



April 2019

CHILDREN AFFECTED BY TRAUMA

Selected States
Report Various
Approaches and
Challenges to
Supporting Children

GAO Highlights

Highlights of [GAO-19-388](#), a report to congressional requesters

Why GAO Did This Study

Trauma is a widespread, harmful, and costly public health problem, and its effects are especially detrimental to children. Any frightening, dangerous, or violent event that threatens a child or their loved ones can potentially be traumatic. While not every child who experiences trauma will suffer lasting effects, trauma significantly increases the risk of mental health problems, difficulties with social relationships and behavior, physical illness, and poor school performance. GAO was asked to review selected states' efforts to support children affected by trauma.

This report describes (1) the assistance that HHS and Education provide to help state and local agencies support children affected by trauma; (2) how child welfare and education agencies in selected states support these children; and (3) the challenges these agencies have faced in selected states in supporting these children.

GAO interviewed state and local officials in six states that were selected based on recommendations from subject-matter experts and federal officials, among other factors; administered a questionnaire to 16 state agencies in the selected states; interviewed federal officials from HHS and Education; and reviewed relevant federal, state, and local agency documents, such as reports and guidance. Although our findings cannot be generalized to all states, they provide insight into government support for children affected by trauma.

GAO is not making recommendations in this report.

View [GAO-19-388](#). For more information, contact Kathryn A. Larin at (202) 512-7215 or larink@gao.gov.

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What GAO Found

The Department of Health and Human Services (HHS) and the Department of Education (Education) provide grants, disseminate information, and fund training and technical assistance to help state and local agencies support children affected by trauma. HHS's Administration for Children and Families and Substance Abuse and Mental Health Services Administration (SAMHSA) have awarded discretionary grants specifically to address childhood trauma. In addition, state and local officials reported making use of other discretionary grants from HHS and Education—as well as formula funds meant for broad purposes like mental health, substance abuse, child welfare, and education—to support their work with children affected by trauma. In terms of non-financial support, state and local officials in six selected states all referred to the National Child Traumatic Stress Network, which is funded by SAMHSA, as an important resource for information, training, and technical assistance. Both HHS and Education have also made other guidance and informational resources available to states.

Officials in child welfare and education agencies in the six selected states reported using a range of approaches to help children affected by trauma, including training staff, screening children, and providing services and support systems. To train child welfare workers, educators, and birth and foster parents to understand trauma and its effects on children, agencies in the six selected states used various approaches, such as learning communities, which include in-person learning and coaching, and online courses. Several state child welfare agencies also used learning communities to train clinicians in trauma-focused therapies. In addition, child welfare and education agencies in five states used screening tools to identify children exposed to and exhibiting symptoms of trauma. Children identified as experiencing trauma are referred for a trauma-informed mental health assessment. Also, to help children affected by trauma, child welfare and education agencies in five of the six states provide support and services. For example, in one state, caseworkers provide specialized services, including weekly visits, to children and families.

Officials in the six selected states reported facing various challenges in their efforts to support children affected by trauma, and they emphasized the importance of engaged leadership in establishing and sustaining support for these children. In three states, officials said that a lack of such leadership hindered their efforts, and they described cases that included delayed, incomplete, or unsuccessful implementation of initiatives. Officials in all six states also talked about limitations on their agency's capacity to support children affected by trauma, including:

- high rates of staff turnover, especially in child welfare;
- limited staff time to dedicate to trauma initiatives;
- lack of clinicians trained in trauma-focused therapies; and
- insufficient funding to support trauma initiatives.

Officials in some states reported strategies they have used to help address these challenges, including providing additional support to employees and coordinating with partner agencies to jointly leverage resources, expertise, and data.

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Abbreviations

ACF	Administration for Children and Families
CMS	Centers for Medicare and Medicaid Services
Education	U.S. Department of Education
HHS	U.S. Department of Health and Human Services
MCO	managed care organization
NCTSI	National Child Traumatic Stress Initiative
NCTSN	National Child Traumatic Stress Network
Project AWARE	Project Advancing Wellness and Resilience Education
SAMHSA	Substance Abuse and Mental Health Services Administration
STS	secondary traumatic stress
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy

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April 24, 2019

The Honorable Danny K. Davis
Chairman
Subcommittee on Worker and Family Support
Committee on Ways and Means
House of Representatives

The Honorable Richard J. Durbin
United States Senate

Trauma is a widespread, harmful, and costly public health problem, and its effects are particularly detrimental to children, according to the U.S. Department of Health and Human Services (HHS). Children can be exposed to various types of trauma. Any frightening, dangerous, or violent event that threatens the life or safety of a child or their loved ones can potentially be traumatic. For example, in fiscal year 2017, HHS reported that there were approximately 674,000 victims of child maltreatment, including neglect and physical and sexual abuse.¹ In addition, in 2016, students ages 12 through 18 experienced an estimated 749,400 victimizations (theft and nonfatal violent victimization) at school and 601,300 victimizations away from school.² While not every child who experiences trauma will suffer lasting effects, studies have shown that for many there are serious short- and long-term consequences. As GAO has previously reported, trauma significantly increases the risk of mental health problems, difficulties with social relationships and behavior, physical illness, and poor school performance.³

¹U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *Child Maltreatment 2017* (Washington, D.C.: Jan. 28, 2019).

²For the estimate of victimizations at school, the 95 percent confidence intervals range from 585,000 to 913,000; and for the estimate of victimizations away from school, the 95 percent confidence intervals range from 460,000 to 743,000 for students ages 12-18. See L. Musu-Gillette, A. Zhang, K. Wang, J. Zhang, J. Kemp., M. Diliberti, and B.A. Oudekerk, *Indicators of School Crime and Safety: 2017*, NCES 2018-036 / NCJ 251413 (Washington, D.C.: U.S. Department of Education, National Center for Education Statistics & U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, March 2018).

³GAO, *Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care*, [GAO-13-15](#) (Washington, D.C.: Dec. 10, 2012).

You asked us to review how selected states identify and treat children and families who have experienced or are at risk of experiencing trauma. This report examines:

1. the assistance HHS and the U.S. Department of Education (Education) provide to help state and local agencies support children affected by trauma;
2. how child welfare and education agencies in selected states are supporting children affected by trauma; and
3. the challenges child welfare and education agencies in selected states have faced in supporting children affected by trauma.

To address these objectives, we conducted in-person and telephone interviews with state and local officials in six states, and administered a questionnaire to 16 state agencies. The states we selected were Colorado, Massachusetts, North Carolina, Ohio, Washington, and Wisconsin. These states were selected based on four criteria: (1) recommendations from subject-matter experts and federal agency officials; (2) reviews of state child welfare and education agency websites to locate statewide initiatives to support children affected by trauma; (3) variation in state child welfare system administrative frameworks (two state-administered, three county-administered, and one hybrid partially administered by the state and partially administered by counties); and (4) geographic diversity.⁴ We spoke with state child welfare officials in all six states and with state education and Medicaid⁵

⁴For purposes of this report, the term “education agency” includes state educational agencies and local educational agencies (specifically, school districts).

⁵Medicaid is a joint federal-state program that finances health coverage for low-income and medically needy individuals. See 42 U.S.C. § 1396 et seq. Certain children in foster care are categorically eligible for Medicaid, such as those receiving foster care maintenance payments under title IV-E of the Social Security Act. States are required to provide Medicaid coverage to such children. Children in foster care who are not eligible under this category may qualify for Medicaid under optional eligibility criteria established by a particular state. According to the Congressional Research Service, nearly all children who are in foster care are eligible for health care services funded via Medicaid. In addition, some children in foster care may be eligible for the State Children’s Health Insurance Program, a federal-state program that provides health care coverage to children living in families whose incomes exceed the eligibility requirements for Medicaid. We spoke with Medicaid officials in Colorado, Massachusetts, North Carolina, and Ohio to obtain their perspective because child welfare officials in those states reported challenges in using Medicaid to support children affected by trauma. We did not conduct interviews with state Medicaid agencies in Washington or Wisconsin because child welfare officials in those states did not report facing challenges using Medicaid.

officials in four states.⁶ Also, in each state we selected two localities and interviewed local officials from the respective child welfare and education agencies, where practicable. These localities were selected based on recommendations from state officials and geographic diversity (one urban and one rural). In addition, we interviewed officials from other selected state and local agencies and organizations, such as departments of health, interagency trauma groups, universities, and hospitals, as appropriate. We also reviewed relevant state and local child welfare and education agency documents, such as annual reports and policy guidance.

We supplemented and confirmed the information obtained during interviews with state officials through a questionnaire sent to 16 state agencies⁷ across the six states from August to October 2018.⁸ We pre-tested the questionnaire with three state agencies in Washington and updated the questions based on feedback from those agencies. All 16 agencies completed the questionnaire.

To obtain additional information about the assistance federal agencies provide to help child welfare and education agencies in selected states in their efforts to support children affected by trauma, we interviewed officials from HHS's Administration for Children and Families (ACF), Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS). We also interviewed officials from Education, including officials with the Office of Elementary and Secondary Education. We reviewed relevant agency documents, such as guidance provided to states, issue briefs, and budget documents. Our findings cannot be generalized to states or localities outside our selection sample.

We conducted this performance audit from January 2018 to April 2019 in accordance with generally accepted government auditing standards.

⁶State education officials in North Carolina and Ohio told us that they did not have statewide initiatives to support children affected by trauma, so we did not interview them.

⁷In one of the selected states, two state agencies collaborate on a statewide initiative. We sent the questionnaire to officials in both agencies, but one official was primarily responsible for completing it.

⁸The 16 agencies represent all state-level government agency officials we interviewed, except for state Medicaid agencies. Our interviews with state Medicaid officials were narrowly focused on challenges raised by child welfare officials, so we did not ask state Medicaid officials to complete the questionnaire.

Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Childhood Trauma

Trauma or adverse childhood experiences⁹ may include physical and sexual abuse, neglect, bullying, community-based violence, extreme poverty, the loss of a parent or primary caretaker, or natural disasters, among other things. These experiences may overwhelm a child's natural ability to cope¹⁰ and can cause stress reactions in children, including feelings of intense fear, terror, and helplessness.¹¹ When children are exposed to chronic stressful events, their neurodevelopment can be disrupted. As a result, a child's cognitive functioning or ability to cope with negative or disruptive emotions may be impaired, causing long-term harm to their physical, social, and emotional well-being.¹² These adverse effects may include changes in a child's emotional responses; ability to think, learn, and concentrate; impulse control; self-image; attachments to caregivers; and relationships with others. Traumatic experiences have been linked to a wide range of health-related conditions, including addiction, depression and anxiety, and risk-taking behavior, and may also

⁹Adverse childhood experiences are stressful or traumatic events, including abuse and neglect. In a landmark study, researchers from the Centers for Disease Control and Prevention and Kaiser Permanente found a "strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults." V. Felitti, MD, FACP; R. Anda, MD, MS; D. Nordenberg, MD; D. Williamson, MS, PhD; A. Spitz, MS, MPH; V. Edwards, BA, M. Koss, PhD; and J. Marks, MD, MPH, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventive Medicine*, Volume 14, Number 4, (1998), p. 245.

¹⁰U.S. Department of Health and Human Services, Children's Bureau, Child Welfare Information Gateway, *Developing a trauma-informed child welfare system* (Washington, D.C.: 2015).

¹¹Vanessa Sacks and David Murphey, Child Trends, *The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity* (Feb. 12, 2018), accessed March 13, 2018.

¹²Child Welfare Information Gateway, *Developing a trauma-informed child welfare system*.

increase the likelihood of chronic ill health conditions, such as obesity, diabetes, heart disease, cancer, and even early death. Not all children will experience all of these effects. Children's responses to traumatic events are unique and affected by many factors, including their age at the time of the event, the frequency and perceived severity of trauma, and the child's innate sensitivity, as well as protective factors such as the presence of positive relationships with healthy caregivers, physical health, and natural coping skills.¹³

While all children can be affected by trauma, trauma is common among children who enter the child welfare system.¹⁴ Many of these children have been abused or neglected, and involvement in the child welfare system, primarily through placements into a foster care home, may cause additional trauma due to the separation from family; changes in school placement, neighborhood, and community; as well as fear and uncertainty about the future. Child welfare experts generally believe that child welfare systems that use trauma-informed approaches¹⁵ are better able to

¹³Child Welfare Information Gateway, *Developing a trauma-informed child welfare system*.

¹⁴Other subpopulations may also be likely to experience trauma, such as homeless children, children who live in unsafe neighborhoods, and unaccompanied alien children—those under 18 years old with no lawful immigration status and no parent or legal guardian in the United States available to provide care and physical custody. During the 2015-16 school year, there were 1.3 million homeless students enrolled in the nation's public school districts. Also, in 2017, GAO reported that the safety of a child's environment, including their neighborhood, can affect a wide range of health, functioning, and quality-of-life outcomes and risks, including a child's sense of security and well-being. See National Center for Homeless Education, *Federal Data Summary: School Years 2013-14 to 2015-16, Education for Homeless Children and Youth* (Browns Summit, NC: Dec. 2017); GAO, *Child Well-Being: Key Considerations for Policymakers, Including the Need for a Federal Cross-Agency Policy Goal*, [GAO-18-41SP](#) (Washington, D.C.: Nov. 9, 2017); and Statement of Jack P. Shonkoff, M.D., Director, Center on the Developing Child at Harvard University, before the Energy and Commerce Committee, Subcommittee on Oversight and Investigations, United States House of Representatives, February 7, 2019.

¹⁵According to SAMHSA, a program, organization, or system that is trauma-informed: (1) realizes the widespread impact of trauma and understands potential paths for recovery; (2) recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; (3) responds by fully integrating knowledge about trauma into policies, procedures, and practices; and (4) seeks to actively resist re-traumatization.

address children’s safety, permanency, and well-being needs.¹⁶ Although trauma-informed frameworks may vary, they generally include interventions as well as a change in culture; thus if an agency or organization is taking a trauma-informed approach, it is incorporating knowledge of trauma and its effects into its policies, procedures, and practices. A trauma-informed child welfare system may offer services to help identify and mitigate the effects of trauma, including screening and assessing children for trauma, and providing or referring children to services. These approaches may produce improved outcomes for children in the child welfare system, including fewer children requiring crisis services, such as residential treatment, and fewer foster home placements, placement disruptions, and reentries into foster care. Other trauma-informed approaches may result in reduced lengths of stay in foster care and improved child functioning and increased well-being.¹⁷

In addition to child welfare agencies, school staff and members of the school community can play a key part in recognizing and responding to children who have experienced trauma. In a 2017 report on child well-being, GAO reported that an expert noted that health and human service agencies are not the only entities needed to address child well-being and suggested that community stakeholders work together to determine what resources are needed for the children in their community.¹⁸ A trauma-informed school, characterized by an understanding and a commitment of teachers and staff to an awareness of how trauma affects students, is an example of a coordinated approach to trauma. Trauma-informed teachers and staff are aware of trauma’s impact on students’ behavior, their relationships, their ability or inability to self-regulate behavior, and how it

¹⁶Federal funding is available to states to support their child welfare and foster care programs under Titles IV-B and IV-E of the Social Security Act. In 2018, the Act was amended to enable states to use federal funds provided under Title IV-B and Title IV-E to provide enhanced support to children and families and prevent foster care placements through the provision of mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services. The law requires that any such services provided under Title IV-E be trauma-informed. Bipartisan Budget Act of 2018, Pub. L. No. 115-123, §§ 50701-50734, 132 Stat. 64, 232-253. ACF published program instructions about the Title IV-E prevention and family services programs in November 2018. Department of Health and Human Services, Administration on Children, Youth and Families, Administration for Children and Families, Children’s Bureau, *Program Instruction: State Requirements for Electing Title IV-E Prevention and Family Services Programs*, ACYF-CB-PI-18-09 (Washington, D.C: Nov. 30, 2018).

¹⁷Child Welfare Information Gateway. *Developing a trauma-informed child welfare system*.

¹⁸[GAO-18-41SP](#).

contributes to their classroom behavior. Specific elements of a trauma-informed school may include addressing and treating traumatic stress, developing partnerships with students and families, evaluating and revising school discipline policies and practices, and creating a trauma-informed learning environment.¹⁹

Trauma Treatments and Approaches

Federal agencies, academic institutions, and community-based treatment centers have generated evidence-based trauma treatments that clinicians and therapists can use when working with children and their families.²⁰ See table 1 for examples of treatments.

Table 1: Selected Evidence-Based Treatments

Attachment, Self-Regulation, and Competency	Includes multiple modalities, such as individual, group and family treatment; parent workshops; and a home-based prevention program. The approach addresses how a child's entire system of care can become trauma-informed to better support trauma-focused therapy.
Child-Parent Psychotherapy	Focuses on the way the trauma has affected the parent-child relationship, and the family's connection to their culture and cultural beliefs, spirituality, immigration experiences, and parenting practices, among other things.
Early Pathways	Focuses on helping caregivers better understand and manage their child's behavior and emotional problems; strengthening the child's prosocial behaviors and setting limits on challenging behaviors; and learning trauma-informed strategies to include safety, calming techniques, and recovery, among other things.
Parent-Child Interaction Therapy	Treats young children exposed to interpersonal violence. It offers concrete, practical parenting skills. The emphasis is on changing negative parent/caregiver child patterns.
Structured Psychotherapy for Adolescents Responding to Chronic Stress	Designed as a group treatment to improve the emotional, social, academic, and behavioral functioning of adolescents exposed to chronic interpersonal trauma (such as ongoing physical abuse) and/or separate types of trauma (e.g. community violence, sexual assault).
Trauma Focused-Cognitive Behavioral Therapy	Focuses on development of skills for regulating behavior; improving relationships; and enhancing safety, trust, parenting skills, and family communication

Source: GAO summaries from National Child Traumatic Stress Network fact sheets. | GAO-19-388

¹⁹Individuals with experiences of trauma are found in multiple service sectors. In addition to child welfare and education agencies, trauma-informed approaches can be adapted to other sectors, such as criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual's capacity to cope with traumatic experiences. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, 14-4884 (Rockville, MD: 2014).

²⁰Evidence-based programs generally indicate those interventions and activities that evaluations have shown to be effective at addressing a particular outcome.

Recent studies have also found that trauma-informed approaches that are infused into the practices and work of child welfare and school staff can help children, their families, and others. While these studies are limited in terms of the number of participants, they indicate the positive effects of including trauma-informed approaches into the work of child welfare staff and educators. For example, one study that used child welfare administrative data for about 1,500 children from Kansas found that implementing a trauma-informed approach was associated with improved child well-being and placement stability for children in foster care.²¹ Another study of two public child welfare agencies that involved 52 children, as well as child welfare staff, mental health providers, and foster parents and kinship caregivers, suggests, among other things, that fewer children exited foster homes for negative reasons, such as running away or moving to a group home, when families were trained in a trauma-informed approach.²² In addition, a study of 126 female youths residing in two treatment centers in Massachusetts suggests that the youth at the center receiving the trauma-informed approach experienced a reduction in post-traumatic stress disorder symptoms compared with the youth in the residential center that did not offer this approach.²³ A study of five schools that adopted a trauma-sensitive approach also reported positive outcomes. For example, the study found a decrease in disciplinary actions, and staff at one school reported that the school felt safer and calmer. School staff also reported improved relations among colleagues

²¹Researchers studied the effectiveness of a research-informed therapeutic model, Trauma Systems Therapy, implemented across a child welfare system. K. Murphy, K. Anderson Moore, Z. Redd, K. Malm, "Trauma-informed child welfare systems and children's well-being: A longitudinal evaluation of KVC's bridging the way home initiative," *Children and Youth Services Review*, 75 (2017): 23–34.

²²This study examined how a trauma-informed care approach (Trauma Systems Therapy-Foster Care, an adapted version of Trauma Systems Therapy for foster care) was implemented in two child welfare agencies. Jessica Dym Bartlett, Berenice Rushovich, Martha Beltz, Esther Gross, and Ann Schindler, Child Trends, *Evaluation of the Implementation of Trauma Systems Therapy-Foster Care in a Public Child Welfare Setting* (Nov. 17, 2017), accessed March 28, 2018.

²³The residential treatment centers used the evidenced-based, trauma-informed treatment Attachment, Regulation and Competency, an intervention for children with complex trauma. H. B. Hodgdon, K. Kinniburgh, D. Gabowitz, M. E. Blaustein, and J. Spinazzola, "Development and Implementation of Trauma-Informed Programming in Youth Residential Treatment Centers Using the ARC Framework," *Journal of Family Violence*, vol. 28 (2013): 679–692.

and with students, as well as better relations between students and increased parent engagement.²⁴

**HHS and Education
Provide Grants,
Disseminate
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**HHS and Education
Provide Multiple Sources
of Funding That State and
Local Agencies Can Use
to Support Children
Affected by Trauma**

HHS's ACF and SAMHSA have awarded discretionary grants to states specifically to address childhood trauma. From 2011 to 2013, ACF awarded 20 state and local agencies and other organizations discretionary grants to address childhood trauma, according to ACF officials, totaling about \$58 million.²⁵ Each grantee, including two state child welfare agencies and a county agency as well as two universities in five of the six states we selected to review, received up to 5 years of

²⁴"The Trauma and Learning Policy Initiative, a joint program of Massachusetts Advocates for Children and Harvard Law School, developed an inquiry-based process for creating trauma-sensitive schools, which was implemented by educators in four elementary and one middle-high school over the course of two school years." Wehmah Jones, Juliette Berg, and David Osher, *Trauma and Learning Policy Initiative (TLPI): Trauma-Sensitive Schools Descriptive Study* (Washington, D.C.: American Institutes for Research, October 2018).

²⁵These funding opportunities were referred to as: Integrating Trauma-Informed and Trauma-Focused Practice in Child Protective Service Delivery; Initiative to Improve Access to Needs-Driven, Evidence-Based/Evidence-Informed Mental and Behavioral Health Services in Child Welfare; and, Promoting Well-Being and Adoption after Trauma. All three grants were administered under the authority of the Adoption Opportunities Program, see 42 U.S.C. § 5113. As part of its administration of these grants, ACF provided technical assistance to states and convened annual conferences so grantees could share information with each other. Several grantees collaborated to publish articles about their efforts to support children affected by trauma.

funding. The grants were used to screen and refer children to treatment, implement or expand trauma-focused, evidence-based treatments, and bridge the gap between child welfare and mental health. According to HHS officials, funding for the last of these grants will end in September 2019.

SAMHSA also awards discretionary grants specifically to address childhood trauma to state and local agencies, universities, and other organizations through an initiative to transform mental health care for children and adolescents affected by trauma. The National Child Traumatic Stress Network (NCTSN), a collaborative network of experts created through the National Child Traumatic Stress Initiative (NCTSI),²⁶ conducts research on trauma treatment approaches and provides services to children affected by trauma. In fiscal year 2017, SAMHSA received over \$48 million for the NCTSN, and it awarded four new grants and supported 82 5-year grant continuations through NCTSI. Officials that we spoke with from one state child welfare agency, three universities, and two nonprofits in four of the selected states received grants through this initiative. Several of these entities used these funds to train clinicians and educate other child serving professionals about trauma and mental health conditions.

In addition to grants that were specifically meant to address childhood trauma, the selected states used other HHS discretionary grants to support children affected by trauma. For example, officials from five state education agencies in the selected states told us that they received SAMHSA's Project Advancing Wellness and Resilience Education (Project AWARE) grant.²⁷ Wisconsin officials also said they received

²⁶NCTSI is authorized under the Children's Health Act of 2000, see 42 U.S.C. § 290hh-1. Established in 2000, the National Child Traumatic Stress Initiative (NCTSI) seeks to improve the quality of community-based trauma treatment and services and increase access to effective trauma-focused interventions.

²⁷Through Project AWARE, education agencies may receive funds to increase awareness of mental health conditions among school-age youth, prepare educators and other adults to detect and respond to such conditions, and connect youth with appropriate services. These Project AWARE grants are authorized under the Public Health Service Act, as amended, see 42 U.S.C. § 290bb-32.

Education's School Climate Transformation Grant,²⁸ which was used to create the state's trauma-sensitive schools initiative. Washington officials credited SAMHSA's Mental Health Transformation Grant²⁹ with driving the state's initial trauma-informed work, including its guide about trauma in schools.³⁰

State agency officials also reported using formula funds, meant for broad purposes like mental health, substance abuse, child welfare, and education, to support their work with children affected by trauma. Officials from five agencies in the selected states reported using formula funding from Title IV-E of the Social Security Act to help children affected by trauma.³¹ According to Colorado officials, the state's Title IV-E waiver has allowed child welfare workers to screen, assess, and provide interventions that are trauma-informed.³² Also, North Carolina officials told us that Title IV-E, combined with other funding sources, has helped pay for trauma-informed learning communities to help counties build trauma-informed programming. Two states reported using the Substance Abuse

²⁸Education administers the School Climate Transformation Grant program, which provides competitive grants to state and local educational agencies to develop, enhance, or expand systems of support for schools implementing an evidence-based, multi-tiered behavioral framework for improving behavioral outcomes and learning conditions for all students. These grants are authorized under Title IV-F of the Elementary and Secondary Education Act of 1965, as amended, see 20 U.S.C. § 7281.

²⁹The Mental Health Transformation Grant program was intended to support changes in the organization, management, and delivery of public mental health services. Grants were administered by SAMHSA and authorized under the Public Health Service Act, see 42 U.S.C. 290bb-32. The final 5-year grants were awarded in fiscal year 2010, according to HHS officials.

³⁰Ray Wolpow, Mona M. Johnson, Ron Hertel, and Susan O. Kincaid, *The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success (WA: Washington State Office of Superintendent of Public Instruction, September 2009)*, accessed July 23, 2018.

³¹Title IV-E authorizes the large majority of federal funding dedicated to child welfare, with funds chiefly available for specific foster care and adoption expenses. Title IV-E is codified at 42 U.S.C. §§ 670-679c.

³²HHS was authorized to waive certain Title IV-E requirements to enable states to carry out approved demonstration projects. HHS was authorized to approve new demonstration projects through FY 2014. Demonstration projects are generally limited to five years and may not continue after September 30, 2019. See 42 U.S.C. § 1320a-9.

and Mental Health Block Grants.³³ (See table 2 for additional grants states reported using to support children affected by trauma.)

Table 2: Selected Federal Funding Sources Used to Support Children Affected by Trauma as Cited by Selected State Officials

Federal funding sources	CO	MA	NC	OH	WA	WI
Department of Health and Human Services						
<i>Discretionary grants</i>						
Administration for Children and Families trauma grants ^a	-	✓	✓	-	✓	-
Mental Health Transformation Grants	-	-	-	✓	✓	-
National Child Traumatic Stress Initiative Grants	-	-	✓	-	-	✓
Project Advancing Wellness and Resilience Education (Project AWARE) Grants	✓	-	✓	✓	✓	✓
Safe Schools, Healthy Students Initiative Grants ^b	-	-	-	-	-	✓
System of Care Expansion Planning Grants ^c	✓	-	-	✓	-	-
<i>Formula funds</i>						
Medicaid ^d	✓	✓	✓	✓	✓	✓
State Opioid Response Grants ^e	-	-	-	✓	-	-
State Targeted Response to the Opioid Crisis Grants ^f	-	-	-	✓	-	-
Social Services Block Grants ^g	-	-	✓	-	✓	-
Substance Abuse and Mental Health Block Grants	-	-	-	✓	-	✓
Temporary Assistance for Needy Families ^h	-	-	✓	-	✓	-
Title IV-B of the Social Security Act ⁱ	-	-	✓	✓	✓	✓
Title IV-E of the Social Security Act	✓	-	✓	✓	✓	✓
Department of Education						
<i>Discretionary grants</i>						
State Personnel Development Grants ^j	✓	-	-	-	-	-
School Climate Transformation Grants	-	-	-	-	-	✓
<i>Formula funds</i>						
Title I-A of the Elementary and Secondary Education Act ^k	-	-	-	-	✓	-

³³The Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant (Substance Abuse and Mental Health Block Grants) provide funds and technical assistance for substance abuse and mental health services. These grants are administered by SAMHSA and authorized under the Public Health Service Act. See 42 U.S.C. § 300x *et seq.*

Federal funding sources

	CO	MA	NC	OH	WA	WI
Title IV-A of the Elementary and Secondary Education Act ^l	-	-	-	-	✓	-

Legend: ✓ = Officials at one or more state agencies reported using funding source to support children affected by trauma.

Source: GAO analysis of questionnaire responses received August-November 2018. | GAO-19-388

Note: With two exceptions, officials are points of contact at the 16 state child welfare, education, and other agencies—such as departments of health—which completed our questionnaire across the six states. For Massachusetts and Wisconsin, statements about Medicaid from our interviews with state child welfare officials were used to supplement questionnaire responses. Additionally, North Carolina and Ohio education agencies were not asked to complete the questionnaire because officials in these states told us that they did not have statewide initiatives to support children affected by trauma, but a state education official in each state told us that they have received Project Advancing Wellness and Resilience Education grants.

^aThe ACF’s Children’s Bureau awarded trauma-focused discretionary grants across three cohorts from 2011 to 2013.

^bLaunched in 1999 as a joint program of the Departments of Education, Health and Human Services, and Justice, the Safe Students, Healthy Schools Initiative has awarded grants to school districts to prevent youth violence and promote healthy development of youth.

^cSystem of Care Expansion Planning Grants are administered by SAMHSA and intended to facilitate adoption of a system of care approach for children and youth with serious emotional disturbances. SAMHSA has not awarded these grants since 2014, according to officials.

^dAlthough the Massachusetts and Wisconsin officials who completed our questionnaire did not mention Medicaid as a source of funding to support children affected by trauma, under the Medicaid program, states are required to provide eligible children under age 21 with coverage for certain health services, which may include mental health services, through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Additionally, state child welfare officials we interviewed in both of these states talked about using Medicaid to support children affected by trauma. For example, the Wisconsin Department of Health Services and the Department of Children and Families partnered to implement Care4Kids, a program designed to offer comprehensive and coordinated health services for children in foster care. The Care4Kids program creates a “medical home” team for children in foster care, assuring that children receive individualized treatment plans in order to address their specific health care needs, including trauma-related care.

^eState Opioid Response Grants are administered by SAMHSA and aim to address the opioid crisis by increasing provision of prevention, treatment, and recovery activities for opioid use disorder.

^fState Targeted Response to the Opioid Crisis Grants are administered by SAMHSA and aim to address the opioid crisis by increasing provision of prevention, treatment, and recovery activities for opioid use disorder.

^gSocial Services Block Grant goals include, among others, preventing or remedying child abuse and neglect, preventing or reducing inappropriate institutional care, and achieving or maintaining self-sufficiency.

^hTemporary Assistance for Needy Families is a block grant that supports four overarching goals, including providing assistance to needy families so that children can live in their homes or the homes of relatives.

ⁱTitle IV-B of the Social Security Act authorizes federal funds to support state child welfare programs and services. In addition to formula grants under the Stephanie Tubbs Jones Child Welfare Services program and the Promoting Safe and Stable Families program, Title IV-B also authorizes some discretionary grants.

^jThe Individuals with Disabilities Education Act authorizes federal funds for the State Personnel Development Grants program. The program provides grants to help state educational agencies reform and improve their training and professional development systems for individuals who serve children with disabilities.

^kTitle I-A of the Elementary and Secondary Education Act of 1965, as amended, provides formula grants to states for their school districts to improve educational programs in schools with high concentrations of students from low-income families.

^lTitle IV-A of the Elementary and Secondary Education Act of 1965, as amended by the Every Student Succeeds Act, authorizes the Student Support and Academic Enrichment program, which is intended to increase the capacity of state and local education agencies, schools, and local communities to provide all students with a well-rounded education and to improve school conditions and the use of technology.

In addition to federal funding, officials in the six selected states reported receiving state funding to support children affected by trauma. For example, officials in North Carolina told us that, in 2013, the North Carolina General Assembly appropriated \$1.8 million in annually recurring funds to train clinicians in evidence-based trauma treatments. Also, in Massachusetts, state funding may be used to create and support trauma-sensitive initiatives in schools, among other things. In addition to state funding, officials in three of the selected states reported using nonprofit funding to support their efforts.

HHS and Education Share Information and Fund Training and Technical Assistance to Help State and Local Agencies Support Children Affected by Trauma

HHS offers information and funds training and technical assistance to help state and local agencies support children affected by trauma.³⁴ For example, state and local child welfare officials in each of the six selected states cited the National Child Traumatic Stress Network (NCTSN) as an important resource for information, training, or technical assistance.³⁵ State and local officials in four of the selected states told us that they use the NCTSN's Child Welfare Trauma Training Toolkit curriculum to train their staff. The curriculum, designed to be completed in about 13 hours, covers topics such as the essential elements of a trauma-informed child welfare system, the impact of trauma on the brain and body, and the

³⁴The Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, which was enacted on October 24, 2018, directs federal agencies to take several actions related to trauma-informed care. Among other things, it authorizes HHS to collect and report data on adverse childhood experiences, and it requires HHS to disseminate information and resources to early childhood care and education providers on how to recognize children impacted by trauma and respond appropriately. The act also establishes an Interagency Task Force on Trauma-Informed Care, comprised of various components within HHS, Education, and the Departments of Veterans Affairs and Justice, among others, to identify, evaluate, and make recommendations regarding: (1) best practices with respect to children and youth who have experienced or are at risk of experiencing trauma, and (2) ways in which federal agencies can better coordinate to improve the federal response to families impacted by substance use disorders and other forms of trauma. In addition, the act authorizes HHS to award grants, contracts, or cooperative agreements to state and local education agencies for the purpose of increasing student access to evidence-based trauma support services and mental health care. See Pub. L. No. 115-271, §§ 7131-7135, 132 Stat. 3894, 4046-56 (2018). Given its recent enactment, we did not review the implementation of this law for this report.

³⁵The NCTSN develops and disseminates interventions and resource materials, offers education and training programs, and engages in data collection and evaluation, among other activities, to help education and child welfare agencies and others support children affected by trauma. As noted earlier, NCTSN is part of SAMHSA's NCTSI and is comprised of its current and former grantees.

identification of trauma-related needs of children and families.³⁶ Also, two state child welfare agencies told us that they use the Resource Parent Curriculum to train foster parents and others about trauma, and another used the Think Trauma curriculum to prepare trainers of group home and residential center staff; both curricula are provided through the NCTSN.³⁷ In addition, the NCTSN makes other resources available to state and local communities on its website. For example, NCTSN offers fact sheets about various assessments and treatments, including those mentioned in table 1, as well as two evidence-based treatments for use in school settings.³⁸

In addition to information and training provided through the NCTSN, in 2012, HHS's ACF issued guidance to encourage state child welfare directors to focus on improving behavioral and social-emotional outcomes for children who have experienced abuse or neglect. In 2013, SAMHSA, in collaboration with ACF and CMS, issued joint guidance to encourage the integrated use of trauma-focused screening, functional assessments, and evidence-based practices in child-serving settings.³⁹ Also, in 2014, SAMHSA, in an effort to help service sectors, such as child welfare, education, and juvenile justice, become more trauma-informed, released *Concept of Trauma and Guidance for a Trauma-Informed Approach*. This

³⁶The NCTSN also offers a Child Trauma Toolkit for Educators.

³⁷The Resource Parent Curriculum helps foster parents to understand how traumatic events may impact children and to recognize behaviors as symptoms of those experiences. Think Trauma provides an overview for juvenile justice staff of how to work towards creating a trauma-informed juvenile justice residential setting. According to a summary of the curriculum, creating a trauma-informed setting is a process that requires not only knowledge acquisition and behavioral modification, but also cultural and organizational paradigm shifts and policy and procedural change at every level of the facility.

³⁸The two evidence-based treatments, Bounce Back and Support for Students Exposed to Trauma, are aimed at relieving symptoms of child traumatic stress, anxiety, depression, and functional impairment among children, ages 5-11 and 10-16, respectively. Bounce Back includes group sessions where children learn and practice feelings of relaxation, problem solving, and conflict resolution, among other activities. Support for Students Exposed to Trauma includes 10 lessons in which children learn about common reactions to trauma, practice relaxation, learn problem solving skills, build social support, and process the traumatic event. Between sessions, children practice the skills they have learned. For more information, see NCTSN fact sheets on Bounce Back and Support for Students Exposed to Trauma.

³⁹As GAO noted in a previous report, enhancing the well-being of children requires a coordinated federal approach that takes into account the interrelatedness of federal actions and policies that aim to improve the lives of children. See [GAO-18-41SP](#).

document included a framework of key assumptions and principles of a trauma-informed approach. SAMHSA intended that the trauma framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families, and communities. (See table 3.)

Table 3: Summary of Substance Abuse and Mental Health Services Administration’s Trauma-Informed Care Framework for State, Local, or Nonprofit Organizations

Key assumptions	
Realization	Staff realize and understand trauma’s effects on individuals, families, groups, organizations, and communities.
Recognize	Staff recognize the signs of trauma.
Respond	Staff respond to people with the understanding that traumatic events affect all people involved.
Resist re-traumatization	Staff seek to not re-traumatize their clients.
Key principles	
Safety	Staff and clients should feel physically and psychologically safe.
Trustworthiness and transparency	Staff build and maintain trust with their clients and each other to ensure transparency.
Peer support	Children or family members who have also experienced trauma support each other to promote recovery.
Collaboration and mutuality	Staff and clients build and maintain relationships, recognizing that everyone can help people heal from trauma.
Empowerment, voice, and choice	Staff foster clients’ empowerment and support clients’ shared decision making.
Cultural, historical, and gender issues	Staff respond to the racial, ethnic, and cultural needs of their clients by overcoming stereotypes and biases.
Examples for implementing a trauma-informed care organization	
Organization’s physical environment	Physical spaces feel safe, open, and transparent, and there are shared spaces for staff and clients.
Screening, assessment, and treatment services	Practitioners are trained in and use evidence-based therapies that reflect trauma-informed care principles.
Evaluation	Staff design trauma-informed care focused evaluations that measure service and program implementation.

Source: GAO summary of SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach. | GAO-19-388

Note: Besides SAMHSA’s framework, other organizations, such as nonprofits, have developed models to help organizations incorporate awareness of trauma into their work.

In addition to the information and training and technical assistance referenced above, HHS and Education fund technical assistance centers and make other resources available to states, including:

- SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint offers technical assistance to various publicly-funded systems and organizations on issues relating to trauma education, among other things.
- Education's Readiness and Emergency Management for Schools Technical Assistance Center helps local education agencies before, during, and after emergency situations. Among its various activities, this technical assistance center offers information and technical assistance to local education agencies and others on Psychological First Aid for Schools, which is an intervention model to assist students, staff, and families in the immediate aftermath of an emergency.
- Education's National Center on Safe Supportive Learning Environments as well as its Positive Behavioral Interventions and Supports Technical Assistance Center offer an array of materials about trauma and approaches to supporting children affected by it.
- ACF, through its Child Welfare Information Gateway website, provides information on building trauma-informed systems, assessing and treating trauma, and addressing secondary trauma in caseworkers. It also offers trauma resources for caseworkers, caregivers, and families, as well as information about trauma training. In some instances, the website directs users to SAMHSA or the NCTSN's website.

Selected States Use Various Approaches to Support Children Affected by Trauma

Officials we spoke with in the six selected states told us they used a variety of approaches to help staff understand trauma and its effects on children, identify children affected by trauma, and provide support to them. These approaches range from training child welfare workers, educators, and clinicians to screening children for symptoms caused by traumatic experiences. They also include developing support systems, including providing services, to children and their families who need more help. While we did not evaluate the effectiveness of the selected state and county initiatives, many of them incorporate key trauma principles and activities cited in the SAMHSA framework above.⁴⁰ For additional

⁴⁰For this review, we did not evaluate the effectiveness of the selected states' or counties' initiatives. Also, we did not independently verify the information provided, but

information on examples of approaches taken in each selected state and in selected counties, see appendixes I and II.

Training

State and local child welfare and education agency officials in the six selected states use various approaches to train staff and birth and foster parents⁴¹ about trauma and its effects on children and families. Child welfare officials in two states, Wisconsin and North Carolina, told us that they use learning communities to train staff, and in some instances, foster parents. For example, North Carolina's child welfare agency used a learning community approach—which included face-to-face training, as well as coaching and practice, over an extended period—to work with child welfare staff in 32 of the state's 100 counties, according to a state official. In a 2016 agency report, state officials reported that the 9- to 12-month learning community process was designed to allow staff the time required to become steeped in trauma knowledge, to learn how to spread that knowledge into skills and practices, and to develop a sustainable program. Conversely, state and local education and child welfare officials in three states told us that they use online learning or university coursework to train staff. For example, Wisconsin education agency officials told us that they developed a three-tiered training, including online modules for educators and school staff. The modules are designed for self-study and, among other things, include guidance on making policies and procedures more trauma-sensitive, as well as information about the characteristics of safe, supportive learning environments. Also, Massachusetts state child welfare officials told us that they partnered with three universities to provide trauma-focused courses to child welfare workers, and local school officials told us that a university offers a graduate certificate in trauma and learning to area educators.

In addition to training staff, state and local child welfare agency officials in four of six selected states told us they train clinicians in trauma-focused, evidence-based therapies. For example, Wisconsin child welfare officials told us that clinicians participate in learning communities where they receive training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based therapy. Clinicians participate in 5 days of in-person training, receive 16 consultation calls with a trainer, and complete

corroborated, when possible, the information we received during our state and county interviews with relevant state documents. We provided officials the opportunity to review the content for accuracy and provide revisions or corrections.

⁴¹These parents can also include kinship caregivers.

a 10-hour, self-paced webinar. According to Wisconsin's child welfare website, clinicians who complete the training are eligible for certification as TF-CBT therapists and can be listed on a national website of certified clinicians.⁴² Similarly, North Carolina's state child welfare agency, in partnership with a nonprofit organization, trains clinicians in four trauma-focused, evidence-based therapies, including TF-CBT and Parent-Child Interaction Therapy. Similar to the Wisconsin effort, over the course of a year, clinicians learn about these therapies and practice them with children and families.

Screening

While training staff and parents is important to broaden understanding of trauma and its impact on affected children, identifying these children is also key to helping them receive needed support, including trauma-focused treatment. State and local child welfare and education officials in five of the six selected states told us that they screen certain children to determine whether they have experienced trauma, are exhibiting symptoms of trauma, or need to be referred for a trauma-informed mental health assessment. For example, North Carolina and Washington child welfare officials told us they screen children for trauma when they enter the child welfare system. North Carolina counties that participated in the state's training efforts, described above, use two screening tools: one for children under age 6 and the other for those ages 6 through 21. The social worker, with input from the caregiver, completes the screening tool for children under age 6. Older children are asked questions about their exposure to trauma, including physical abuse, domestic violence, sexual abuse, and other traumatic events. According to the North Carolina child welfare agency, the trauma screen has a number of benefits for child welfare practice, including informing placement decisions for the youth, prioritizing children who might need to receive treatment quickly, and providing the mental health professional with a better understanding of a child's issues. Child welfare officials in Washington also reported integrating trauma screening into the state's child screening program, using a 2012 ACF trauma grant.⁴³ Children and youth are screened within 30 days of placement in foster care if officials expect them to remain in

⁴²When we spoke with Wisconsin officials in May 2018, they planned to expand their training program for clinicians to include Child-Parent Psychotherapy. The 18-month program would be coordinated by the University of Wisconsin-Madison.

⁴³As described earlier in this report, ACF awarded trauma-related discretionary grants in 2011, 2012, and 2013. Among the recipients of these grants are university and state government entities in four of the six selected states—Colorado, Massachusetts, North Carolina, and Washington.

care 30 days or more. With these grant funds, officials reported that Washington's child welfare agency added a tool to screen for children's trauma symptoms and developed a protocol that rescreens these children every 6 months.⁴⁴ In addition, education agency officials from three states told us that schools have developed processes to identify students who may have experienced trauma. For example, one Wisconsin school district official told us that any staff member, family member, or student can refer a student for screening. This official explained that the school district formed school-based teams to review information, such as data on suspensions and class disruptions, to identify at-risk students. In addition to the screening process, the school district developed school-based and community mental health service partnerships at 23 schools where therapists provide mental health services, according to this official.

Support Systems

State and local child welfare and education agency officials in five of six selected states told us they have developed support systems, which can include providing services, to try to help children affected by trauma. For example, Colorado and Ohio child welfare agencies have spearheaded efforts to provide services and support to children who may have experienced trauma. The Colorado child welfare agency, as part of its system of care, uses an evidence- and team-based planning model, referred to as high-fidelity wraparound services, to manage care for children with or at risk of serious emotional disturbance and who are involved in multiple systems, such as the child welfare and juvenile justice systems.⁴⁵ As part of these wraparound services, county child welfare staff and local service providers and professionals work with the family to create a plan for them and their children. A coordinator sets up meetings, oversees the plan, and makes sure all team members participate in achieving the plan's goals. In addition to the coordinator, a family advocate provides peer support, via weekly visits, to parents and caregivers of youth receiving wraparound services. In addition, depending on the needs of the child, wraparound services may include participating

⁴⁴Trauma screening tools include the Pediatric Symptom Checklist and Screen for Child Anxiety Related Emotional Disorders. A Washington child welfare official explained that they started using the Screen for Child Anxiety Related Emotional Disorders tool to screen for trauma because it is more sensitive than the Pediatric Symptom Checklist to identify symptoms of trauma, such as anxiety and Post-Traumatic Stress Disorder. In addition to these two screening tools, they reported piloting other trauma screening tools to use for children ages 3-7.

⁴⁵The Colorado child welfare agency collaborates with the Office of Behavioral Health to implement Colorado's Trauma Informed System of Care, or COACT Colorado. As of February 2019, 17 counties participate in this effort.

in a support group or meeting with a therapist or grief counselor, among other things. In Ohio, child welfare officials in two counties told us about a partnership that provides services to children and their families who have experienced trauma because of parents' substance use disorder.⁴⁶ As part of the program, children and parents are screened for trauma and may get referred for treatment and services. Families receive wraparound services that are provided by a caseworker and family peer mentor; the family peer mentor has personal experiences with addiction and is in recovery.

In addition, state education agency officials in four selected states told us that they had at least one statewide effort administered by the state education agency to help support all children, including those affected by trauma.⁴⁷ Colorado, Washington, and Wisconsin encourage schools to implement tiered systems of behavioral support, according to state officials. Tiered systems of support generally consist of three tiers of support: (1) universal supports that apply to all children; (2) specialized supports for smaller groups of children; and (3) supports for individual children who need intensive interventions. To implement the first tier, school staff support students in various ways, such as interacting with students and setting up a dedicated space in a classroom for students to regulate their behavior. The second tier may include convening small groups to help children with similar behavioral issues learn how to regulate their emotions, and the last tier may include intensive support for students who need more help, such as developing and implementing wraparound services plans. School district officials that we spoke with in Massachusetts told us that although they do not use tiered systems of behavioral support, they help children affected by trauma by employing practices to create safe classroom environments for all students, such as developing and building upon relationships and engaging students in structured conversations.

⁴⁶Ohio's Sobriety, Treatment, and Reducing Trauma is administered by the Public Children Services Association of Ohio, an organization representing Ohio's county child welfare agencies. The program is primarily funded by the Ohio Attorney General's Office through a Victims of Crime Act grant, according to a state official. Child welfare agencies participating in the program partner with local behavioral health providers and juvenile and family courts. As of March 2019, 32 counties participate in this effort.

⁴⁷North Carolina and Ohio do not have statewide education initiatives that support children affected by trauma, according to state education agency officials.

Child Welfare and Education Agencies in Selected States Identified Leadership and Capacity Limitations as Challenges to Supporting Children Affected by Trauma

Officials in Selected States Reported That Leadership Is Important for Supporting Children Affected by Trauma

Officials in all six selected states spoke of the importance of having engaged leadership in establishing and sustaining support for children affected by trauma.⁴⁸ They cited a wide range of leaders, including state government officials; managers and supervisors; and those in partner agencies, such as schools or nonprofits, who supported these states' trauma efforts. In some cases, these leaders helped establish new trauma initiatives. For example, Wisconsin's former First Lady launched the work of a statewide, interagency trauma initiative. Additionally, Ohio county child welfare officials spoke about the value of obtaining management support for their plan to become a trauma-informed organization. In other cases, leaders were seen as important to sustaining trauma initiatives and ensuring their impact. In Massachusetts, university officials said that, to ensure the continued availability of evidence-based therapies, they train not only clinicians, but also the individuals who supervise them. Also, a county public health official in Washington, whose agency is implementing trauma initiatives in schools, told us that their efforts tend to be unsuccessful unless they first engage school leadership and align their health initiatives with the schools' existing efforts.

Federal officials and reports have also cited leadership as an important factor in the implementation of trauma initiatives, with some maintaining that leadership is necessary to support children affected by trauma

⁴⁸Officials in this context include education and child welfare officials, as well as officials from other agencies and organizations we interviewed, including a university and other government bodies, such as interagency groups and departments of public health.

because of the need to change an organization's culture. In 2013, NCTSN reported on takeaways from a learning collaborative in which nine teams led by child welfare agencies developed, implemented, and tested trauma-informed child welfare practices.⁴⁹ Based on the experiences of the teams, the NCTSN report stated that strong and consistent leadership is necessary to implement trauma-informed practice because it requires a shift in organizational culture. SAMHSA's 2014 guidance for a trauma-informed approach similarly suggests that organizations consider the importance of leadership to initiate a systems-wide change.⁵⁰ In addition, HHS officials, who worked with states on a series of trauma-related grants awarded between 2011 and 2013, also told us that leadership commitment was important for their grantees in building organizational and worker resiliency, acting upon data and evaluation, and sustaining initiatives. These documents and statements echo previous GAO work on organizational transformation; for example, in 2003 we reported on key practices found at the center of successful transformation efforts, noting that leadership must set the direction, pace, and tone and provide a clear, consistent rationale that brings everyone together behind a single mission.⁵¹

In addition to discussing the important role that leadership plays in establishing and sustaining support for children affected by trauma, officials in three states highlighted instances in which a lack of leadership hindered their efforts to support these children. The cases they described included delayed, incomplete, or unsuccessful implementation of trauma initiatives.

- **Delayed implementation.** Officials in one school district said they had developed policies around multi-tiered system of supports in 2009 but did not receive support from political leaders or funding for the

⁴⁹J. Agosti, L. Conradi, J. H. Goldman, and H. Langan, *Using Trauma-Informed Child Welfare Practice to Improve Placement Stability Breakthrough Series Collaborative: Promising Practices and Lessons Learned* (Los Angeles, CA & Durham, NC: NCTSN, June 2013).

⁵⁰Substance Abuse and Mental Health Services Administration, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*.

⁵¹GAO, *Results-Oriented Cultures: Implementation Steps to Assist Mergers and Organizational Transformations*, [GAO-03-669](#) (Washington, D.C.: July 2, 2003). For more recent work in this area, see GAO, *Government Reorganization: Key Questions to Assess Agency Reform Efforts*, [GAO-18-427](#) (Washington, D.C.: June 13, 2018).

initiative until 2016. They told us that this hindered the initiative's implementation.

- **Incomplete implementation.** State education officials in that same state said that a lack of leadership hindered their ability to track school districts' implementation of the state's trauma initiatives. These officials said that a lack of requirements for districts to scale up trauma work was a barrier to collecting data on local activities. In another state, there was a county child welfare initiative to implement universal trauma screening which was conducted in partnership with a local university. The university reported that less than half of children with open cases were screened during the project period, which university officials attributed to some supervisors not supporting the screening initiative.
- **Unsuccessful implementation.** According to officials in a third state, turnover among high-level leaders contributed to difficulties integrating trauma-informed practices at the state's child welfare agency, and the agency was not successful at implementing a trauma screening process.

Child Welfare and Education Officials in Selected States Also Reported Capacity Limitations and Other Challenges to Supporting Children Affected by Trauma

Capacity Limitations

Officials in all six selected states talked about limitations on their agency's or organization's capacity to support children affected by trauma. Limitations included high rates of staff turnover, limited staff time to focus on trauma, insufficient numbers of clinicians trained in trauma-focused, evidence-based therapies, and insufficient funding for trauma initiatives. Some agencies and organizations had taken actions to address these challenges.

Staff Turnover

High rates of staff turnover were reported in all six selected states. This limitation was more commonly raised by child welfare agencies than by

Secondary Traumatic Stress

According to the National Child Traumatic Stress Network (NCTSN), Secondary Traumatic Stress (STS) is the emotional duress experienced when hearing about another person's traumatic experiences. Professionals working with children affected by trauma, such as child welfare workers, are commonly at risk of developing STS. STS can compromise these professionals' ability to do their jobs and may drive them to leave their job or their professional field.

NCTSN notes that several factors can increase the risk for developing STS, including heavy caseloads of children affected by trauma, social or organizational isolation, and feeling unprepared for the job due to lack of training. NCTSN suggests taking a multi-dimensional approach to STS, which includes both prevention and intervention. This could include strategies such as establishing self-care groups, helping workers maintain work-life balance, and training organizational leaders on STS.

Source: National Child Traumatic Stress Network | GAO-19-388

education agencies. Child welfare officials in all six states talked about high rates of staff turnover, while education officials did so in two states (Colorado and Wisconsin).⁵² Staff turnover resulted in difficulties maintaining staff trained in trauma-informed approaches and sustaining institutional trauma knowledge and trauma-related activities, according to officials. Colorado university officials partnering with a county child welfare agency said that staff turnover forced them to invest additional time in training replacement staff and made it more difficult for child welfare officials to conduct regular follow-ups. Similarly, one education official in another part of Colorado said that high turnover at many agencies, including education and child welfare, hindered the county's efforts to maintain institutional knowledge about trauma-informed practices and sustain the services these agencies were providing to children affected by trauma. Some state and local officials in three states attributed high rates of staff turnover to fatigue and secondary traumatic stress, which is the emotional duress that staff may experience when they hear about children's traumatic experiences (see sidebar). Some agencies said that they sought to address staff turnover by supporting employees through training on secondary traumatic stress; at least one agency in each of the six states offered such training. Officials from Ohio and Wisconsin told us that another way they were addressing the issue was by participating in an HHS-funded project to improve child welfare workforce outcomes.⁵³

⁵²In four states, officials from other agencies and organizations partnering with child welfare agencies also commented on the high rates of staff turnover in that field. GAO has previously reported on the high rate of staff turnover in child welfare and its associated challenges. In 2003, we reported that child welfare staff turnover had been estimated at between 30 and 40 percent annually nationwide, with the average tenure of child welfare workers being less than 2 years. We found that turnover hampered agencies' attainment of some key federal safety and permanency outcomes by producing staffing shortages which increased the workloads of remaining staff. We further found that these increased workloads left less time for staff to establish relationships with children and families, to conduct frequent and meaningful home visits, and to make thoughtful and well-supported decisions regarding safe and stable placements. GAO, *Child Welfare: HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff*, [GAO-03-357](#) (Washington, D.C.: Mar. 31, 2003).

⁵³The Quality Improvement Center for Workforce Development was established in 2016 under a 5-year cooperative agreement with HHS's Children's Bureau. This center is working with eight public and tribal child welfare agencies in different states to develop strategies for improving child welfare workforce outcomes. Quality Improvement Center for Workforce Development, *Building Knowledge to Strengthen the Child Welfare Workforce*, accessed Jan. 31, 2019, <https://www.qic-wd.org/sites/default/files/about-qicwd.pdf>.

Limited Staff Time

Many agencies also said they faced limitations on the time that staff could dedicate to trauma initiatives. This issue was more commonly raised by education agencies than by child welfare agencies. Education agency officials reported this limitation in three of four states that had education initiatives,⁵⁴ whereas child welfare officials reported it in two of the six selected states. Some of these officials explained that lack of staff time to focus on trauma may have limited the implementation of their trauma initiatives. State education officials in Washington and local education officials in Massachusetts told us that they have the expertise to provide trauma training to schools and community groups, but time limitations restrict their ability to do so. A Colorado county child welfare official told us that some caseworkers see trauma screening as an additional burden due to their already large workload, and a child welfare official in another Colorado county told us that many caseworkers forget to do trauma screening because they are busy. At least one agency we interviewed in each of the six states has or had a staff position dedicated to trauma work, which could help address this limitation.

Lack of Clinicians

Officials in all six selected states said that there were not enough clinicians trained in trauma-focused, evidence-based therapies to serve children affected by trauma.⁵⁵ GAO has previously reported on difficulties finding specialty care for children.⁵⁶ For example, in 2017 we found that limited access to mental health services was a challenge for several

⁵⁴State education officials in two of our six selected states told us that they did not have statewide trauma initiatives.

⁵⁵Though this issue was raised in all six states by child welfare or Medicaid officials, it was not reported by any education officials.

⁵⁶In a 2010 national survey of physicians, in which GAO asked about difficulties referring children to specialty care and the particular specialties for which making a referral is difficult, one of the specialist types most frequently cited was mental health specialists, such as psychiatrists, psychologists, drug counselors, and other therapists. Physicians surveyed offered various explanations for why making referrals is difficult, including the short supply of specialists in their area and long waiting lists for specialists. GAO, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, [GAO-11-624](#) (Washington, D.C.: June 30, 2011). GAO has also reported on behavioral health workforce shortages for low-income adults, see GAO, *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States*, [GAO-15-449](#) (Washington, D.C.: June 19, 2015).

selected states due to a variety of factors, including insufficient numbers of providers in certain specialties, such as child psychiatrists.⁵⁷ Some officials indicated that a shortage of clinicians trained in trauma-focused, evidence-based therapies can limit the ability of child welfare agencies to address trauma. For example, state child welfare officials in Massachusetts specifically noted that identifying children affected by trauma is not helpful if there are not enough clinicians trained in these therapies to treat them. County child welfare officials in Massachusetts and local healthcare partners in Ohio said that providers sometimes rely on interns to address the shortage of clinicians, but Massachusetts officials viewed this as problematic because interns have short tenures that prevent them from establishing relationships with the children. Officials in five of the six selected states told us about initiatives to address the shortage by training clinicians in trauma-focused, evidence-based therapies, and university officials in Massachusetts described an initiative to make trained clinicians more accessible. (See text box.)

⁵⁷This challenge was identified by state and county officials in four of the seven selected states and five of the nine national organizations that were interviewed for the report. GAO, *Foster Care: HHS Has Taken Steps to Support State Oversight of Psychotropic Medications, but Additional Assistance Could Further Collaboration*, [GAO-17-129](#) (Washington, D.C.: Jan. 5, 2017).

LINK-KID: A centralized trauma treatment referral service

The Child Trauma Training Center at the University of Massachusetts Medical School trains clinicians and operates a centralized referral service called LINK-KID. The goal of LINK-KID is to facilitate connections between children in need of trauma-focused, evidence-based therapies and clinicians who have been trained to provide such therapies. LINK-KID maintains an active database of trained clinicians throughout the state of Massachusetts.

University officials told us that anyone in Massachusetts with concerns about a child, including family, teachers, clinicians, and child welfare workers, may call the service. LINK-KID collects information about the child and family, works with them to decide which treatment is most appropriate, and ensures the child is referred for that treatment.

University officials said that using LINK-KID is easier for families and child welfare workers, who otherwise might have to call multiple service providers to determine who offers the needed treatment and accepts their insurance. These officials also said they have seen a reduction in the time children must wait for treatment when using LINK-KID. They said that prior to LINK-KID, they saw many children waiting 6 months to a year to receive treatment after having been identified as having experienced trauma, whereas wait times are generally between 25 and 40 business days with LINK-KID.

Source: GAO and Child Trauma Training Center. | GAO-19-388

Limited Funding

Finally, some agencies said they had difficulties getting or maintaining sufficient funding to support trauma initiatives. Officials in Washington, including, among others, state and local education officials and a local public health partner, reported this issue. In addition, local officials in four other states noted limited funding to support trauma initiatives. School district officials in Washington indicated that a lack of funding limited their implementation support for one major trauma initiative to approximately one-quarter of their schools. These schools were chosen based on need, as demonstrated by measures such as discipline and absenteeism rates. County child welfare officials in Ohio said they had to stop one of their trauma initiatives 3 years ago because the state funding supporting the initiative ran out. Those Ohio officials said they have relied on relationships and collaboration to address the issue of scarce funding. For example, they said that county organizations, including local government agencies, private healthcare providers, and nonprofits, share data

extensively and pool funding to support various initiatives. One initiative they pointed to is a local interagency council which provides services to children affected by trauma.

Other Challenges

Child welfare and other officials in the six selected states, including officials with nonprofit partners, a state department of health, and a state interagency collaborative, also raised at least one other challenge. Challenges included sharing data while remaining in compliance with state and federal privacy laws; sharing data across incompatible systems; limitations on services billable to Medicaid; and Medicaid reimbursement rates. Some agencies had taken actions to address or avoid data sharing challenges. In the states where child welfare officials identified Medicaid-related challenges, state Medicaid officials offered a different perspective on perceived Medicaid challenges and cited alternative ways to support children affected by trauma.⁵⁸

Officials in all six states talked about sharing data with other agencies for various purposes; however, privacy laws and regulations were sometimes cited by these officials as a barrier to sharing data about children affected by trauma.⁵⁹ For example, officials in two Massachusetts school districts told us they are notified by police or child welfare workers when a child has been involved in an incident with those agencies. One official described the goal of this effort as making staff aware of incidents and events that may affect children's learning and behavior and ensuring that children feel supported. However, child welfare officials in four of the six selected states and other officials in two states said that it was difficult to share data while remaining in compliance with state and federal privacy

⁵⁸Child welfare and Medicaid programs share responsibility for providing for the health care needs of children in foster care. In its June 2015 report to Congress, the Medicaid and CHIP Payment and Access Commission noted that collaboration among agencies responsible for the health care needs of such children is critical, but can be hampered by a lack of knowledge among staff regarding benefits, among other things. Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP* (Washington, D.C.: June 2015).

⁵⁹For various reasons, not all agencies we interviewed reported collecting or wanting to share data specific to children's traumatic experiences or their initiatives to support children affected by trauma. For example, Washington state education officials reported that they did not have the resources for formalized data collection on their trauma initiatives, while an official from an interagency collaborative in the same state said they lacked the administrative power or capacity to collect such data. Massachusetts state and Ohio county child welfare officials said they did not want to track traumatized children as a distinct population, as they assume every child entering the child welfare system has been exposed to trauma.

and confidentiality laws and regulations, though the reasons they cited for these difficulties varied.⁶⁰ State child welfare officials in Massachusetts told us that the state has strict privacy laws in addition to federal laws such as the Health Insurance Portability and Accountability Act of 1996.⁶¹ These officials said that data sharing is possible but generally requires a specific memorandum of understanding because of privacy laws. In contrast, a state child welfare official in North Carolina said they had difficulties with counties not understanding what data they are allowed to share. That official told us that the state tries to mitigate this challenge by helping counties understand what they can share and encouraging them to share screening information with mental health and medical providers. Additionally, a North Carolina university has published state-specific guidance on sharing education, mental health, and other records.

Systems incompatibility and technology issues were also sometimes seen as barriers to sharing data about children affected by trauma. Child welfare officials in three of the six selected states, and state health

⁶⁰Various GAO reports have outlined challenges states have faced in navigating federal privacy and security protections for health, child welfare, education, and other data. These challenges have included uncertainty over the types of data that states are able to share under these laws. See GAO, *Foster Care: HHS Has Taken Steps to Support States' Oversight of Psychotropic Medications, but Additional Assistance Could Further Collaboration*, [GAO-17-129](#) (Washington, D.C.: Jan. 5, 2017); *Human Services: Sustained and Coordinated Efforts Could Facilitate Data Sharing While Protecting Privacy*, [GAO-13-106](#) (Washington, D.C.: Feb. 8, 2013); and *Postsecondary Education: Many States Collect Graduates' Employment Information, but Clearer Guidance on Student Privacy Requirements Is Needed*, [GAO-10-927](#) (Washington, D.C.: Sept. 27, 2010). In response to a GAO recommendation from [GAO-13-106](#), HHS published a "Confidentiality Toolkit" in August 2014 that aims to support state and county data sharing efforts by bringing greater clarity to the rules governing confidentiality in certain human services programs. In response to a GAO recommendation from [GAO-10-927](#), the Department of Education revised its Family Educational Rights and Privacy Act regulations in December 2011 to, among other things, clarify the means by which states can collect and share graduates' employment information consistent with federal requirements. Additionally, the Department of Education published a data-sharing tool kit for civic and community leaders in March 2016.

⁶¹The Health Insurance Portability and Accountability Act of 1996 required HHS to promulgate regulations addressing the privacy and security of health information. Pub. L. No. 104-191, tit. II, subtit. F, 110 Stat. 1936, 2021-34 (codified at 42 U.S.C. §§ 1320d-1320d-8). HHS has published Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) and Security Standards for the Protection of Electronic Protected Health Information (the Security Rule). 45 C.F.R. pts. 160 and 164. The Privacy Rule establishes national standards for safeguarding individually identifiable health information that is transmitted or maintained in any form or medium (protected health information). The Security Rule establishes nationwide standards for safeguarding protected health information that is held or transferred electronically.

officials in a fourth state, said that incompatibility among various systems made data sharing very difficult or impossible.⁶² For example, county officials in Wisconsin said that the state's child welfare and juvenile justice offices use one data reporting system while the state's mental and behavioral health offices use another, and these two statewide data systems are unable to communicate. While state child welfare officials in Colorado also reported systems incompatibility issues, county child welfare officials in that state talked about efforts to make data systems more accessible to relevant partners. Officials in one county said that they have a database which is accessible by all members of the county's multi-agency partnership, including child welfare, school districts, public health, and others. Those officials also said they use a universal release-of-information which includes all partner agencies, enabling them to share data at multi-agency meetings.⁶³

Additionally, child welfare officials in Colorado, Ohio, and Massachusetts said that certain services for children affected by trauma or certain service providers were not billable to Medicaid, although Medicaid officials in these states offered a different perspective and cited alternative ways to support these children.⁶⁴ Depending on the state, child welfare officials said they could not bill wraparound services, trauma assessments, transportation, or non-traditional therapies, such as animal therapy or

⁶²HHS officials also told us that data integration was a challenge for the recipients of the trauma-related grants ACF awarded from 2011 to 2013. They said that moving and integrating data between systems was a problem for grantees even though states were able to develop memoranda of understanding and data sharing agreements.

⁶³This release-of-information is an authorization, signed by the individual receiving services or a parent or legal guardian, which allows specified county agencies to receive, use, and disclose certain types of confidential information for specified purposes.

⁶⁴NCTSN has also reported on Medicaid challenges faced by those serving children and families affected by trauma. In 2016, they conducted a financing and sustainability survey of NCTSN members. Of 110 responders from 33 states and the District of Columbia, 52 percent reported difficulties with Medicaid reimbursements as a financing challenge. NCTSN, *NCTSN Financing and Sustainability Survey Report* (November 2016).

community and relationship building.⁶⁵ County child welfare officials in Ohio also mentioned restrictions on providers; they said that potential peer support specialists with a criminal background and interns could not bill Medicaid.⁶⁶ However, Medicaid officials in these states generally said that such services were billable to Medicaid, and Ohio Medicaid officials said that interns and those with a criminal background could bill Medicaid, under certain circumstances. For example, they said that while certain severe criminal offenses, such as homicide, could exclude someone from providing services, those with lesser offenses could become eligible after a waiting period. Colorado and Ohio Medicaid officials we spoke with offered some alternative ways to use Medicaid to support children affected by trauma in cases where services could not be billed to Medicaid. For example, a Colorado Medicaid official and a child welfare official both said that Medicaid does not pay providers for travel time or mileage and that this can be a problem in rural areas; however, the state Medicaid official said that telehealth is available to address this issue and that reimbursement rates for services in rural areas can be higher to reflect the additional cost of travel.⁶⁷

Finally, child welfare and Medicaid officials in Colorado and North Carolina also had different perspectives regarding Medicaid reimbursement rates. Child welfare and other officials in these states said that certain services for children affected by trauma, such as trauma assessments and trauma-focused, evidence-based therapies, are expensive, and that Medicaid reimbursement rates are too low to incentivize providers to offer these services. However, Colorado and North Carolina Medicaid officials explained that most children in Medicaid in their states receive mental health care through managed care, where

⁶⁵While the theme of certain services not being billable to Medicaid was reported by child welfare officials across these three states, the specific services the officials mentioned varied by state. The variance of reimbursable services across states is consistent with differences in state approaches to supporting children affected by trauma and with the state-by-state variance of Medicaid programs generally. Medicaid, by design, allows significant flexibility for states to design and implement their programs, which has resulted in over 50 distinct state-based programs. Federal law requires state Medicaid programs to cover a wide array of mandatory services, such as physician, laboratory, and preventive services, and permits states to cover additional services at their option. GAO, *Medicaid: Key Issues Facing the Program*, [GAO-15-677](#) (Washington, D.C.: July 30, 2015).

⁶⁶Officials noted that individuals who have gone through the criminal justice system may have life experiences that make them uniquely well-suited to be peer support specialists.

⁶⁷The official said that Colorado Medicaid does pay for transportation for children to receive medically necessary services covered by Medicaid.

the state pays a set rate per child to managed care organizations (MCOs) to provide or arrange for any mental health services a child may need, including trauma-related care. MCOs, in turn, reimburse providers for the services they deliver, and MCOs set the rates they pay providers for those services rather than the state. Medicaid officials in Colorado and North Carolina noted that MCOs have flexibility to negotiate rates with providers and may choose to reimburse at a higher rate.⁶⁸ North Carolina Medicaid officials said that some MCOs in their state were reimbursing providers at a higher rate for comprehensive, trauma-informed mental health assessments, and a Colorado Medicaid official also noted that MCOs in their state may vary reimbursement rates based on provider availability, offering higher rates in areas where there are shortages.

Agency Comments

We provided a draft of this report to HHS and Education for review and comment. HHS did not provide written comments. Education provided technical comments, which were incorporated into the report as appropriate.

⁶⁸Used effectively, Medicaid managed care may help states reduce Medicaid program costs and better manage utilization of health care services. However, GAO has also previously reported on problems associated with managed care. For example, in 2018 we reported that managed care payments have the potential to create program integrity risks and that there exist multiple challenges to program integrity oversight for managed care. GAO, *Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks*, [GAO-18-528](#) (Washington, D.C.: July 26, 2018). We also found that CMS has provided states with limited information on how to fulfill regulatory requirements related to oversight of MCO data, and we recommended that CMS provide states with additional information on this topic. GAO, *Medicaid Managed Care: Additional CMS Actions Needed to Help Ensure Data Reliability*, [GAO-19-10](#) (Washington, D.C.: Oct. 19, 2018).

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretaries of HHS and Education, congressional committees, and other interested parties. In addition, this report will be available at no charge on the GAO website at <https://www.gao.gov>

If you or your staff have any questions about this report, please contact me at (202) 512-7215 or larink@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

A handwritten signature in black ink, reading "Kathryn A. Larin". The signature is written in a cursive style with a large, stylized initial "K".

Kathryn A. Larin
Director, Education, Workforce, and Income Security Issues

Appendix I: Selected State Information

Table 4: Examples of State Child Welfare Agencies' Initiatives to Support Children Affected by Trauma in the Six Selected States

State	Initiative	Description of the initiative that supports children affected by trauma
Colorado	Trauma Informed System of Care (known as COACT Colorado)	Uses an evidence-based and collaborative approach to help families of children and youth with complex needs involved in multiple systems in 17 counties throughout the state. Agencies involved with this initiative include child welfare, juvenile justice, and education. Dedicated staff exist to assist families and provide them with support as children receive services.
Massachusetts	Child Trauma Project ^a	Provided a series of training and activities organized throughout the state that expanded on inter-agency collaboration to support children affected by trauma. It also created leadership teams focused on trauma in all of Massachusetts' child welfare offices. In addition, it trained clinicians in three trauma-focused, evidence-based therapies, including Trauma-Focused Cognitive Behavioral Therapy.
North Carolina	Project Broadcast	Trains county child welfare workers over a 9-12 month period to incorporate an understanding of trauma and its effects into their every day practices. It also trains staff to use two screening tools—one for children 6 and under and one for children ages 6-21—to identify whether they have experienced trauma and refer them for an assessment if needed. Additionally, it trains clinicians on four trauma-focused, evidence-based therapies to treat children's trauma symptoms.
Ohio	Child Welfare Training Program	Provides training on core and specialized competencies for child welfare caseworkers, supervisors, and foster parents. The training program includes courses for the three groups that teach about the effects of trauma on children. For example, caseworkers can take trainings on the impact of emotional abuse and interventions for children who have suffered trauma while caregivers can take trainings on providing discipline that is trauma-informed and dealing with the effects of complex trauma.
Washington	Child Health and Education Tracking Program	Screens children in five areas, including physical and behavioral health, within the first 30 days of entering the child welfare system. In addition, dedicated staff are trained to use tools to identify children's trauma symptoms, including anxiety and attention problems. One tool includes questions about children's anxiety, such as whether they are scared to go to school. Children are rescreened every 6 months using these tools.
Wisconsin	Trauma Project	Consisting of three parts, this initiative trains clinicians who treat children affected by trauma in trauma-focused, evidence-based therapies; holds workshops for foster, birth, adoptive, and kinship parents attended by social workers and others to learn about trauma and its effects; and provides learning communities for state and county child welfare staff that infuse an understanding of trauma into staff's every day work.

Source: GAO analysis of state child welfare agency documents and Administration for Children and Families grant reports. | GAO-19-388

^aA Massachusetts child welfare official told us that this initiative, funded by an Administration for Children and Families grant, ended in 2017. According to another Massachusetts state child welfare official, once the funding was eliminated for the full-time staff person who organized the Child Trauma Project, the agency could not sustain it throughout the state.

Table 5: Examples of State Education Agencies’ Initiatives to Support Children Affected by Trauma in Selected States

State ^a	Initiative	Description of the initiative that supports children affected by trauma
Colorado	Positive Behavioral Interventions and Supports and Multi-Tiered System of Supports ^b	Encourages the use of Positive Behavioral Interventions and Supports and Multi-Tiered System of Supports as prevention frameworks for improving the outcomes of all students. This occurs through partnerships with families, schools, and communities. It also uses multiple evidence-based practices at the classroom, school, district, region, and state levels.
Massachusetts	The Safe and Supportive Schools Grant Program	Helps school districts ensure that a school creates a safe, positive, healthy and inclusive learning environment. This state-funded grant program also makes sure there is use of a system for integrating services and aligning initiatives that promote, among other things: <ul style="list-style-type: none"> • students’ behavioral health, including social and emotional learning, and trauma sensitivity, • children’s mental health, and • positive behavioral approaches that reduce suspensions and expulsions.
Washington	Compassionate Schools and Social and Emotional Learning	Provides universal supports to all students through these initiatives, which include creating a positive school climate and culture. <ul style="list-style-type: none"> • Compassionate Schools support all students and focus on helping teachers understand fundamental brain development, interpret and manage children’s behaviors successfully, and engage students, families, and the community. • Social and emotional learning is the process through which children learn how to understand and manage emotions, set and achieve goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions.
Wisconsin	Trauma Sensitive Schools	Modeled after the Positive Behavioral Interventions and Supports school improvement process, this initiative focuses first on universal practices (Tier 1), followed by strategies for groups of students who need additional support (Tier 2), and intensive interventions for students who require ongoing support (Tier 3).

Source: GAO analysis of state agency documents and interviews with agency officials. | GAO-19-388

^aFour of the six selected states had at least one statewide initiative administered by state education agencies to support children affected by trauma. North Carolina and Ohio do not have statewide education initiatives, according to state education agency officials.

^bPositive Behavioral Interventions and Supports and Multi-Tiered System of Support utilize evidence-based, prevention-oriented practices and systems. Positive Behavioral Interventions and Supports’ framework provides academic, social, emotional, and behavioral support to all students while Multi-Tiered System of Support focuses on addressing students’ academic issues. Both models comprise three tiers—the first uses universal practices to support children, such as changing a classroom’s environment; the second uses strategies, such as small group cognitive behavioral therapy, for students who need additional support; and the third provides intensive interventions for students who require ongoing support, such as developing and implementing wraparound services plans.

Appendix II: Selected County Information

Table 6: Examples of County and Local Agency Initiatives to Support Children Affected by Trauma in the Six Selected States

County, State	Initiative	Description of the initiative that supports children affected by trauma
Boulder County, CO	Integrated Managed Partnership for Adolescent and Child Community Treatment	Consisting of 11 public agencies and nonprofit organizations, including the Boulder Valley School District and a nonprofit organization that provides mental health services, this initiative is an interagency collaborative partnership. The group provides case coordination and ensures participating agencies and organizations have consistent practices and processes for children involved in multiple systems. Services, such as trauma-focused, evidence-based therapies and mentoring for youth in the juvenile justice system, are also available through this effort.
Plymouth County, MA	Brockton Public Schools	Creating trauma-sensitive schools has been Brockton Public Schools' focus, one official explained. Among other things, the schools create safe and supportive environments by enhancing relationships with students and ensuring educators are aware of students' behavior, according to this same official. In addition, Brockton Public Schools collaborates with the county district attorney's office on two trauma-focused initiatives—the Childhood Trauma Initiative and Handle With Care. The Childhood Trauma Initiative trains educators and law enforcement, among others, about trauma's effects on children's development. Handle With Care allows police officers or caregivers to notify a school that a child may have experienced a traumatic event.
Rowan County, NC	Partnering for Excellence	Consisting of the county department of social services, the county's mental health managed care organization, and private mental health providers, this initiative supports children ages 5-17 and families involved in the child welfare system. Key elements of Partnering for Excellence include screening children for trauma and, if needed, trauma-intensive comprehensive clinical assessments. The initiative also facilitates improved communication, coordination, and monitoring of child and family treatments by ensuring staff train together and participate in ongoing collaborative meetings.
Athens County, OH	School Outreach Caseworkers	Placing caseworkers in local elementary schools, the county child welfare agency's initiative supports students, families, and teachers by promoting positive school relationships to enhance student success and strengthen families. Among other responsibilities, caseworkers help coordinate services for individual students and bring outside resources into schools. They also support parents by providing home and school-based services and coordinating parenting classes to help strengthen skills.
King County, WA	King County Department of Public Health	Beginning in 2017, King County's Department of Public Health implemented changes to become a trauma-informed agency. One official explained that the agency has three areas of focus—creating a trauma-informed care training plan and standardized curriculum; awarding mini-grants to agency "champions" who create small projects connected to the agency's trauma-informed care principles, which includes fostering compassionate relationships; and making policy and human resources changes, including the investigation process for internal human resources complaints.

Appendix II: Selected County Information

County, State	Initiative	Description of the initiative that supports children affected by trauma
Waupaca County, WI	Waupaca County Department of Health and Human Services	Beginning in 2012, the Department of Health and Human Services has worked to transition into a trauma-informed agency by incorporating trauma-informed care into its operations. The agency's operating principles include partnering with clients, promoting safety, and earning clients' trust. The agency has become more family-friendly and is more focused on preventing children from entering the child welfare system, according to an agency official. Since becoming trauma-informed, it was reported that staff have had less secondary stress and there has been a decrease in staff turnover.

Source: GAO analysis of county child welfare, local education, and other county agency official interviews and county agency documents. | GAO-19-388

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Kathryn Larin, (202) 512-7215 or larink@gao.gov

Staff Acknowledgments

In addition to the contact named above, Elizabeth Morrison (Assistant Director), Ramona L. Burton (Analyst-In-Charge), Isabella Guyott, and Robin Marion made significant contributions to this report. Also contributing to this report were Luqman Abdullah, Susan Aschoff, Sarah Cornetto, Kelsey Kreider, Hannah S. Locke, Jean McSween, Mimi Nguyen, Stacy Ouellette, Michelle Rosenberg, Almeta Spencer, Daren K. Sweeney, Shelia L. Thorpe, and Carolyn Yocom.

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