TRAUMA-INFORMED CARE

A. Trauma

The concept of trauma and the accompanying research have shifted the paradigm about the way in which systems, organizations, professionals, and caregivers approach and serve children, youth, young adults, and families who experience the child welfare system. The field of trauma and trauma-informed care is constantly evolving and expanding. The information in this chapter is intended to give judges a basic understanding of these topics to help them manage child welfare cases in a trauma-informed manner.

40 Tex. Admin. Code § 702.701(a) defines trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening with lasting adverse effects on the individual's functioning or the individual's mental, physical, social, emotional, or spiritual well-being."[144]

Some examples of traumatic experiences include:[145]

- Physical, sexual, or psychological abuse and neglect (including trafficking);
- Family or community violence (both experiencing and witnessing);
- Loss of loved ones or traumatic grief;
- Witnessing violence;
- Natural and technological disasters or terrorism;
- Serious accidents;
- Historical trauma;[146]
- Medical trauma; and/or
- Military family-related stressors (e.g., deployment, parental loss, or injury)

B. Trauma Impacts a Child's Development and Health

The groundbreaking 1998 study on Adverse Childhood Experiences (ACEs) and the replicated studies which followed demonstrate that childhood stress is linked to poor health outcomes, including obesity, diabetes, depression, heart disease, cancer, and stroke as well as alcohol and drug abuse, low graduation rates, and poor employment outcomes.[147] The presence of ACEs does not mean that a child is guaranteed to experience poor life outcomes. Positive experiences and protective factors can prevent children from experiencing adversity and protect against many negative health and life outcomes.[148]

Undoubtedly, children and youth who experience abuse or neglect, are removed from their families, or interact with the child welfare system are vulnerable to experiencing trauma. Further, many parents and caregivers may have their own experiences with trauma and systems must respond to the needs

of children and families through a trauma-informed lens. This requires judges, attorneys, court staff, and other stakeholders to understand how traumatic responses manifest in the children and families in front of the court and subsequently change courtroom practices and the courtroom environment to help families feel supported and build resilience. In doing so, serving children and families can move beyond responding to behaviors to promoting healing.

It is important to note that no age is immune to the effects of traumatic experiences, including infants and toddlers. Traumatic stress will manifest differently from child to child and will depend on the child's age and developmental level.[149]

Children who are not experiencing consistent safety, comfort, and protection may develop ways of coping that allow them to survive and function day-to-day. These learned adaptations make sense when a physical and/or emotional threat is pervasive but are not helpful once a person is no longer under such threats.[150] Additionally, unaddressed trauma can lead to long-term effects into adulthood.

Some potential effects of trauma are:[151]

- Difficulties with emotional regulation, focus, and self-control (when in fight or flight mode, the brain loses executive functions that do not serve fight or flight, such as higher learning and problem-solving which contribute substantially to school success);
- Anxious and avoidant behaviors;
- Difficulty developing strong, healthy attachment to caregivers and others;
- Distrust of people in authority, who are seen as threats;
- Over-responding or under-responding to sensory stimuli;
- Misinterpreting motives, facial expressions, body language in others;
- Difficulties belonging and playing well with others;
- Difficulty with problem solving and decision-making;
- Chronic or recurrent physical complaints;
- Potential impacts to self-efficacy; and/or
- More likely to engage in high-risk behaviors.

C. Trauma-Informed Child Welfare System

40 Tex. Admin. Code § 702.701(b) defines Trauma-Informed as:

An individual, program, organization, or system that is trauma-informed fully integrates knowledge about trauma into policies, procedures, and practices by:

- Realizing the widespread impact of trauma, understanding potential paths for recovery, and acknowledging the compounding impact of structural inequities related to culture, history, race, gender, identity, locale, and language;

- Recognizing the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- Maximizing physical and psychological safety and responding to the impact of structural inequities on individuals and communities;
- Building healthy, trusting relationships that create mutuality among children, families, caregivers, and professionals at an individual and organizational level; and
- Striving to avoid re-traumatization.

The document "Building a Trauma-Informed Child Welfare System: A Blueprint" lays out nine Guiding Principles for child welfare stakeholders to use to continue transforming the system to one that is trauma-informed and trauma-responsive. The nine Guiding Principles as well as suggested trauma-informed practices to be implemented in the courtroom are provided below.

1. **CULTURE:** Texas will create a culture of trauma-informed care for all individuals and organizations that touch the lives of children, youth, young adults, and families while they are involved in the child welfare system.
    - Acknowledge the children, youth, young adults, and family members in court have likely experienced trauma and may continue to experience trauma throughout the case.
    - Review current courtroom practices and environment with a trauma-informed lens and integrate improvements.
    - Base communications between court professionals and participants in trauma-informed principles.
    - Create an environment of safety, respect, honesty, and humility to nurture healing, rehabilitation, and resiliency. Modify the environment, such as seating, lighting, and signage to be trauma-informed.
    - 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. Be watchful for other less obvious triggers that become evident as you know the family better and as family members recognize and can express their individual stress responses more accurately.
    - Promote and support efforts to reduce the use of seclusion and restraint practices.
    - Create service plans and court orders that are individualized to address the trauma-related needs of the child and family to promote healing and minimize re-traumatization.
    - Address trauma-related needs during transition periods.

2. **COLLABORATION:** A trauma-informed child welfare system requires collaboration within and across systems, organizations, and individuals.

    - Create an environment of open collaboration between all stakeholders to enhance services to families.

    - 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)

3. **EQUITY:** A trauma-informed child welfare system is culturally competent and equitable.

    - Consider a child and family's identity and cultural background when addressing participants and making decisions.

    - Seek out equity training for court staff. See the Chapter on Disproportionality for additional resources.

    - Review disaggregated data and address disproportionalities and disparities in collaboration with community partners. See the Bench Book chapter *Disproportionality and Equity* for more information.

4. **YOUTH & FAMILY VOICE:** A trauma-informed child welfare system includes and respects youth and family voice and cultivates resilience.

    - Gather the child's perspective on their case through the appropriate avenue for each individual child (in-person, video conference, letter, etc.).

    - Engage children, youth, parents, and family members in identifying the best approach for achieving reunification or other permanency options when reunification is not possible.

    - 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.

    - 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.

    - Facilitate healthy relationship building with a trusted adult (e.g., CASA; community member; family member)

    - Support and encourage normalcy activities as defined by the individual child. See the Bench Book chapter *Child and Youth Voice* for more information.

5. **SECONDARY TRAUMA:** A trauma-informed child welfare system recognizes and addresses secondary trauma.

- Assess courtroom practices to evaluate the work environment and its impact on court staff and professional wellness as it relates to secondary trauma.[152]
- Encourage court staff and professionals to complete periodic self-assessments for personal reflection.[153]
- Provide trainings and resources that support self-care and minimize the impact of secondary trauma.

6. **TRAINING:** A trauma-informed child welfare system recognizes that ongoing, quality training is fundamental.
   - Train court staff and professionals on the basic concepts of brain science, trauma, and trauma-related behaviors. Collaborate with stakeholders and community partners to leverage existing training and technical assistance resources. (The Judicial Trauma Institute replay and materials are available on the Children's Commission's website.)[154]
   - Provide ongoing, regular training to court staff and professionals to sustain trauma-informed changes and provide opportunities to implement what they learn.
7. **INFORMATION SHARING:** A trauma-informed child welfare system has information sharing capabilities that are accessible, manageable, innovative, and user-friendly.
   - Enhance collaboration pathways within and outside the courtroom to enhance information sharing processes.
   - Encourage the creation of a learning collaborative in the community to increase opportunities for sharing resources and knowledge and building relationships.
8. **DATA:** A trauma-informed child welfare system is informed by data and committed to continuous quality improvement.
   - Collaborate with stakeholders to ensure quality data collection practices.
   - Evaluate data and institute necessary changes with a trauma-informed lens.
9. **FUNDING & SUSTAINABILITY:** A trauma-informed child welfare system is adequately funded and sustainable.
   - Partner with community stakeholders to develop strategies for sustaining a trauma-informed courtroom.

D. Statutory Requirements for Trauma-Informed Care Training

1. Training for Attorney Ad Litems

As of September 1, 2021, an attorney who is on the list maintained by the court as being qualified for appointment as an attorney ad litem for a child in a child welfare case must provide proof that the attorney has completed a training program regarding trauma-informed care and the effect of trauma on children in DFPS conservatorship. Attorneys should complete the training as soon as practicable

once placed on the appointment list. Thereafter, an attorney must provide proof each year of compliance with the statute. Tex. Fam. Code § 107.004(b)-(b-3).

An attorney ad litem is responsible for periodically reviewing the child client's safety and well-being, including effects of trauma to the child. Tex. Fam. Code § 107.004 (d-3). Attorney ad litem training must now include information regarding:

- The symptoms of trauma and the impact that trauma has on a child, including how trauma may affect a child's development, emotions, memories, behavior, and decision-making;
- Attachment and how a lack of attachment may affect a child;
- The role that trauma-informed care and services can have in a child's ability to build connections, feel safe, and regulate the child's emotions to help the child build resiliency and overcome the effects of trauma and adverse childhood experiences;
- The importance of screening children for trauma and the risk of mislabeling and inappropriate treatment of children without proper screening, including the risks and benefits associated with the use of psychotropic medication;
- The potential for re-traumatization of children in the conservatorship of the Department of Family and Protective Services; and
- The availability of:
    - research-supported, trauma-informed, non-pharmacological interventions; and
    - trauma-informed advocacy to increase a child's access, while the child is in the conservatorship of the Department of Family and Protective Services, to:
        - trauma-informed care; and
        - trauma-informed mental and behavioral health services. Tex. Fam. Code § 107.004 (b-4).

2. DFPS Training

In 2011, the Texas Family Code was amended to require DFPS to include training in trauma-informed programs and services in any training which DFPS provides to foster parents, adoptive parents, kinship caregivers, department caseworkers, and department supervisors. Tex. Fam. Code § 264.015.

DFPS caseworkers are required to complete an initial, in-person training on trauma-informed care during their basic skills development training and an annual refresher course online. Supervisors and mentors are also required to complete a secondary trauma training. DFPS internal learning management system offers several optional trainings on trauma-related topics.

3. 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; and
- At least two hours of trauma-informed care annually, and contractors may select their own curriculum/model for the annual refresher training.

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. DFPS utilizes the CANS 2.0 to assess children and youth placed in substitute care ages 3 to 17 years within 30 days. Tex. Fam. Code § 266.012.

4. **Related Fields**

Since 2013, the Texas Human Resources Code requires 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) and Tex. Hum. Res. Code § 221.0061.

E. Emergency Behavior Interventions

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 to provide a means to avoid the use of restraint and seclusion. In Texas, the Administrative Code offers the following guidelines on utilizing Emergency Behavior Interventions, such as restraints and seclusion, on children in General Residential Operations and Residential Treatment Centers. These guidelines are summarized in the chart which follows.

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

- As last resort

  26 Tex. Admin. Code § 748.2455(a)(1) and (2); 26 Tex. Admin. Code § 749.2055(a)(1) and (2); 26 Tex. Admin. Code § 748.2551(a); and 26 Tex. Admin. Code § 749.2151

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

  26 Tex. Admin. Code § 748.2455(a)(1) and (2); 26 Tex. Admin. Code § 749.2055(a)(1) and (2); 26 Tex. Admin. Code § 748.2551(a); and 26 Tex. Admin. Code § 749.2151(a)

- Only in an emergency situation or to administer intra-muscular medication or other physician prescribed medication

  26 Tex. Admin. Code § 748.2455(a)(2); 26 Tex. Admin. Code § 749.2055(a)(2); 26 Tex. Admin Code § 748.43(22); and 26 Tex. Admin. Code § 749.43(25) (Definition of emergency situation)

- When immediately necessary

26 Tex. Admin. Code § 748.43(20); 26 Tex. Admin. Code § 749.43(23) (Definition of Emergency Behavioral Intervention (EBI); 26 Tex. Admin Code § 748.43(22); and 26 Tex. Admin. Code § 749.43(25) (Definition of emergency situation)

- To prevent imminent probable death or substantial physical injury

  26 Tex. Admin. Code § 748.43(20); 26 Tex. Admin. Code § 749.43(23) (Definition of EBI); 26 Tex. Admin. Code § 748.43(22); 40 Tex. Admin. Code § 749.43(25) (Definition of emergency situation); 26 Tex. Admin. Code § 748.43(68); and 26 Tex. Admin. Code § 749.43(72) (Definition of substantial physical injury)

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

  26 Tex. Admin. Code § 748.2463 and 26 Tex. Admin. Code § 749.2063

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

   - Short personal restraint and personal restraint

     26 Tex. Admin. Code § 748.2451(a)(1) and (2); 26 Tex. Admin. Code § 749.2051(a)(1) and (2); 26 Tex. Admin. Code § 748.43(51) and (65); and 26 Tex. Admin. Code § 749.43(52) and (69) (Definition of personal restraint and short personal restraint)

   - Emergency medication

     26 Tex. Admin. Code § 748.2451(a)(3); 26 Tex. Admin. Code § 749.2051(a)(3); 26 Tex. Admin. Code § 748.2753 (simultaneous use with another EBI); 26 Tex. Admin. Code § 749.2233 (simultaneous use with personal restraint); 26 Tex. Admin. Code § 748.43(21); and 26 Tex. Admin. Code § 749.43(24) (Definition of emergency medication)

   - Seclusion

     26 Tex. Admin. Code § 748.2451(a)(4); 26 Tex. Admin. Code § 748.2651; 26 Tex. Admin. Code § 748.43(63); 26 Tex. Admin. Code § 749.43(67) (Definition of seclusion); and 26 Tex. Admin. Code § 749.2051(b)

   - Mechanical restraint

     26 Tex. Admin. Code § 748.2451(a)(5) (only in Residential Treatment Centers); 26 Tex. Admin. Code § 748.2701; 26 Tex. Admin. Code § 748.2703; 26 Tex. Admin. Code § 748.2755 (simultaneous use with emergency medication); 26 Tex. Admin. Code § 748.43(39); 26 Tex. Admin. Code § 749.43(40) (Definition of mechanical restraint); and 26 Tex. Admin. Code § 749.2051(b)

3. **Restraint/Seclusion May Only Be Administered by:**

   - A caregiver qualified in emergency behavior interventions

     26 Tex. Admin. Code § 748.2453; 26 Tex. Admin. Code § 749.2053; (Requirements); 26 Tex. Admin. Code § 748.947; 26 Tex. Admin. Code § 749.947 (Annual training

requirements)26 Tex. Admin. Code § 748.863(a); 26 Tex. Admin. Code § 749.863(a) (Pre-service training requirements); 26 Tex. Admin. Code § 748.930; and 26 Tex. Admin. Code § 749.930 (Training hours).

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

  26 Tex. Admin. Code § 748.43(5) and 26 Tex. Admin. Code § 749.43(9)

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

   - Immediately if an emergency health situation arises

     26 Tex. Admin. Code § 748.2553(1)(A), (2)(A), (4)(A), and (5)(A); 26 Tex. Admin. Code § 749.2153(1)(A) and (2)(A); 26 Tex. Admin. Code § 748.2603; and 26 Tex. Admin. Code § 749.2203

   - Immediately once the danger is over

     26 Tex. Admin. Code § 748.2553(2)(C) and 26 Tex. Admin. Code § 749.2153(2)(C)

   - Once maximum time allowed is reached

     26 Tex. Admin. Code § 748.2553(2)(E); 26 Tex. Admin. Code § 749.2153(2)(E); and 26 Tex. Admin. Code § 748.2553(2)(E) and (4)(D)

Figure: 26 Tex. Admin. Code § 748.2553

Type of Emergency Behavior Intervention	**The caregiver must release the child if any of the following apply:**
(1) Short personal restraint	(A) Immediately when an emergency health situation occurs during the restraint and the caregiver must obtain treatment immediately; or (B) Within one minute, or sooner if the danger is over or the emergency situation no longer exists.
(2) Personal restraint	(A) Immediately when an emergency health situation occurs during the restraint. The caregiver must obtain treatment [for the child] immediately; (B) Within one minute of the implementation of a prone or supine transitional 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.

Figure: 26 Tex. Admin. Code § 748.2553	
Type of Emergency Behavior Intervention	**The caregiver must release the child if any of the following apply:**
(4) Seclusion	(A) Immediately when an emergency health situation occurs during the seclusion and 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, 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: (i) As soon as the child is no longer a danger to himself or others; (ii) Upon the arrival of a medical professional; or (iii) Upon assistance from law enforcement or the fire department.
(5) Mechanical restraint	(A) Immediately when an emergency health situation occurs during the restraint and 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.

Figure: 26 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 of any age, 30 minutes; (B) A prone or supine personal restraint transitional 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

  26 Tex. Admin. Code § 748.2501(3) and 26 Tex. Admin. Code § 749.2101(3)

- By a licensed psychiatrist when administering mechanical restraints

  26 Tex. Admin. Code § 748.2501(5)

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

  26 Tex. Admin. Code § 748.2501(2); 26 Tex. Admin. Code § 749.2101(2)(A); 26 Tex. Admin. Code § 748.2751(3); and 26 Tex. Admin. Code § 749.2231(a)

- When using restraints simultaneously

  26 Tex. Admin. Code § 748.2501(2); 26 Tex. Admin. Code § 749.2101(2)(A); 26 Tex. Admin. Code § 748.2753(a)(3) and (b); 26 Tex. Admin. Code § 749.2233(a) (Emergency medications with personal restraint); and 26 Tex. Admin. Code § 748.2755(a)(3) and (b) (Mechanical restraints with emergency medications)

- When maximum length of time allowed is exceeded

  26 Tex. Admin. Code § 748.2805; however under 26 Tex. Admin. Code § 749.2283, time extension prohibited.

- Also see: 26 Tex. Admin. Code § 748.2505; 26 Tex. Admin. Code § 749.2105 (Content of written orders); 26 Tex. Admin. Code § 748.2507; 26 Tex. Admin. Code § 749.2107 (PRN orders); and 26 Tex. Admin. Code § 748.2807 (verbal orders to exceed maximum time allowed)

Figure: 26 Tex. Admin. Code § 748.2501		
Type of Emergency Behavior Intervention	**Are written orders required to administer the intervention for a specific child?**	**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 26 Tex. Admin. Code §748.2507 of this title (relating to "Under what conditions are PRN orders permitted for a specific child?").	Not applicable.
(3) Emergency medication	YES.	A licensed physician.
(4) Seclusion	YES, except written orders are not required when [professionals] 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:

- Personally restrained four times in a seven-day period or more than 12 times in 30-day period or same child personally restrained more often than order allows.

  26 Tex. Admin. Code § 748.2901(a)(2) and 26 Tex. Admin. Code § 749.2331(a)(2)

- Emergency medications used three times in a thirty-day period

  26 Tex. Admin. Code § 748.2901(3) and 26 Tex. Admin. Code § 749.2331(3)

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

26 Tex. Admin. Code § 748.2901(a)(4) (Note that this is not applicable to foster care placements.)

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

  26 Tex. Admin. Code § 748.2901(a)(5) (Note that this is not applicable to foster care placements.)

Restraint/Seclusion that is NOT allowed:

- Mechanical restraint may not be simultaneously used with seclusion or pursuant to PRN order
- 26 Tex. Admin. Code § 748.2757 and 26 Tex. Admin. Code § 748.2507(5)
- No chemical restraints

  26 Tex. Admin. Code § 748.1119(1); 26 Tex. Admin. Code § 749.1021(1); 26 Tex. Admin. Code § 748.2451(b); 26 Tex. Admin. Code § 749.2051(b); 26 Tex. Admin. Code § 748.43(7); and 26 Tex. Admin. Code § 749.43(12) (Definition)

- Prone or supine restraints except for a transitional hold for 1 minute or less or as a last resort

  26 Tex. Admin. Code § 748.2605(b); 26 Tex. Admin. Code § 749.2205(b) and (c); 26 Tex. Admin. Code § 748.2461(b)(1); 26 Tex. Admin. Code § 749.2061(b)(1); 26 Tex. Admin. Code § 748.2553(2)(B); 26 Tex. Admin. Code § 749.2153(2)(B); 26 Tex. Admin. Code § 748.2801(2)(B); and 26 Tex. Admin. Code § 749.2281(2)(B)

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

Also see other relevant provisions:

- 26 Tex. Admin. Code § 748.1119 and 26 Tex. Admin. Code § 749.2051 (Techniques prohibited)
- 26 Tex. Admin. Code § 748.2303 and 26 Tex. Admin. Code § 749.1953 (May not use or threaten corporal punishment)
- 26 Tex. Admin. Code § 748.2307 and 26 Tex. Admin. Code § 749.1957 (Methods of punishment prohibited)
- 26 Tex. Admin. Code § 748.2605 and 26 Tex. Admin. Code § 749.2205 (Prohibited physical restraint techniques)
- 26 Tex. Admin. Code § 748.2705 (Types of mechanical & other restraint devices prohibited)

F. Trauma Work in Texas

1. Reports

Building a Trauma-Informed Child Welfare System: A Blueprint[155]

Trauma-Informed Care Final Report, The Meadows Mental Health Policy Institute for Texas[156]

2. Statewide Initiatives

- **The Statewide Collaborative on Trauma-Informed Care**

In July 2017, the Children's Commission launched the Statewide Collaborative on Trauma-Informed Care (SCTIC), which aims to elevate trauma-informed policy in the Texas child welfare system by creating a statewide strategy to support system reform, organizational leadership, cross-systems collaboration, and community-led efforts with data-informed initiatives to develop champions, consensus, and funding. The SCTIC began with a planning group with the Children's Commission, Meadows Mental Health Policy Institute (MMHPI), Texas CASA, and the Department of Family and Protective Services and created workgroups to carry out its mission. Since its inception, the SCTIC assisted in the release of resource documents and training events which can be found on www.TraumaInformedTexas.com.

- **Behavioral Health Division at DFPS**

In Fiscal Year 2019, DFPS formed the Behavioral Health Services Division within CPS. The division now includes a Behavioral Health Services Division Administrator, a Trauma-Informed Care Manager, six new regional Trauma-Informed Care Program Specialists, a Behavioral Health Services Program Specialist, three Substance Use Program Specialists, two CANS Program Specialists, and a Mental Health Program Specialist. The Medical Services Division covers medical and dental issues for CPS with Nurse Consultants and Well-Being Specialists. The Behavioral Health Services Division Administrator and the Trauma Informed Care Program Manager are based at the State Office in Austin. The Behavioral Health Services Program Specialist is located in Houston, one CANS Program Specialist operates in San Antonio and a second CANS Program Specialist is in Houston. The Trauma Informed Care Program Specialist positions are based in San Antonio, Dallas, Houston, Corpus, Midland, and Paris or surrounding areas. The division includes three Substance Use Program Specialists located in San Antonio, Dallas, and Houston. These positions complement a two additional Substance Use Program Specialists and two Mental Health Program Specialists who are based in Austin and report to Child Protective Investigations. These staff work together to provide support, resources, and technical assistance to direct delivery staff in their work with families experiencing substance use disorders through every stage of service.

- **Cross-Systems Trauma-Informed Care initiative**

The Texas Health and Human Services Commission (HHSC) Office of Mental Health Coordination leads a Cross Systems Trauma-informed Care (CSTIC) initiative. The vision of the CSTIC is a coordinated behavioral health system, as envisioned by the Behavioral Health Strategic Plan, which is healing-centered and trauma-informed in its foundation and unified in its implementation of a person-centered and family-focused approach across Texas. The CSTIC initiative involves working with state agencies across Texas to advance trauma-informed organizations, culture, and services. The collaboration includes representatives from state agencies who receive state funding for

behavioral health training or services. As part of the CSTIC initiative, HHSC leads an internal Trauma Transformation Team with representatives from different divisions and departments within the agency who facilitate trauma-informed change within HHSC.

- **Children's Advocacy Centers (CAC) 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.

- **Trauma-Informed Care Specialty Network**

Created by STAR Health, the Trauma-Informed Care Specialty Network 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.

3. **Examples of Community-Level Initiatives**

- Region 3 Foster Care Consortium

Established in 2015 to promote collaboration and information sharing among the many stakeholders committed to the well-being of children in the child welfare system. the Consortium facilitates productive partnerships and sponsors informative programming, drawing on the resources of integrated health care and other service providers, child advocates, policy groups, child placing agencies, education liaisons, foster parents, court personnel, single source continuum contractors, and DFPS leadership.

- The Travis County Collaborative for Children (TCCC)

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

- 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.

- The South Texas Trauma-Informed Care Consortium

The South Texas Trauma Informed Care Consortium is a collaboration between The Children's Shelter, Voices for Children, and City of San Antonio Metro Health Department that brings together community participants who are committed to addressing the impact of trauma.

G. National Resources

NCJFCJ, Ten Things Every Juvenile Court Judge Should Know about Trauma and Delinquency[157]

NCJFCJ, Assessing Trauma for Juvenile and Family Courts[158]

NCSC, Study of Virtual Child Welfare Hearings Facilitating Trauma-Responsive Virtual Hearings for Dependency Cases[159]

National Child Traumatic Stress Network (NCTSN), Bench Cards for the Trauma-Informed Judge[160]

NCTSN, LGBTQ Issues and Child Trauma[161]

Mental Health America (MHA) and the National Association of State Mental Health Program Directors (NASMHPD), Position Statement on Seclusion and Restraint[162]

H. Training Resources

Children's Commission's Judicial Trauma Institute[163]

Trauma Informed Texas www.TraumaInformedTexas.com[164]

DFPS Trauma-Informed Care Training[165]

NCTSN Learning Center[166]

Superior HealthPlan, the STAR Health Managed Care Organization (MCO), offers online webinars through their parent organization, Centene Foster Care[167]