TRAUMA INFORMED CARE

A traumatic experience is an event that threatens someone's life, safety, or well-being and overwhelms one's capacity to cope. Some examples include:

- Child maltreatment
- Witnessing violence
- Natural disasters
- Loss of loved ones
- Serious accidents
- Medical trauma

A. Trauma Impacts a Child's Development and Health

1. **Altered Biological Stress Systems and Neural Circuitry/Structure**
    - Difficulties with poor emotional regulation, focus and self-control (when in fight or flight mode, the brain loses executive functions that do not serve fight or flight, like higher learning and problem-solving which contribute substantially to school success)
    - Anxious and avoidant behaviors
    - Potential impacts to self-efficacy
2. **Disruptions in Attachment Behavior**
    - Disruptions in relationships
    - Distrust of people in authority, seen as threats
3. **Changes in Social Development and Understanding of Social Stimuli**
    - Altered encoding and interpreting of social stimuli
    - Hostile attribution bias (child perceivers negative motives, facial expressions, body language)
    - Larger repertoire of aggressive responses
    - Aggression as an acceptable response

- Difficulties belonging and playing well with others

4. **Behaviorally, Trauma Can Look Like Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and/or Conduct Disorder and Can Lead to**:

    - Substance use/abuse
    - Aggression
    - Numbness
    - Risk taking
    - Delinquency and adult offending

B. Current Challenges

- Alarmingly high rates of childhood trauma exposure, Post Traumatic Stress Disorder (PTSD) and victimization among children in foster care.
- Trauma concerns are frequently overlooked. Consistent observations suggest that denial of PTSD and blaming of its victims are not isolated omissions or distortions, but a pattern that spans over time, crosses national and cultural boundaries, and defies accumulated knowledge.

C. Trauma-Informed Practices

1. **Increase Accessible and Effective Trauma Services Through Education and Collaboration Among the Many Stakeholders** (mental health providers, caseworkers, foster parents, caregivers at kinship placements and residential treatment centers, judges, attorneys, CASAs, medical community, law enforcement)

Collaboration leads to:

- Better screening (brief, focused inquiry) at initial contact;
- More detailed assessments (a more in-depth exploration by a trained mental health professional of the nature and severity of the traumatic events, and current trauma-related symptoms);
- More specialized, evidenced-based treatments (with mental health professionals);
- Less misdiagnosis of schizophrenia, psychosis NOS, borderline personality disorder, and conduct or oppositional-defiant disorder;
- Fewer psychoactive medications, restraints and seclusions; and

- More self-reporting of trauma by children and youth survivors.
    - children and youth become educated about effects of trauma, e.g. violent physical abuse in childhood may not be disclosed because it is thought of as "discipline" or "normal"
    - the fear, guilt or shame of perceived mental illness is lessened once child is able to connect the trauma and its effects
    - promote positive neurological effects on the foster youth's immune function and overall physical health through disclosure of and confrontation of trauma

2. Create Environment of Safety, Respect, Honesty, and Humility to Nurture Healing, Rehabilitation, and Resiliency

- Communicate to the children in foster care that their caregivers believe abuse and violence are significant events. Survivors' healing stories often begin with the experience of being believed, taken seriously and protected by an adult.
- Develop a shared understanding of the role that trauma has played in shaping the survivor's life. Connect trauma concerns with the rest of the child's problems and goals, and understand that experiences of physical, sexual, and emotional abuse can shape fundamental patterns of perceiving the world, other people, and oneself.
- Identify current circumstances that may trigger trauma responses, e.g., unexpected touching, threats, loud arguments, violations of privacy or confidentiality, being in confined spaces with strangers, or sexual situations.
- Determine potential contraindications to use of restraint (and other coercive measures).
- Be watchful for other less obvious triggers that become evident as you know the child better and as he or she recognizes and can express her or his individual stress responses more accurately.
- Enable children to understand their strengths (adaptive capacities) as well as weaknesses that have grown out of their responses to horrific events, rather than seeing their "symptoms" and "disorders" as evidence of fundamental defects. Identify with child the resources such as social support, self-esteem and resilience, self-comforting, sense of meaning and purpose – to help them to recognize and draw on underused strengths.
- Help children and youth identify strategies helpful in the past in dealing with overwhelming emotions. Place priority on child's preferences regarding self-protection and self-soothing needs by using de-escalation preference surveys.

3. **Increase Visitation**

Minimize the trauma from removal and attachment disruption by increasing visitation with parents, siblings and other close family (especially in children ages zero to three) to provide meaningful and consistent connections with appropriate family members.

4. **Promote Comforting and Calming Techniques**

Encourage collaborative service plan. If crisis occurs again, caregivers in foster homes and residential can draw on the child's own knowledge of what has previously helped and hurt. Prepare for de-escalation in foster homes and residential treatment centers.

5. **Provide Ongoing Support for Caregivers**

Responses of care giving adults to traumatic events are significant. Survivors often report the debilitating effects of being disbelieved, or having their accounts minimized or dismissed.

6. **Encourage Foster Youth Connection with Healthy Adults**

Facilitate connections with "persons of character", e.g. CASAs.

7. **Help Reduce Barriers to Youth Participating in Positive Activities of Interest**

Problem-solve transportation issues preventing youth from engaging in positive afterschool activities, tutoring, etc.

D. Trauma-Informed Organizations[97]

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

- **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. This includes:
  - 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 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; this includes 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 Different Scenarios	
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.
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	• Wrap around 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.

E. Restraint and Seclusion Guidelines

Many trauma-informed care trainings promote specific strategies including self-care approaches, peer-provided services, arts programs, and comfort rooms to enhance healing and as means to avoid the use of restraint and seclusion. In Texas, the Administrative Code offers the following guidelines on restraining and secluding children in General Residential Operations and Residential Treatment Centers.

1. **Restraint/Seclusion May Only Be Used:**

   - As last resort

     40 Tex. Admin. Code § 748.2455(a)(1)(2); 40 Tex. Admin. Code § 749.2055(a)(1)(2); 40 Tex. Admin. Code § 748.2551(a); and 40 Tex. Admin. Code § 749.2151

   - After less restrictive and more positive measures have been tried and failed

     40 Tex. Admin. Code § 748.2455(a)(1)(2); 40 Tex. Admin. Code § 749.2055(a)(1)(2); 40 Tex. Admin. Code § 748.2551(a); and 40 Tex. Admin. Code § 749.2151(a)

   - Only in an emergency situation

     40 Tex. Admin. Code § 748.2455(a)(1)(2); 40 Tex. Admin. Code § 749.2055(a)(1)(2); 40 Tex. Admin. Code § 748.2401(5); and 40 Tex. Admin. Code § 749.2001(5)

     (Definition of emergency situation)

   - Where immediately necessary

     40 Tex. Admin. Code § 748.43(17); 40 Tex. Admin. Code § 749.43(18) (Definition of EBI) 40 Tex. Admin. Code § 748.2401(5); and 40 Tex. Admin. Code § 749.2001(5) (Definition of emergency situation)

   - To prevent imminent probable death or substantial bodily harm

     40 Tex. Admin. Code § 748.43(17); 40 Tex. Admin. Code § 749.43(18) (Definition of Emergency Behavioral Intervention (EBI)); 40 Tex. Admin. Code § 748.2401(5); 40 Tex. Admin. Code § 749.2001(5) (Definition of emergency situation); 40 Tex. Admin.

Code § 748.43(47); and 40 Tex. Admin. Code § 749.43(56) (Definition of substantial bodily harm)

- NEVER as punishment, retaliation, convenience, treatment, or means of compliance

  40 Tex. Admin. Code § 748.2463 and 40 Tex. Admin. Code § 749.2063

2. Types of Restraints That May Be Administered with Restrictions:

- Physical restraint

  40 Tex. Admin. Code § 748.2451(a)(2); 40 Tex. Admin. Code § 749.2051(a)(2); 40 Tex. Admin. Code § 748.2401(7); and 40 Tex. Admin. Code § 749.2001(7) (Definition)

- Emergency medication

  40 Tex. Admin. Code § 748.2451(a)(3); 40 Tex. Admin. Code § 749.2051(a)(3); 40 Tex. Admin. Code § 748.2753 (simultaneous use with another EBI); 40 Tex. Admin. Code § 749.2233 (simultaneous use with personal restraint); 40 Tex. Admin. Code § 748.2401(4); and 40 Tex. Admin. Code § 749.2001(4) (Definition)

- Seclusion

  40 Tex. Admin. Code § 748.2451(a)(4); 40 Tex. Admin. Code § 748.2651; 40 Tex. Admin. Code § 748.2401(10); 40 Tex. Admin. Code § 749.2001(10) (Definition); and 40 Tex. Admin. Code § 749.2051(b)

- Mechanical restraint

  40 Tex. Admin. Code § 748.2451(a)(5); 40 Tex. Admin. Code § 748.2701; 40 Tex. Admin. Code § 748.2703; 40 Tex. Admin. Code § 748.2755 (simultaneous use with emergency medication); 40 Tex. Admin. Code § 748.2401(6); 40 Tex. Admin. Code § 749.2001(6) (Definition); and 40 Tex. Admin. Code § 749.2051(b)

3. Restraint/Seclusion May Only Be Administered by:

- Qualified caregiver

  40 Tex. Admin. Code § 748.2453 and 40 Tex. Admin. Code § 749.2053

- Trained in emergency behavior interventions

  40 Tex. Admin. Code § 748.947; 40 Tex. Admin. Code § 749.947; 40 Tex. Admin. Code § 748.903; 40 Tex. Admin. Code § 749.903; 40 Tex. Admin. Code § 748.863(a); 40 Tex. Admin. Code § 749.863(a); 40 Tex. Admin. Code § 748.901; and 40 Tex. Admin. Code § 749.901

- Whose duties include the direct care, supervision, guidance, and protection of child

40 Tex. Admin. Code § 748.43(5) and 40 Tex. Admin. Code § 749.43(7)

4. **A Child Must Be Released from a Restraint**:

- IMMEDIATELY if an emergency health situation arises

  40 Tex. Admin. Code § 748.2553(4)(A); 40 Tex. Admin. Code § 748.2553(5)(A); 40 Tex. Admin. Code § 748.2603; and 40 Tex. Admin. Code § 749.2203

- IMMEDIATELY once the danger is over

  40 Tex. Admin. Code § 748.2553(2)(C) and 40 Tex. Admin. Code § 749.2153(2)(C)

- Once maximum time allowed is reached

  40 Tex. Admin. Code § 748.2553(2)(E); 40 Tex. Admin. Code § 749.2153(2)(E); and 40 Tex. Admin. Code § 748.2553(4)(D)

Type of Emergency Behavior Intervention	The caregiver must release the child:
(1) Short personal restraint	(A) Immediately when an emergency health situation occurs during the restraint. The caregiver must obtain treatment immediately; or (B) Within one minute, or sooner if the danger is over or the disruptive behavior is de-escalated.
(2) Personal restraint	(A) Immediately when an emergency health situation occurs during the restraint. The caregiver must obtain treatment immediately; (B) Within one minute of the implementation of a prone or supine hold; (C) As soon as the child's behavior is no longer a danger to himself or others; (D) As soon as the medication is administered; or (E) When the maximum time allowed for personal restraint is reached.
(3) Emergency medication	Not applicable.
(4) Seclusion	(A) Immediately when an emergency health situation occurs during the seclusion. The caregiver must obtain treatment immediately; (B) As soon as the child's behavior is no longer a danger to himself or others; (C) No later than five minutes after the child begins exhibiting the required behaviors; (D) When the maximum time allowed for seclusion is reached; (E) If the child falls asleep in seclusion. In this situation, the caregiver must: (i) Unlock the door; (ii) Continuously observe the child until he awakens; and (iii) Evaluate his overall well-being; or (F) If the child is receiving emergency care services:

Type of Emergency Behavior Intervention	The caregiver must release the child:
(5) Mechanical restraint	(A) Immediately when an emergency health situation occurs during the restraint. The caregiver must obtain treatment immediately; (B) As soon as the child's behavior is no longer a danger to himself or others; (C) No later than five minutes after the child begins exhibiting the required behaviors; (D) When the maximum time allowed for mechanical restraint is reached; or (E) If the child falls asleep in the mechanical restraint. In this situation, the caregiver must release the child from the restraint and continuously observe the child until he awakens and evaluate him.

The maximum amount of time for a restraint/seclusion:

- Physical Restraint – under the age of 9, 30 minutes; 9 or over, 1 hour
- Seclusion – <9, 1 hour; ≥9, 2 hours; < cumulative total of 2 hrs./12 hr. period
- Mechanical Restraint – <9, 30 minutes; ≥9, 1 hour; <cumulative total of 1 hr./12 hr. period

Figure: 40 Tex. Admin. Code § 748.2801	
Types of Emergency Behavior Intervention	**The maximum length of time is:**
(1) Short personal restraint	One minute.
(2) Personal restraint	(A) For a child under nine years old, 30 minutes; (B) For a child nine years old or older, one hour; or (C) A prone or supine personal restraint hold may not exceed one minute.
(3) Emergency medication	Not applicable.
(4) Seclusion	(A) For a child under nine years old, one hour. (B) For a child nine years old or older, two hours.
(5) Mechanical restraint	(A) For a child under nine years old, 30 minutes. (B) For a child nine years old or older, one hour.

When restraining/secluding, a written order is required:

- By a licensed physician when administering emergency medications

  40 Tex. Admin. Code § 748.2501(3) and 40 Tex. Admin. Code § 749.2101(3)(A)

- By a licensed psychiatrist when administering mechanical restraints

  40 Tex. Admin. Code § 748.2501(5)

- By a licensed psychiatrist, physician, or psychologist when administering seclusion when using successive restraints

  40 Tex. Admin. Code § 748.2501(2); 40 Tex. Admin. Code § 749.2102(2)(A); 40 Tex. Admin. Code § 748.2751(3); and 40 Tex. Admin. Code § 749.2231(a)

- When using restraints simultaneously

  40 Tex. Admin. Code § 748.2501(2); 40 Tex. Admin. Code § 749.2101(2)(A); 40 Tex. Admin. Code § 748.2753(a)(3) and (b); 40 Tex. Admin. Code § 749.2233(a) (Emergency medications with personal restraint); and 40 Tex. Admin. Code § 748.2755(a)(3) and (b) (Mechanical restraints with emergency medications)

- When maximum length of time allowed is exceeded

  40 Tex. Admin. Code § 748.2805; 40 Tex. Admin. Code § 749.2283(2)

- Also see: 40 Tex. Admin. Code § 748.2505; 40 Tex. Admin. Code § 749.2105 (content of written orders); 40 Tex. Admin. Code § 748.2507; 40 Tex. Admin. Code § 749.2107 (PRN orders); and 40 Tex. Admin. Code § 748.2807 (verbal orders to exceed maximum time allowed)

Type of Emergency Behavior Intervention	**Are written orders required to administer the intervention for a**	**Who can write orders for the use of the intervention for a specific child?**
(1) Short personal restraint	NO.	Not applicable.
(2) Personal restraint	NO. However, successive restraints, a restraint simultaneous with emergency medication, and/or a restraint that exceeds the maximum time limit all require orders as specified in this subchapter. PRN orders are also permitted under §748.2507 of this title (relating to Under what conditions are PRN orders permitted	Not Applicable.
(3) Emergency medication	YES.	A licensed physician.
(4) Seclusion	YES, except written orders are not required when you provide emergency care services to the child placed in seclusion.	A licensed psychiatrist, psychologist, or physician.

(5) Mechanical restraint	YES.	A licensed psychiatrist.

A review is triggered when:

- Restrained four times in a seven day period

  40 Tex. Admin. Code § 748.2901(2)(A) and 40 Tex. Admin. Code § 749.2331(2)(A)

- Emergency medications used three times in a thirty day period

  40 Tex. Admin. Code § 748.2901(3) and 40 Tex. Admin. Code § 749.2331(3)

- Secluded >twelve hours or three times in a seven day period

  40 Tex. Admin. Code § 748.2901(4) **NOTE: Not applicable to foster care placements.

- Mechanically restrained > three hours or three times in a seven day period

  40 Tex. Admin. Code § 748.2901(5) **NOTE: Not applicable to foster care placements.

Restraint/Seclusion that is NOT allowed:

*Foster care placements may never administer chemical restraints, mechanical restraints, or seclusion.

- Mechanical restraint may not be simultaneously used with seclusion or pursuant to PRN order

  40 Tex. Admin. Code § 748.2757 and 40 Tex. Admin. Code § 748.2507(5)

- No chemical restraints

  40 Tex. Admin. Code § 748.1119(1); 40 Tex. Admin. Code § 749.1021(1); 40 Tex. Admin. Code § 748.2451(b); 40 Tex. Admin. Code § 749.2051(b); 40 Tex. Admin. Code § 748.2401(1); and 40 Tex. Admin. Code § 749.2001(1) (Definition)

- Prone or supine restraints except for a personal restraint for 1 minute or less

  40 Tex. Admin. Code § 748.2605(b); 40 Tex. Admin. Code § 749.2205(b) & (c); 40 Tex. Admin. Code § 748.2461(b)(1); 40 Tex. Admin. Code § 749.2061(b)(1); 40 Tex. Admin. Code § 748.2553(2)(B); 40 Tex. Admin. Code § 749.2153(2)(B); 40 Tex. Admin. Code § 748.2801(2)(C); and 40 Tex. Admin. Code § 749.2281(2)(C)

Also see other relevant provisions:

- 40 Tex. Admin. Code § 748.1119 and 40 Tex. Admin. Code § 749.2021 (techniques prohibited)
- Tex. Admin. Code § 748.2303 and 40 Tex. Admin. Code § 749.1953 (may not use or threaten corporal punishment)
- 40 Tex. Admin. Code § 748.2307 and 40 Tex. Admin. Code § 749.1957 (methods of punishment prohibited)
- 40 Tex. Admin. Code § 748.2605 and 40 Tex. Admin. Code § 749.2205 (prohibited physical restraint techniques)
- 40 Tex. Admin. Code § 748.2705 (types of mechanical & other restraint devices prohibited)

F. Trauma Work in Texas

1. Reports

Meeting the Needs of High Needs Children in the Texas Child Welfare System, November 2015[98]

Understanding Trauma-Informed Care in the Texas Child Welfare System, Data and Recommendations from the Field, October 2015[99]

Respecting the Needs of Children and Youth in Texas Foster Care: Acknowledging Trauma and Promoting Positive Mental Health throughout the System, December 2014 [100]

2. Legislation

In 2011, the Texas Family Code was amended to require 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. Tex. Fam. Code § 264.015.

DFPS Trauma-Informed Practice Workgroup was formed to look at:

- Training;
- Assessment and screening;
- Kinship caregiver support; and
- Secondary traumatic stress for direct care staff.

DFPS caseworkers are now required to complete:

- An initial, in-person training on trauma-informed care during their basic skills development training; and
- An annual refresher course online.

Residential Child Care Contract (RCCC) Requirements

- As of September 1, 2015, DFPS required all caregivers and employees who are subject to RCCC for direct care to complete:
- At least eight hours of trauma-informed care training prior to being the only caregiver responsible for children.
- At least two hours of trauma-informed care annually, and contractors may select their own curriculum/model for the annual refresher training

Changes to the Family Code in 2013 required trauma-informed care training for certain staff of county and state juvenile facilities, including probation officers, supervision officers, correctional officers, parole officers and court-supervised community-based program personnel. Tex. Hum. Res. Code § 221.002(c-1).

Since 2015, DFPS is required to institute a comprehensive psychosocial assessment tool to assess all children who enter the foster care system within 45 days. The tool must include a trauma assessment and an interview with at least one individual who knows the child. Tex. Fam. Code § 266.012.

3. Community-Level Initiatives

The Travis County Collaborative for Children (TCCC)

Led by Texas Christian University's (TCU) Institute of Child Development (ICD), the TCCC intended to bring system-wide changes to the way foster children in Travis County are cared for during and after their time in state custody. TCCC's ultimate goal is to accelerate healing and speed to permanency for children in foster care utilizing ICD's evidence-based Trust-Based Relational Intervention (TBRI®) principles and practices.

Mental Health Connection Trauma Implementation Team

In Tarrant County, originally formed in 2011 to bring Trauma-Focused Cognitive Behavioral Therapy to the community. The Mental Health Connection launched a public awareness campaign in May 2013 called "Recognize Trauma." The campaign included movie ads, bus ads and billboards, in addition to brochures, posters and wallet cards.

The Trauma-Informed Care Consortium of Central Texas (TICC)

Established in 2013 by St. David's Foundation and Austin Child Guidance Center, the TICC brings together professional organizations quarterly to network, share information, and

coordinate trainings for mental health clinicians, school personnel, medical /nursing professionals, law enforcement and juvenile justice professionals.

4. Statewide Initiatives

DePelchin led an effort in 2011 to create the Texas Child Trauma Network (TCTN) for the coordination, organization, implementation and expansion of trauma-informed and trauma-focused practices within the Texas state child welfare system. Texas was not awarded the Substance Abuse and Mental Health Services Administration (SAMSHA) grant, so the TCTN did not come to fruition, but we can refer to the application for guidance.

Children's Advocacy Centers' (CACs) Practice Model

In 2013, the Texas Legislature raised the standard for mental health services in CACs, requiring that all mental health services be trauma-focused and evidence-based. Additionally, mental health services must be provided by professionals who have a master's degree and are licensed, or who are students in an accredited graduate program and supervised by a licensed mental health professional.

Texas Children Recovering from Trauma (TCRFT)

In 2012, the Department of State Health Services (DSHS) was awarded a 4-year cooperative grant from the National Child Traumatic Stress Initiative of SAMHSA. This initiative focuses on transforming the existing children's mental health services in Texas into trauma-informed care services. The target population of this grant is children and youth ages 3 to 17 that have been exposed to or witnessed trauma or are children of military families.

Trauma-Informed Care Specialty Network

Created by STAR Health, it allows its providers to list the training on trauma that they have pursued and helps identify providers who have been trained in trauma-informed care in the STAR Health network for caseworkers, caregivers and others in the child welfare community. STAR Health also offers TIC trainings to CPA, kinship families, RTC staff and Emergency Shelter staff.

The National Quality Improvement Center's Adoption and Guardianship Support and Preservation (QIC-AG) awarded grant funds to Texas to study TIC practice. Pathways to Permanence, training for active caregivers, was selected and will be randomly given to groups of caregivers for children whose parents' had their parental rights terminated; or children who have been in care for at least two years with no or partial rights terminated.

G. National Resources

Ten Things Every Juvenile Court Judge Should Know about Trauma and Delinquency at: http://www.ncjfcj.org/sites/default/files/trauma%20bulletin_0.pdf

Roadmap to Seclusion and Restraint Free Mental Health Services at: https://store.samhsa.gov/shin/content/SMA06-4055/SMA06-4055-A.pdf

Position Statement on Seclusion and Restraint, National Association of State Mental Health Program Directors (NASMHPD), at: http://www.mentalhealthamerica.net/go/position-statements/24

The National Child Traumatic Stress Network (NCTSN) Bench Card for the Trauma Informed Judge, at: http://www.nctsn.org/sites/default/files/assets/pdfs/judge_bench_cards_final.pdf

The National Child Traumatic Stress Network, LGBTQ Issues and Child Trauma, at: http://www.nctsn.org/sites/default/files/assets/pdfs/safe_spaces_safe_places_flyer_2015.pdf