3. CWL-Medium	321st District Court of Smith County-Judge Carole Clark; Associate Judge Aurora Martinez Jones; Presbyterian Children's Home and Services
Cognitive Behavioral Interventions for Trauma in Schools (CBITS) NREPP Rating CBITS Bounce Back: Effective for trauma and stress-related disorders and symptoms. CECB Ratings CBITS Bounce Back: SR-3, CWL-Medium CBITS: SR-3, CWL-Medium	Pastoral Counseling Center
Dan Siegel-No Drama Discipline This is a parenting approach and is not rated.	Austin Child Guidance Center; Cal Farley's Boys Ranch; Helping Hands Home for Children; Presbyterian Children's Home and Services; STARRY
Eye Movement Desensitization and Reprocessing (EMDR) NREPP Rating EMDR-Included as a legacy program not currently rated in the new system. CECB Ratings EMDR Child and Adolecent: SR-1, CWL-Medium	321st District Court of Smith County; Austin Travis County Integral Care; Centers for Children and Families; Dallas CAC; El Paso Child Guidance Center; Helping Hands Home for Children; Pastoral Counseling Center; Settlement Home; STARRY
Managing Aggressive Behavior (MAB) MAB is a crisis management program. Not rated in the NREPP or CECB databases.	Presbyterian Children's Home and Services
MindUp MindUp is reported to be and evidence-based social and emotional learning program.	Helping Hands Home for Children
Nurturing Parenting CECB Ratings NP SR-3, CWL-High	Presbyterian Children's Home and Services

Trauma-Informed Practice	Agencies/Organizations
Parent Child Interaction Therapy (PCIT) CECB Ratings PCIT: SR-1, CWL-Medium	Associate Judge Aurora Martinez Jones; Austin Child Guidance Center; Centers for Children and Families; Central Plains Center; Dallas CAC; El Paso Child Guidance Center; Heart of Texas Regional MHMR; Presbyterian Children's Home and Services
Pathways to Permanence Not currently evidence-based. DFPS with UT Austin is in the process of conducting a study on its effectiveness.	DFPS - Region 7
Play Therapy No rating for play therapy in general. Theraplay is rated below.	Presbyterian Children's Home and Services
Problematic Sexual Behavior Cognitive Behavioral Therapy (PSB-CBT) NCTSN provides and overview of PS-CBT's clinical and anecdotal evidence.	Dallas CAC
Psychological First Aid CECB Ratings PFA: SR-NR, CWL-Medium	321st District Court of Smith County-Judge Carole Clark; Presbyterian Children's Services
Sandtray The website for Evidence-based Child Therapy indicates that Sandtray play therapy has one randomized-waitlist controlled study, and two nonrandomized-waitlist controlled studies.	Presbyterian Children's Home and Services
Satori Alternatives to Manage Aggressive Behavior (SAMA) SAMA focuses on risk management of aggressive behaviors. This practice is not contained in the NREPP or the CECB database.	Cal Farley's Boys Ranch; Helping Hands Home for Children
Seeking Safety NREPP SS: Is listed as a legacy program and has not been rated using the new rating scale. CECB Ratings SS: SR-3, CWL-Medium	Aliviane; Associate Judge Aurora Martinez Jones; Austin Child Guidance Center; Austin Travis County Integral Care; Centers for Children and Families; Central Plains Center; Presbyterian Children's Home and Services

Trauma-Informed Practice	Agencies/Organizations
Sensory Integration Therapy SIT is not included in NREPP or CECB. The American Occupational Therapy Association supports the implementation of SIT for disagnosis such as autism.	Associate Judge Aurora Martinez Jones; Central Plains Center; Helping Hands Home for Children
Solution-focused Brief Therapy CECB Rating SFBT: SR-NR, CWL-High SFBT not rated by NREPP or CECB. It was rated as "promising" by the Office of Juvenile Justice and Delinquency Prevention.	Associate Judge Aurora Martinez Jones; Austin Child Guidance Center; Centers for Children and Families; Pastoral Counseling Center; Presbyterian Children's Home and Services; Williamson County Juvenile Detention Center
Theraplay NREPP Rating Theraplay: Effective for internalizing problems. CECB Rating Theraplay: SR-3, CWL-Medium	Helping Hands Home for Children
Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A) NREPP Rating TARGET: Effective for anxiety disorders and symptoms, coping, general functioning and well-being, internalizing problems, and trauma and stress-related disorders. CECB Rating TARGET: SR-3, CWL-Medium	Heart of Texas Regional MHMR
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) NREPP Rating TF-CBT: Effective for trauma and stress related disorders CECB Ratings TF-CBT: SR-1, CWL-High	Aliviane; Associate Judge Aurora Martinez Jones; Austin Child Guidance Center; Austin Travis County Integral Care; Centers for Children and Families; Central Plains Center; Dallas CAC; Heart of Texas Regional MHMR; Helping Hands Home for Children; Pastoral Counseling Center; Presbyterian Children's Home and Services; Settlement Home; Texas Tech University Health Sciences Center; Williamson County Juvenile Detention Center; Ysleta Del Sur Pueblo

Appendix Five: Trauma-focused Approaches Utilized by Key Informants

Child and Adolescent Evidence-Based and Evidence-Informed Practices by Agency

Agencies/Organizations	Trauma-Informed Practice
321st District Court of Smith County	Circle of Security, EMDR, Psychological First Aid, and TBRI®
Aliviane	Seeking Safety and TF-CBT
Associate Judge Aurora Martinez Jones	Circle of Security, EMDR, NMT, PCIT, Seeking Safety, Sensory Integration Therapy, Solution Focused Therapy, TF-CBT, TBRI®, and variations of CBT
Austin Child Guidance Center	Dan Siegel-No Drama Discipline, PCIT, Seeking Safety, Solution Focused Therapy, and TF-CBT
Austin Travis Integral Care	ART, EMDR, Seeking Safety, TF-CBT, and TBRI®
Cal Farley's Boys Ranch	Dan Siegel-No Drama Discipline, NMT, NME, Satori Alternatives to Manage Aggressive Behavior, and TBRI®
CASA of Tarrant County	TBRI®
CASA of Travis County	TBRI®
Centers for Children and Families	ARC, EMDR, PCIT, Seeking Safety, Solution Focused Therapy and TF-CBT, and TBRI®
Central Plains Center	PCIT, Seeking Safety, Sensory Integration Therapy, and TF-CBT
Dallas Child Advocacy Center	EMDR, PCIT, PSB-CBT, and TF-CBT
DePelchin Children's Center	TBRI®
El Paso Child Guidance Center	EMDR and PCIT
Heart of Texas MHMR	ARC, PCIT, TARGET-A, TF-CBT
Helping Hands Home for Children	Dan Siegel-No Drama Discipline, EMDR, Mindup, NMT, Satori Alternatives to Manage Aggressive Behavior, Sensory Integration Therapy, TBRI®, TF-CBT, and Theraplay
Pastoral Counseling Center	CBITS, EMDR, Solution Focused Therapy, and TF-CBT
Presbyterian Children's Home and Services	Circle of Security, Dan Siegel-No Drama Discipline, Managing Aggressive Behavior, Nurturing Parenting, PCIT, Play Therapy, Psychological First Aid, Sandtray, Seeking Safety, Solution Focused Therapy, TF-CBT, and TBRI®
Settlement Home	EMDR, TBRI®, and TF-CBT
STARRY	Dan Siegel-No Drama Discipline, EMDR, and TBRI®

Agencies/Organizations	Trauma-Informed Practice
Texas Tech University Health Sciences Center	TF-CBT
Williamson County Juvenile Detention Center	ART, Solution Focused Therapy, TBRI®, and TF-CBT
Ysleta Del Sur Pueblo	TF-CBT

Appendix Six: Travis County Collaborative for Children: Defining a Trauma-Informed Organization, Program, or System

An organization, program, or system that is trauma-informed does the following:

- **Realizes the impact of trauma**, including how it can emotionally, behaviorally, and physically affect children, families, staff, volunteers as well as the organizations that work with them.
  - Understands a person's behavior in the context of coping strategies that are designed to survive adversity, including responses to primary and secondary trauma. For instance what presents as anger may be fear, and what presents as disruptive behavior may be self-preservation.
  - Understands that the need for a trauma-informed response is not limited to mental and behavioral health specialty services but is integral to all organizations and systems involved in children's lives. It may prevent healing and wellness if not addressed across the entire web of these systems.
  - Understands that a pharmacological response and/or reducing the risk of repeat trauma alone cannot meet the needs of vulnerable children. Building relationships, community, and the feeling of safety are necessary for neuro-development and healing from early trauma.
- **Recognizes the signs of trauma** and consistently incorporates trauma screening and assessment into all aspects of work, including interactions with children, families, staff, and volunteers.
- **Responds by applying the principles of a trauma-informed approach** to all areas of functioning. These include the following:
  - Staff and volunteer training on trauma and trauma-informed practices.
  - Leadership that realizes the role of trauma in their staff and the children/families they serve.
  - Policies and practices that ensure the following three core pillars of trauma-informed care are addressed:
    - **Connection**: focusing on the relational needs of children, with special attention towards building and strengthening secure attachments between caregivers and children
    - **Safety**: creating an environment of physical, social, and psychological safety and meeting the child's physiological needs; these needs include good nutrition, adequate sleep, attention to sensory needs, and regular physical activity.
    - **Regulation:** providing structured experiences to enhance emotional and behavioral self-regulation in children, enhancing caregivers' mindful awareness and their ability to use proactive strategies for behavioral change.
- **Avoids re-traumatizing** children, caregivers, and staff by recognizing how organizational and system practices such as placement disruptions, seclusion, restraints, and abrupt

transitions can cause additional harm and interfere with healing. Relationships and nutrition are not used as part of a system of awards/consequences.

Examples of What Trauma-Informed Care Looks Like In…	
Court Rooms	• Judges and attorneys are informed of research-based, trauma-informed responses. • Where possible, court orders allow adequate time for children and families to prepare for a transition to a new placement. • Placement decisions are based on ensuring connection, safety, and regulation.
Caseworker Environment	• Caseworkers are connected emotionally with the children they serve. • Caseworkers have sensory items available for children to use if desired. • Nutritious snacks and water are available. • Caseworkers have skill sets that are informed by research-based, trauma-informed response and practices.
Medical Provider Offices	• Medical providers are aware of how trauma can emotionally, behaviorally, and physically affect children. • Medical providers understand that a pharmacological response alone cannot meet the needs of vulnerable children.
Residential Treatment Centers	• Nutritious snacks are available on request, not locked or used as rewards for good behavior. • Sensory rooms are available for children to use when they request or choose to. • All staff and volunteers are trained on research-based, trauma-informed responses and practices. • Behavioral correction strategies are trauma-informed; caregivers and staff understand the role of fear in behavior. • Children may use sensory techniques/items during instructional time; they may move and use other strategies to help them feel in control physically.

Examples of What Trauma-Informed Care Looks Like In…	
Homes	• Caregivers focus on the relational needs of children with special attention towards building and strengthening secure attachments. • Behavioral correction strategies are trauma-informed; caregivers understand the role of fear in behavior. • Caregivers create an environment of physical, psychological, and social safety. • Children have nutritious food and water available at regular intervals throughout the day to maintain stamina and focus. • Children are given the opportunity for a break and "re-do" after disruptive behavior. • Caregivers are self-aware and are able to use proactive strategies for behavioral change.
Houses of Worship	• Wraparound support is available for children and families who have experienced trauma. • Learning and worship settings are conducive to physical, psychological, and social safety.
Classrooms	• Students may use sensory techniques/items during instructional time; they may move and use other strategies to help them feel in control physically. • Students have nutritious food and water available at regular intervals throughout the day to maintain stamina and focus. • Students are given the opportunity for a break and "re-do" after disruptive behavior rather than having a mark moved or other penalty imposed.