# FACTS FOR POLICYMAKERS

## Complex Trauma and Mental Health of Children Placed in Foster Care

### Highlights from the National Center for Child Traumatic Stress (NCCTS) Core Data Set

## BACKGROUND

*National Child Traumatic Stress Network*

Authorized by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a federally-funded child mental health service initiative designed to raise the standard of care and increase access to services for traumatized children and their families across the United States.

The NCTSN is an interdisciplinary network comprised of community-, university-, and hospital-based practice and research centers. The NCTSN addresses a broad range of trauma types and serves all age groups ranging from early childhood to early adulthood (0 to 21 years). The centers provide trauma-informed, evidence-based mental health treatment and other services to children in diverse settings, including child mental health, child welfare, schools, primary care, and juvenile justice systems.

An integral part of the mission of the NCTSN is to collect, analyze, and disseminate clinical data relating to the needs and effective treatment of trauma-exposed youth and families.

## STUDY RESULTS

The study "Complex Trauma and Mental Health of Children Placed in Foster Care" (Greeson et al., 2012) examined trauma histories (including complex trauma[1] exposure) and trauma reactions (i.e., PTSD, behavioral and emotional problems) of 2,251 children and adolescents in foster care, referred for treatment to NCTSN centers throughout the United States between spring 2004 and fall 2010.

Children and adolescents in the child welfare system (CWS) typically have experienced at least one caregiver-related trauma (e.g., abuse or neglect). In fact, many children in the CWS have extensive histories of complex and chronic maltreatment (Table 1) associated with a range of severe reactions.

The study's findings are consistent with the growing literature on multiple victimization indicating that **individuals who experience multiple types of trauma are at greater risk for psychosocial maladjustment and mental health problems** (Finkelhor, Ormrod, & Turner, 2007; Kisiel et al., 2009).

The study found that:

- Over 70% of youth reported at least 2 of the traumas that constitute complex trauma[1]

- At least 83% of youth received at least one clinical diagnosis, such as depression and generalized anxiety disorder

- The mean number of types of traumatic exposure was 5 for the total sample and 6 for the complex trauma subsample

- Youth with complex trauma histories experienced significantly more trauma types overall than those without such histories

[1] The term *complex trauma* is used to describe the exposure to chronic interpersonal traumatic experiences at the hands of a caregiver. The authors use the term *complex trauma* to describe exposure to *at least two* of the following interpersonal traumas: physical abuse, sexual abuse, emotional abuse, neglect, and domestic violence (For more information see Kisiel et al., 2009).

- Youth with complex trauma histories were significantly more likely to be white, non-Hispanic, and currently residing in foster care

- Compared to youth with other types of trauma, youth with complex trauma histories had significantly higher rates of mental health and behavioral problems

**Table 1.** The frequency of trauma types for the total sample of children in foster care (2,251) as well as for the subsample of children with complex trauma histories (1,584).

| Variable | Total Sample (%) | Complex Trauma Subsample (%) |
|---|---|---|
| Neglect | 68.0 | 82.6 |
| Traumatic loss/bereavement/separation | 63.1 | 66.2 |
| Impaired caregiver | 59.8 | 74.4 |
| Domestic violence | 54.2 | 72.0 |
| Emotional abuse | 51.4 | 71.9 |
| Physical abuse | 48.4 | 64.0 |
| Sexual abuse | 32.0 | 41.9 |
| Sexual assault | 15.1 | 17.2 |
| Community violence | 14.3 | 16.7 |
| Physical assault | 12.0 | 14.6 |
| Other trauma | 11.8 | 12.8 |
| Illness/medical trauma | 8.3 | 9.7 |
| School violence | 8.0 | 8.8 |
| Serious injury/accident | 7.5 | 8.8 |
| Extreme interpersonal violence | 5.4 | 6.7 |
| Natural disaster | 3.0 | 3.2 |
| Forced displacement | 2.2 | 2.4 |
| Kidnapping | 1.8 | 2.3 |
| War/terror in United States | 0.3 | 0.4 |
| War/terror outside United States | 0.5 | 0.4 |

## RECOMMENDATIONS

1. **Children in the child welfare system should be systematically screened, assessed, and referred to appropriate trauma-informed services.[2]**

   A comprehensive assessment of traumatic experiences, posttraumatic stress symptoms, emotional/behavioral problems, and functional difficulties is essential for making appropriate service recommendations within child welfare (Kisiel et al., 2009). Unfortunately, many child welfare systems do not routinely screen for trauma exposure and associated symptoms beyond an initial assessment of the precipitating event.

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[2] A trauma-informed child and family-serving system is one in which all parties involved recognize and respond to the  impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers.  Programs and agencies within such a system infuse and sustain this 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 facilitate and support the recovery and resiliency of the child and family.  A service system with a trauma-informed perspective is one in which programs, agencies and service providers would: (1) routinely screen for trauma exposure and related symptoms; (2) use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) make resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and collaboration across child-serving systems; and (7) maintain an environment of care for staff that addresses, minimizes and treats secondary traumatic stress and increases staff resilience. (www.nctsn.org)

2. **Partnerships across disciplines such as mental health, child welfare, and other child-serving professions should be established and strengthened.**

   Mental health therapists and child welfare workers often share similar goals for children (e.g., reduced number of placements, better academic and health outcomes, and improved emotional and social functioning), but they often confront barriers that prevent nurturing of long term and positive professional relationships. These cross-discipline partnerships should be supported so as to ensure that children have their needs met following a traumatic experience.

   NCTSN has been successful in establishing and enhancing positive working relationships across mental health, child welfare, and family partners through the Breakthrough Series Collaborative (BSC) training and systems change approach. One such BSC, *Using Trauma-Informed Child Welfare Practice to Improve Foster Care Placement Stability* (TICWP), focuses on making child welfare more trauma-informed with a primary goal of stabilizing placements of children in foster care. Mental health and child welfare professionals—along with family members—collaborate toward this shared goal. The BSC is a useful model for mental health and child welfare groups to promote ongoing communication, share relevant information and resources, and develop policies and procedures. Such collaboration can streamline the process of identifying trauma, assess the impact of trauma, link children to effective treatments, and improve systems for the benefit of children.

3. **Identify subgroups of children and adolescents in child welfare who face uniquely challenging issues (e.g., multiple trauma exposures), in order to better target resources.**

   By developing "risk profiles," of such groups (e.g., young children who may be at increased risk for chronic trauma exposures and multiple placements, older youth who may be at risk for crossover placements in juvenile justice systems, and youth who have experienced multiple interpersonal traumas exhibiting emotional and behavioral problems), more informed decisions can be made with regard to cost-effective allocation of scarce resources and promotion of specific positive outcomes.

## IMPLICATIONS FOR FUTURE RESEARCH

1. **Findings from this study suggest the value of understanding "profiles of risk" for behavioral problems and symptoms related to prevention and early intervention efforts.** Factors—such as being older, being female, being eligible for public insurance, and residing in foster care as a primary residence—increased the likelihood that a youth would experience specific problems which, left unaddressed, could have long-term implications for health. Future studies should examine patterns of complex trauma in children in foster care and assess the distinct risks for mental health and behavioral problems.

2. **An emerging issue for the child trauma field is how best to define different types of trauma exposure histories (e.g., exposure to sequential and repeated traumas, or to multiple types of traumatic events, or to specific constellations of types of traumas).** Currently, the child trauma field utilizes multiple terminologies for the same phenomena, including "complex trauma," "poly-victimization," and "cumulative risk/adversity." It will be important to clarify the conceptual similarities and differences inherent in these and other terms, thereby establishing a common language and providing greater clarity for researchers, clinicians, and policymakers.

3. **Race and ethnicity were found to have significant associations with complex trauma.** Future research should explore the relationship between complex trauma and race/ethnicity, including among urban minority children and adolescents who are at greater risk for placement in foster care, and residential treatment facilities.

## REFERENCES

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