Implementing Trauma Systems Therapy in a Child Welfare System

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The Practice
Trauma Systems Therapy in a Child Welfare Setting

- Therapist
- Birth Families
- Case Managers/Supervisors
- Resource Families
- BHTs
- Aftercare Workers/Supervisors
- FSCs
- Aftercare Workers/Supervisors
- Resource Families
- Birth Families
- Therapist

Child
System Development (TST)

**Primers**
- Concepts
- Culture

**Overview w/trainers**
- Concepts
- Culture
- Practice

**Core Training (Direct, On-line, Workbook)**
- Concepts
- Culture
- Practice

**Individual/Group Supervision**
- Practice
- Culture
- Reflection

**Maintenance (Coaching Sessions)**
- Concepts
- Culture
- Practice

**Evaluation (Check Ins)**
- Fidelity
- Principles
- Accountability
Integrating TST into practice: tools

- Child assessments being utilized
  - UCLA –PTSD Index is completed by child’s case manager within first 14 days after entry into out of home care
  - Child Ecology Check In (CECI) conducted each month, no challenges to administering this tool were reported

- Other tools
  - Emotion Regulation (ER) Guide – primarily mentioned as tool in residential/hospital setting, beginning to be used in resource homes
  - “Moment by Moments” well-received by case manager and hospital staff, indication that some resource parents using
Integrating of TST into practice: communication

- Staff can more efficiently communicate between departments and across staff levels
  - All staff talking “the same language” (e.g., triggers, regulation)
  - UCLA-PTSD assessment as starting point
- Staff report that communication within departments has either increased or maintained high levels
- Use of “trauma informed” language across staff and departments creating a more unified approach to helping children
Integrating TST into practice: case consultations

- Scheduled two days a week (two hours per case)
- Case managers and supervisors decide which cases need staffing
- Extensive involvement including therapist, case manager, resource parent’s family service coordinator, resource parents, residential staff, and possibly school officials
- Grounded in TST approach—discussion of child’s and resource family’s pain, review “moment by moment”, defines next steps
- Follow-up call scheduled two weeks out to discuss progress
Integrating TST into practice: *fidelity assessments*

- TST fidelity assessments (10-point scale) are administered on a quarterly basis with all staff.
- Fidelity assessment data are being monitored as part of the evaluation.
- Indication of improvement in fidelity in implementation of TST over time, scores on assessments have increased.
- Not all staff have been assessed yet.
Based upon TST principles:

- Fix a broken system
- Put safety first
- Put scarce resources where they will work
- Insist on accountability—particularly your own
- Align with reality
- Build from strength
- Do not go before you are ready
- Take care of yourself and your team
- Leave a better system

Scores on 10-point scale (0=Lacking direct evidence, 10=Conclusive evidence)
Status of TST implementation in resource family setting

- Availability of different modes of training key
- Indication that Emotional Regulation guides and “Moment by moments” now being used in some resource homes
- Some resource parents participating in case consultation calls
Implementation strengths

• Use of common language
• Improvement on fidelity assessments over time
• Increased and sustained communication between all levels of staff and across departments
• Consultation calls useful in addressing trauma and subsequent behaviors
• Family service coordinators play a larger role through TST implementation (link to foster parents)
• Multiple training modes and frequency of training
• Data tracking (training completed, CAFAS scores)
Implementation challenges

- Non-KVC therapists (community mental health center staff) less knowledgeable of TST
- Some workers report minimal time to implement TST
- Relative foster homes less engaged in TST training
- Difficulty reported training home-based caregivers (birth parents)
- Training birth family members next step, and staff expect challenges
The Research
Research questions and data collection

• How is TST implemented?
• What is the quality and fidelity of implementation?
• What intervention dosage (how much exposure) do children receive?
• Does children’s well-being improve over time, as TST is broadly implemented?
• Do children experience fewer placement disruptions over time?
• Do children reach more timely permanency?
Research findings: implementation

• Approximately, 1,500 youth ages six and older entering care between 2011 and 2014 received TST

• Approximately 90% of 435 KVC staff were trained in TST

• Approximately 70% of 400 KVC foster parents were trained in TST
Dosage

Outer Circle
- Supervisors
- Family Service Coordinators

Inner Circle
- Resource Parents
- Residential BHTs
- Case Managers
- Therapists

Child
Research findings: well-being

- As children’s care teams implement TST with fidelity, children demonstrated greater improvements in well-being.
- Not all measures of well-being are associated with TST implementation in the same way.
Research findings: placement and permanency

Placement Stability

- Number of new placements per quarter
- Number of placements while in care

- As children’s care teams implement TST with fidelity, children experienced greater placement stability.

- Results paint an unclear picture of how TST dosage is related to children’s permanency.

Permanency

- Reunification
- Adoption
- Legal Guardianship

- Attaining permanency within a child welfare context depends on many factors beyond children’s behavior.
Other key findings

- Care team members may play unique roles in enhancing child well-being and no one member is central to TST.

- May be the confluence of the skills and ability of the child’s team that produces better outcomes.

- Implementation of trauma-informed interventions with non-clinical staff and foster parents shows promise.
Study implications and conclusions

• TST is effective in a non-clinical, large child welfare setting
• Provided knowledge and tools for staff and foster parents to better care for children
• Non-clinical staff and foster parents were open and willing partners in the provision of trauma-informed care, transferring the training and putting the tools to use
• Examining how different care team members individually and collectively influence child outcomes is important research
• No individual (staff or foster parent) is the cornerstone for improved child well-being
Thank you!

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Children and Youth Services Review Journal articles: