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Toolkit for Adapting Cognitive Behavioral Intervention for Trauma in Schools (CBITS) or Supporting Students Exposed to Trauma (SSET) for Implementation with Youth in Foster Care

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Preface

The purpose of this toolkit is to assist school-based mental health professionals and child welfare social workers in adapting Cognitive Behavioral Intervention for Trauma in Schools (CBITS) or Supporting Students Exposed to Trauma (SSET) for youth in foster care. CBITS is a manualized group program that was developed and initially evaluated in the Los Angeles Unified School District (LAUSD). CBITS was developed for use by school-based mental health professionals for any student with symptoms of distress following exposure to trauma. SSET is adapted from CBITS for use by any school personnel with the time and interest to work with students affected by trauma. This toolkit was designed to help deliver CBITS or SSET to youth in foster care. To date, CBITS/SSET has been implemented only within schools, but it may also be possible to implement the programs in other settings, such as community-based mental health clinics, foster family agencies, child protective services (CPS) agencies, and other sites where youth in foster care are served. This resource does not replace the CBITS manual (available at: <http://sopriswest.com/>) or the SSET manual (available at http://www.rand.org/pubs/technical_reports/TR675/); instead it should be considered a supplement to be used in conjunction with either of the manuals when implementing the programs for youth in foster care.

The toolkit was developed as part of a project to implement and evaluate CBITS for youth in foster care. The pilot project identified some of the challenges faced when attempting to deliver a school-based mental health program to these youth, including collaboration between the child welfare and education systems, confidentiality and information sharing policies regarding youth in foster care, and identification of youth in foster care. The lessons learned from the pilot project helped shape the recommendations for implementing CBITS and SSET outlined in this toolkit. As part of the pilot project, we also conducted one focus group that included foster care alumni, LAUSD staff, and staff from the Los Angeles County Department of Children and Family Services (DCFS) for additional insights on adapting the programs for youth in foster care. The pilot project was supported by Casey Family Programs and conducted in the LAUSD. The guidelines and adaptations were developed through RAND's collaboration with LAUSD and the DCFS on this pilot project. For more information about that pilot project, see "Overcoming challenges to implementing and evaluating evidence-based interventions in child welfare: A matter of necessity" by Maher et al. in *Children and Youth Services Review*, 31(5): 555–562.

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our Community Advisory Board, and the foster care alumni who helped us to develop this toolkit.

This toolkit has three parts: a background section, an overview of CBITS and SSET, and a step-by-step guide to adapting CBITS/SSET for youth in foster care.

This work was sponsored by Casey Family Programs, the American Legion Child Welfare Foundation, and the National Institute of Mental Health under contract No. MH072591. The research was conducted within RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.

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Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
CBITS	Cognitive Behavioral Intervention for Trauma in Schools
CFOMH	Casey Field Office Mental Health Study
CIDI	Composite International Diagnostic Interview
CPS	child protective services
DCFS	Department of Children and Family Services
DHHS	Department of Health and Human Services
LAUSD	Los Angeles Unified School District
NSCAW	National Survey of Child and Adolescent Well-Being
PTSD	post traumatic stress disorder
SSET	Supporting Students Exposed to Trauma
SSI	Supplemental Security Income

Background

In 2007 in the United States, there were over 3.2 million referrals to child protective services (CPS) agencies for abuse or neglect, with 794,000 confirmed victims of child maltreatment (U.S. Department of Health and Human Services, Administration on Children and Families [DHHS], 2008a). When a child's safety cannot be assured in the home, he or she is often removed by CPS. In 2007, about one-fifth of confirmed victims (21 percent) were placed in foster care in family and nonfamily settings, such as residential treatment centers (DHHS, 2008a). The average daily census of children in out-of-home placement was 510,000 children as of September 30, 2007, with a total of about 783,000 children in care during the 2007 federal fiscal year (DHHS, 2008b). Although precise data on the reasons for youth placement in out-of-home care are not available, most children enter foster care because of parent-related problems, largely child abuse or neglect (Berrick, Needell, Barth, & Johnson-Reid, 1998; DHHS, 2008a). However, a considerable proportion of children (18 percent) enter care because of behavioral problems; this proportion rises to 50 percent among children ages 11 and older (Barth, Wildfire, & Green, 2006).

Nearly half of the children who are placed in foster care will remain in care for a year or longer, with an average length of stay of two years. For example, of those children in foster care on September 30, 2006, 58 percent had been there for 12 months or longer. Of those leaving care in fiscal year 2006, 16 percent had been there for three years or more. Over 26,000 older youth are emancipated to adulthood from a foster care setting every year (DHHS, 2008b). Although preventing the placement of children in foster care and minimizing the length of stay in foster care are child welfare priorities, many children spend a substantial amount of their childhood living in foster care (Wulczyn, Barth, Yuan, Harden, & Landsverk, 2005; Wulczyn, Hislop, & Chen, 2007).

While children entering foster care span all age ranges, early adolescents (children aged 10–15) constitute one of the largest groups of children entering foster care (29 percent). Race and ethnicity are important factors that may affect the decision to place a child in foster care (Hill, 2006; Sedlak & Schultz, 2001). In 2006, 52 percent of the 303,000 children who entered foster care placements in the United States were children of color. Of these, 26 percent were African American and 19 percent were Hispanic (DHHS, 2008c). Also, most children in foster care come from impoverished families. Despite their considerable strengths, impoverished families face multiple challenges, such as housing, employment, health, mental health, a lack of parenting skills, and low levels of education (Barth, Wildfire, & Green, 2006).

To provide some background for the need for evidence-based mental health services for youth in foster care, we first describe the impact of trauma on children generally. We then discuss some of the specific mental health challenges faced by children in foster care. Finally, we briefly review the barriers to youth in foster care receiving needed mental health services.

Trauma Is Associated with Increased Risk for Child and Adolescent Mental Health Issues

The risk to children exposed to trauma at home and in their communities has gained widespread recognition (Berkowitz, 2003). Evidence suggests that between 25 and 43 percent of children have experienced a traumatic event in their lifetime (Costello, Erkanli, Fairbank, & Angold, 2002; Giaconia et al., 1995). Traumatic experiences might include child abuse and neglect, natural disasters, death of family members or loved ones, and serious accidents. Children and adolescents experience trauma in different ways: Some experience a single incident, while others have ongoing traumatic experiences (Amaya-Jackson, 2000). A variety of psychiatric disorders and behavioral problems may result from direct or indirect exposure to trauma, with post traumatic stress disorder (PTSD) the most common (Fairbank, Ebert, & Caddell, 2001). Other consequences include acute stress disorder, separation anxiety, generalized anxiety disorder, and behavioral problems (Pine & Cohen, 2002).

Youth in Foster Care Face Unique Mental Health Challenges

Youth in foster care often experience trauma on several levels. Youth in out-of-home care, by definition, have been found to be victims of abuse or neglect after an investigation by CPS. The aftermath of the maltreatment contributes to their traumatic experience. Living in foster care adds the additional stress of being abruptly separated from the family of origin, home, and community. These youth face the uncertainty of multiple placements, unpredictable contact with their families, and the loss of control to make personal life decisions.

Most youth in foster care also have difficult family histories and life experiences that result in increased risk for emotional and behavioral disorders. These children are faced with the loss of their birth parents, extended family, and familiar environments. They also face challenges of living in the foster care system, which can contribute to or exacerbate behavioral and emotional problems because of placement changes, rejection by foster parents or siblings, the stigma of being in care, and other factors. Some of these children develop psychological problems as a result of prior trauma exposure or an accumulation of traumatic stress in their lives (Cook et al., 2005).

The effects of child abuse and neglect on childhood, adolescent, and adult outcomes are numerous and diverse. Research has shown that, although many maltreated youth show resilience in the face of such adversity, children who experience neglect or abuse often have poor immediate and long-term developmental, mental health, and educational outcomes (Bowlby, 1980; Dozier, Albus, Fisher, & Sepulveda, 2002; Schneider & Phares, 2005; Pecora et al., 2010; Brandford & English, 2004). The pathways through which the consequences of maltreatment are manifested are complex—sometimes direct but other times mediated by other maltreatment effects (Kendall-Tackett & Giacomoni, 2003). Increases in aggressive, delinquent, and antisocial behaviors have been noted for children in the general population when exposed to almost any form of child maltreatment (Kendall-Tackett & Giacomoni, 2003). In a study of the effects of maltreatment on development in the areas of communication, daily

living skills, and socialization, researchers found a large gap between maltreated children's chronological age (average 9.9 years) and their developmental age (average 4.4 years), which worsened over time (Becker-Weidman, 2009). Literature also indicates that children with a history of maltreatment are susceptible to mental illness, including PTSD (Dubner & Motta, 1999; Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005), reactive attachment disorder (Greenberg, 1999; Lyons-Ruth & Jacobvitz, 1999) depression, anxiety, and acting-out symptoms (Lyons-Ruth, 1996; Lyons-Ruth, Alpern, & Repacholi, 1993).

In addition to experiencing vulnerabilities in development and mental health, child victims of maltreatment are one of the most educationally at-risk populations of students (Zetlin & Weinberg, 2004). The multiple traumas and experiences of youth in foster care can impair their ability to function in school (Cook et al., 2005). Results from various studies support a causal link between maltreatment and school performance (Eckenrode, Laird, & Doris, 1993; Leiter, 2007). Compared with other children, maltreated children score lower on intelligence and achievement tests, are more often retained for at least one year in school, demonstrate weaker cognitive abilities, earn lower grades in reading and math, and fail to complete high school at higher rates (Altshuler, 1997; Eckenrode, Laird, & Doris, 1993; Parrish et al., 2001; Zetlin & Weinberg, 2004). Children who have experienced maltreatment also have behavioral problems in school. Difficult behaviors exhibited by maltreated children include “. . . aggression, demanding, immature and attention seeking behaviors to withdrawn, anxious and over-compliant behaviors” (Zetlin & Weinberg, 2004). Without adequate support and services to help children with a history of maltreatment, they will continue on a trajectory of being unsuccessful in development, mental health, and academic performance.

Despite this recognition of the negative consequences of child maltreatment and trauma, the data on the mental health functioning of youth in foster care and alumni of care are limited. Consequently, there is growing support for careful assessment and treatment of children entering the child welfare system. Stahmer et al. (2005, p. 891) wrote:

Studies examining behavior problems report as many as 25–40% of children under age six entering out-of-home care have significant behavior problems (Reams, 1999; Urquiza, Wirtz, Peterson, & Singer, 1994; Hochstadt, Jaudes, Zimo & Schachter, 1987). This is much higher than the overall prevalence rate of behavioral issues in the general population of preschoolers, which has been estimated at between 3% and 6% (Achenbach & Edelbrock, 1981; Institute of Medicine, 1990).

A recent study of the National Survey of Child and Adolescent Well-Being (NSCAW) by Stahmer and colleagues (2005) involved a sample of children being served by child welfare. The NSCAW study found that nearly half (48 percent) of the youths aged 2–14 who had been investigated by CPS for suspected maltreatment had clinically significant emotional or behavioral problems (Stahmer et al., 2005). Additionally, Brandford and English (2004), in a study of youth aged 19–20, found that although most young adults participated in counseling services, about two in five (42 percent) had positive indicators for depression. Meanwhile, self-reports of mental health functioning made by older adolescents in foster care have indicated problems falling into the “borderline clinically significant” category for internalizing behavioral problems (25 percent) and externalizing behavioral problems (28 percent) (Auslander et al., 2002). These prevalence rates for behavior problems among youth in foster care are significantly higher than those among children in the general population.

Furthermore, a small study of children in California found consistently high rates of emotional and behavioral disorders among children in foster care using the Child Behavior Checklist, with rates in the borderline or clinical range at 2.5 times that found in the general population (Clausen, Lansverk, Ganger, Chadwick, & Lotrownik, 1998). A large study of children receiving medical assistance found that the rate of emotional and behavioral disorders among children in foster care was twice that of youth who were receiving Supplemental Security Income (SSI) and close to 15 times that of children who were receiving other forms of medical assistance (dosReis, Zito, Safer, & Soeken, 2001).

The Casey Field Office Mental Health Study (CFOMH) included a sample of adolescents aged 14–17 in foster care (White, Havalchak, Jackson, O'Brien, & Pecora, 2007). The study used the Composite International Diagnostic Interview (CIDI) to determine the rates of lifetime and past-year mental health disorders among adolescents in Casey's private foster care program compared with a sample of youth in the general population. About three in five (63.3 percent) youth being served by Casey had a lifetime CIDI diagnosis, and about one in five (22.8 percent) had three or more lifetime diagnoses. The most common lifetime diagnoses were Oppositional Defiant Disorder (29.3 percent), Conduct Disorder (20.7 percent), Major Depressive Disorder (19.0 percent), Major Depressive Episode (19.0 percent), Panic Attack (18.9 percent), and Attention Deficit Hyperactivity Disorder (ADHD) (15.1 percent).

In summary, youth in foster care face unique mental health challenges. Their maltreatment and foster care experiences contribute to the multiple stressors in their lives. While data on the mental health functioning of youth in foster care are limited, the existing literature suggests that the effects of these traumatic experiences can manifest as serious emotional, behavioral, or social problems

Multiple Access Barriers Prevent Youth in Foster Care from Obtaining Mental Health Services

Despite the need for services, youth in foster care—youth of color in particular—often do not have access to the care they need (Van Voorhes et al., 2006; Wisdom, Clark, & Green, 2006). Barriers to reaching the general foster care youth population include (1) lack of available, experienced mental health professionals, (2) limited or no coordination between mental health professionals and child welfare social workers, and (3) lack of training for foster parents on recognizing mental health issues and accessing mental health care (Kerker & Dore, 2006). Among children involved with the child welfare system, 25 percent had received mental health services in the past year, and 32 percent had high levels of behavioral and emotional problems and received no mental health services in the past year (Kortenkamp & Ehrle, 2002).

Summary

As this brief review suggests, the research on the effects of child maltreatment on child and adolescent mental health provides key information that establishes that significant rates of single disorders and comorbid disorders that are present among these children. In spite of the

need for mental health services for youth in foster care, numerous obstacles prevent adequate provision of these services to this population. This toolkit was developed in response to a clear need for accessible mental health treatment for youth in foster care to address their mental health needs.

This toolkit provides information and resources for implementing CBITS or SSET with youth in foster care. While CBITS/SSET has been implemented only within schools, it may also be possible to implement these programs in other settings, such as community-based mental health clinics, foster family agencies, CPS agencies, and other sites where youth in foster care are served. Depending on the setting, it is possible to form a group made up of only youth in foster care. The implementation steps recommended in this toolkit were based on the pilot project, which involved delivering CBITS to groups made up of only youth in foster care. However, the toolkit was also designed to help provide guidance for implementing and adapting CBITS or SSET in a mixed group with both youth in foster care and others.

In 2007, Casey Family Programs funded a pilot project to implement and evaluate an evidence- and school-based mental health intervention with early adolescents in foster care. The intervention, Cognitive Behavioral Treatment for Trauma in Schools (CBITS), is an evidence-based practice that had previously been implemented in the general education system in Los Angeles, primarily with school children of color. This toolkit was developed through our collaboration with a large urban school district, a county child welfare agency, and other community stakeholders on this project. The pilot project helped identify some of the challenges faced when implementing a mental health program for youth in foster care within the school system. Some of the implementation challenges included collaboration between the child welfare and education systems, confidentiality and information sharing policies regarding youth in foster care, and identification of youth in foster care. For more information about that pilot project, see “Overcoming challenges to implementing and evaluating evidence-based interventions in child welfare: A matter of necessity” by Maher et al. in *Children and Youth Services Review*, 31(5): 555–562. We also conducted a focus group with foster care alumni, Los Angeles Unified School District (LAUSD) staff, and Department of Children and Family Services (DCFS) staff for additional insights on adapting the program for youth in foster care.

While the toolkit has not yet been tested in multiple communities, the content of the toolkit was developed via a rigorous collaboration with foster care alumni and providers (educators, clinicians, social workers) who work with this population. The challenges faced during the pilot project effort helped shape the recommendations and strategies for implementing CBITS/SSET. This toolkit outlines the steps involved in preparing to implement CBITS/SSET with youth in foster care, including recommendations on how to form relationships to facilitate implementation; prepare to deliver services for youth in foster care; prepare participating youth for the program; adapt the program lessons, activities, and examples for youth in foster care; and follow up and track participants.

We hope that the toolkit provides concrete guidance on what to anticipate in planning, implementing, and evaluating the impact of CBITS or SSET for youth in foster care. This toolkit was designed to be used as a companion to the CBITS or SSET manual. Further, it should be used as a starting point to increase dialogue among providers interested in improving how we address issues of trauma for this population.

CBITS and SSET Overview

In this section, we describe both the CBITS and SSET program. We summarize the skills learned, the components of the curricula, who should conduct the program, and how we know the program works. We then discuss why CBITS and SSET are appropriate for youth in foster care.

CBITS Overview

What Is CBITS?

CBITS is an evidence-based, skills-based, cognitive and behavioral therapy intervention for reducing children’s symptoms of PTSD, depression, and general anxiety caused by exposure to violence (Jaycox, 2004; Kataoka et al., 2003; Stein et al., 2003). The theoretical underpinnings are based on cognitive behavioral theory regarding anxiety and trauma. In short, this theory postulates that a traumatic event produces maladaptive assumptions and beliefs about the world (“It is extremely dangerous”), other people (“They cannot be trusted”), and the self (“I am not able to handle things”) that interfere with recovery. Moreover, extremely frightening events can create learned fear responses that may be quite disabling. In these situations, any trauma reminder can create a surge of anxiety. Over time, people who work to avoid such “triggers” in order to reduce the anxiety can have trouble recovering from the experience. Cognitive-behavioral therapies work to teach people skills to combat these underlying issues, including correction of maladaptive assumptions, processing the traumatic experience instead of avoiding it, learning new ways to reduce anxiety and solve problems, building peer and parent support, and building confidence to confront stress in the future.

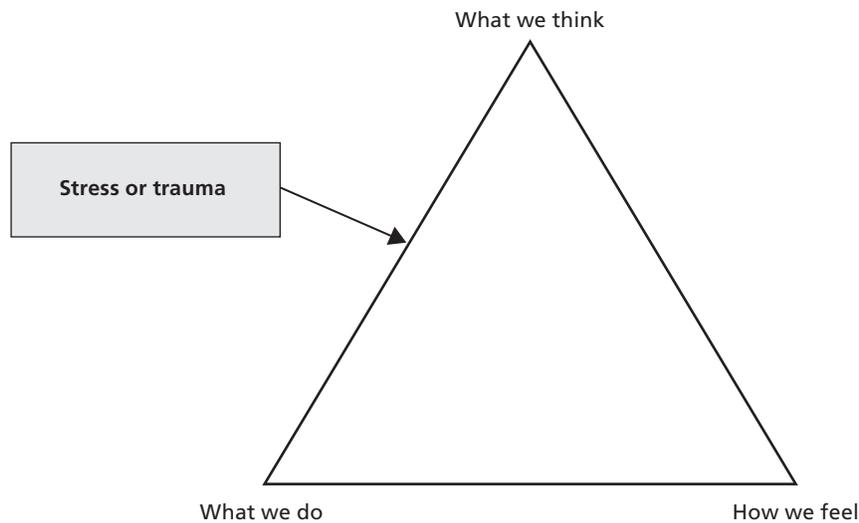
CBITS was designed to overcome some of the barriers to youth receiving mental health services. The intervention is intended for children aged 10–15 (grades 5–9) who have had substantial exposure to violence and who have symptoms of PTSD in the clinical range. CBITS incorporates cognitive-behavioral therapy skills in a group format (6–8 students per group). CBITS is different from other types of therapy because it

- provides structured sessions where skills are practiced
- offers relatively simple tools that youth can use to reframe their stress and anxiety
- combines group and individual sessions
- includes sessions with parents and teachers
- emphasizes collaboration between student and group facilitator.

What Skills Do Youth Learn?

CBITS focuses on several types of skills that are useful for youth dealing with trauma. In short, CBITS focuses on helping students recognize the relationship between thoughts, feelings, and actions using the cognitive triangle (Jaycox, 2004), as shown in Figure 1.

Figure 1—The Cognitive Triangle



The skills that youth learn to deal with their trauma include

- relaxation
- cognitive restructuring
- addressing fears
- social problem solving
- reducing avoidant coping strategies.

What Are the Topics Covered in Each CBITS Session?

Each CBITS session usually begins with a debriefing from the last session and a review of homework, an overview of the new concept for the day's session, practice with that concept via a skills-based activity, and the assignment of homework related to that skill to be completed before the next session (Jaycox, 2004). The session topics are outlined in Table 1.

Who Should Conduct CBITS?

CBITS was developed for use by school-based mental health professionals. This toolkit does not replace the CBITS manual. Instead, it should be used in tandem with the CBITS manual. Mental health professionals who plan to implement the program with youth in foster care should use this resource to supplement the CBITS manual.

Table 1—CBITS Session Topics

Session	Component
Child Sessions	
1	Introduction of group members, group procedures
2	Education about common reactions to stress or trauma
3	Thoughts and feelings: Introduction to cognitive therapy
4	Combating negative thoughts
5	Avoidance and coping
6	Exposure to stress or trauma memory through imagination, drawing, writing
7	Exposure to stress or trauma memory through imagination, drawing, writing
8	Introduction to social problem solving
9	Practice with social problem solving and combating negative thoughts
10	Relapse prevention and graduation ceremony
Parent Sessions	
1	Education about reactions to trauma, how we explain fear, relaxation
2	How we teach children to change their thoughts and actions
Teacher Session	
1	Education about reactions to trauma, elements of CBITS, tips for teaching youth who have been traumatized

How Do We Know CBITS Works?

Two evaluations of the program have been published, both conducted under normal school conditions within LAUSD. In both studies, school-based clinicians were trained for two days on how to implement CBITS and were closely supervised throughout the implementation period to ensure quality and fidelity to the program.

The first study evaluated the program for recent immigrant Latino children in LAUSD schools in a quasi-experimental design, using social workers to implement the program (Kataoka et al., 2003). Students were randomly assigned to the treatment group or a wait list comparison group. At the three-month follow-up, depressive symptoms in the CBITS group significantly decreased (by 17 percent) but did not change in the wait-list group. PTSD symptoms in the CBITS group had significantly decreased at the three-month follow-up (by 29 percent) but did not decline significantly in the wait-list group. Of those students with clinical depressive symptoms at baseline, mean depression scores for the CBITS group dropped significantly at the three-month follow-up (by 22 percent), compared with a nonsignificant drop of 5 percent in the wait-list group. Of those students with clinically significant PTSD symptoms at baseline, follow-up scores declined significantly in the treatment group (by 35 percent), compared with a nonsignificant decline of 16 percent in the wait-list group.

The second evaluation was a randomized controlled study conducted during the 2001–02 academic year to assess the effectiveness of CBITS, using school mental health clinicians to implement the program (Stein et al., 2003). Students were randomly assigned to a ten-session standardized cognitive-behavioral therapy early intervention group or to a delayed intervention group conducted by trained school mental health clinicians. The sample consisted of sixth-grade students at two large middle schools in East Los Angeles. Data from students were collected at baseline, at three months, and at six months. At the three-month follow-up, students who received the CBITS intervention had significantly lower self-reported symptoms of PTSD and depression than students in the wait-list group. Parents of children in the CBITS intervention group reported significantly less psychosocial dysfunction for their children than parents of children in the wait-list group. Three months after completing the intervention, students who initially received the intervention maintained the level of improvement seen immediately after the program ended. At six months, improvement in children on the wait list (who had received CBITS prior to the six-month assessment) was comparable with that of those children who completed the program first.

In addition to these evaluations, CBITS has been implemented in other communities across the country, including ongoing work in the Los Angeles area. These communities include, among others, Baltimore, Maryland; Chicago, Illinois, St. Louis, Missouri; Jersey City, New Jersey; Washington, D.C.; Denver, Colorado; Madison, Wisconsin; several Native American reservations in Montana and Minnesota; and the New Orleans, Louisiana, area. The implementation of CBITS in New Orleans followed closely after the hurricanes of 2005 and focused on post-disaster experiences as well as violence exposure.

SSET Overview

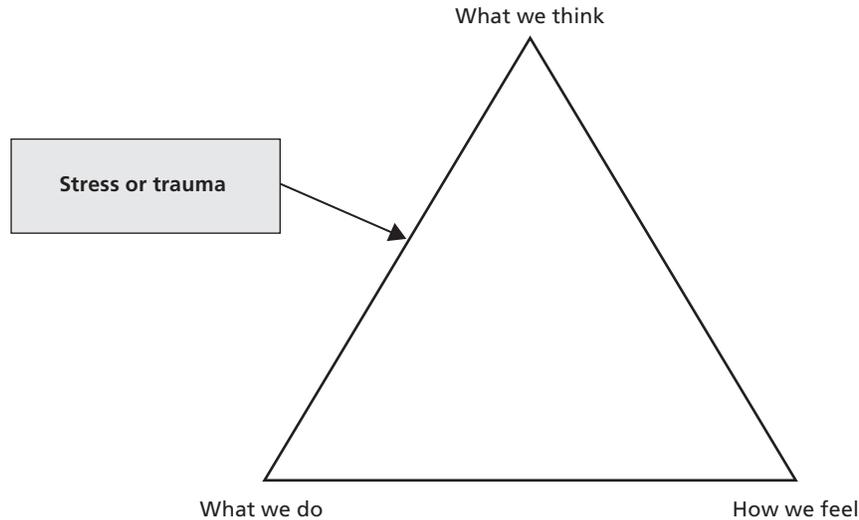
What Is SSET?

The SSET program was developed to train teachers and school counselors in the CBITS model. Since many schools face difficulties in terms of the availability of clinicians to work in schools, in 2009 researchers developed and pilot tested a modified version of the CBITS program that could be implemented by school staff who are not formally trained in mental health or clinical services.

As with CBITS, SSET is meant to be used with students who have experienced trauma and have symptoms of PTSD. SSET was developed for middle school students (ages 10–14) but it may also be useful for those in grades 4–9.

What Skills Do Youth Learn?

Like CBITS, SSET is a skills-based program designed to help youth deal with trauma. SSET also uses the cognitive triangle (Figure 2) to help students recognize how thoughts, feelings, and actions are related (Jaycox, Langley, & Dean, 2009). The skills taught are meant to help students change negative thoughts and to promote positive behavior.

Figure 2—The Cognitive Triangle

What Are the Topics Covered in Each SSET Session?

The SSET sessions usually begin with a review of the agenda for the session and the homework from the previous session. The sessions then move to an introduction to the new concept and a skills-based activity to practice the concept. The sessions end with an explanation of the homework assignment and a review of how to use the skills introduced during the session to complete the homework (Jaycox, Langley, & Dean, 2009). The session topics are outlined in Table 2. The SSET manual describes the implementation process and provides lesson plans, materials, and activity sheets for each of the ten group sessions.

Table 2—SSET Session Topics

Session	Component
1	Introduction
2	Common reactions to trauma and strategies for relaxation
3	Thoughts and feelings
4	Helpful thinking
5	Facing your fears
6	Trauma narrative, part one
7	Trauma narrative, part two
8	Problem solving
9	Practice with social problems and helpful thinking
10	Planning for the future and graduation

Who Should Conduct SSET?

SSET was adapted from CBITS for use by any school personnel, such as a teacher or counselor, with the time and interest to work with students affected by trauma. This toolkit does not replace the SSET manual.

How Do We Know SSET Works?

Results of a pilot test showed that this model was feasible for delivery by teachers and school counselors and acceptable to families and implementers. It showed promise in reducing depressive and PTSD symptoms, particularly among those who began the program with a higher level of distress (Jaycox et al., 2009).

Appropriateness of CBITS and SSET for Youth in Foster Care

As described earlier, youth in foster care often experience multiple and complex trauma and face challenges with the resulting emotional, behavioral, and social problems. Both CBITS and SSET are appropriate for youth in foster care because the programs focus on reducing trauma symptoms and providing skills to help students handle stress. In addition, both programs were developed with youth of color who closely match the racial/ethnic composition of youth in foster care.

Many youth in foster care do not obtain mental health services due to issues of access and service availability. CBITS or SSET overcomes these challenges by providing services in schools, where students spend much of their day. Given the transition and mobility issues for youth in foster care, schools can be a constant place for them where they can be easily reached.

More Information About CBITS or SSET

The CBITS manual is available at <http://sopriswest.com/>, and the SSET manual is available at http://www.rand.org/pubs/technical_reports/TR675/. In addition, more information about the CBITS and SSET programs can be found at <http://www.rand.org/health/projects/cbits/>.

Ongoing technical assistance and training in the CBITS model and other trauma-informed services for schools are offered through the National Child Traumatic Stress Network, Treatment Services Adaptation Center for Schools (www.tsaforschools.org). The center's Web site also contains information on various resources, including fact sheets, brochures, the Students and Trauma DVD, and the CBITS DVD.

Step-by-Step Guide to Adapting CBITS for Youth in Foster Care

This toolkit was developed to provide the tools necessary to adapt CBITS or SSET for implementation with youth in foster care. The following five sections of this manual are designed to help prepare you to deliver CBITS or SSET to youth in foster care. The following checklist provides an overall guide to the recommended steps in this process.

Step 1: Form Relationships to Facilitate CBITS/SSET Implementation with Youth in Foster Care

- Identify and build partnerships with key stakeholders.
- Educate stakeholders about trauma and its affect on youth in foster care.
- Establish a clear staffing, training, and consultation plan.

Step 2: Prepare to Deliver Services to Youth in Foster Care

- Target youth in foster care for inclusion.
- Identify youth in foster care.
- Determine who needs to grant permission and engage relevant parties.
- Disseminate information and recruit youth.
- Obtain permissions and screen youth.

Step 3: Prepare Youth in Foster Care for CBITS/SSET

- Conduct individual meetings with youth to
 - review screening results
 - select traumatic event
 - discuss group format
 - discuss confidentiality
 - assess the youth’s appropriateness for the group.

Step 4: Review Adaptation Materials for Youth in Foster Care

Step 5: Follow Up and Track Youth in Foster Care

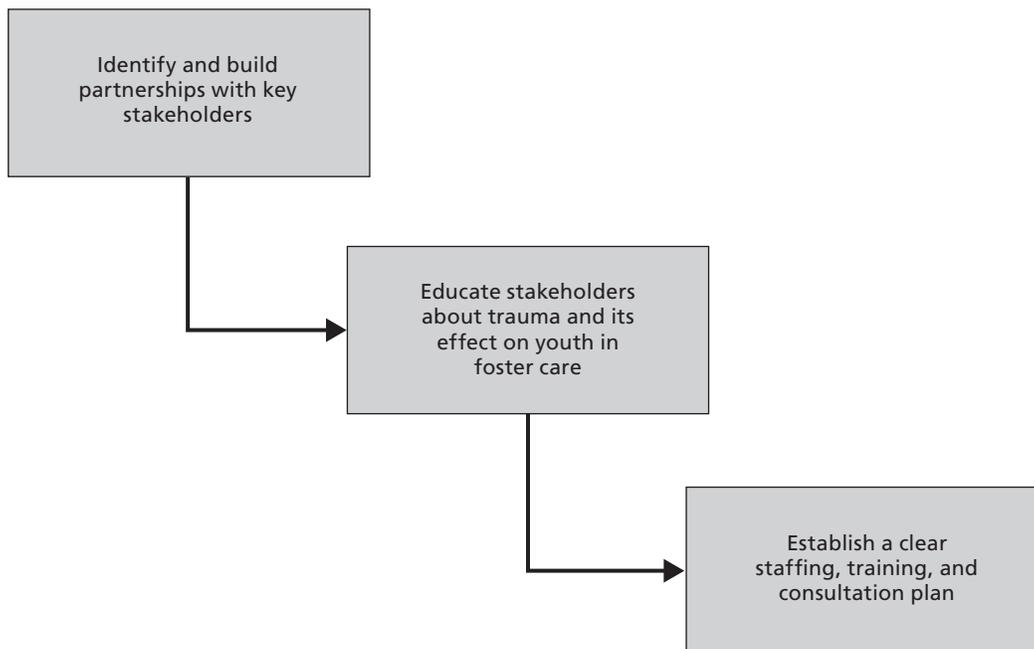
- Notify relevant parties of program completion.
- Plan for additional care and referrals.

The timeline for implementing CBITS/SSET groups will depend in part on the specific jurisdiction, setting, and composition of the groups. Other implementations of CBITS/SSET have taken 6–7 months, including start-up activities, training, screening, and the individual and group sessions. Since there are additional challenges to identifying youth in foster care and obtaining the necessary petitions, it may take longer to create groups of these youth.

Step 1: Form Relationships to Facilitate CBITS/SSET Implementation with Youth in Foster Care

Before starting to implement CBITS/SSET for youth in foster care, several preliminary steps should be taken (see Figure 3).

Figure 3—Preliminary Steps Before Implementation



Identify and Build Partnerships with Key Stakeholders

Several groups are involved in caring for youth in foster care. As early as possible, it is important to engage all key stakeholders in the decisionmaking process for delivering CBITS/SSET to this population. Five broad activities can be used to engage the relevant groups.

Assess the Feasibility of Implementation in the Target Setting. In most instances, CBITS/SSET has been implemented within schools. Other possible settings include community-based mental health clinics, foster family agencies, CPS agencies, and other sites where youth in foster care are served. Regardless of the setting, it is imperative that representatives from the target setting be engaged as early as possible in the planning phase. During this phase, preliminary conversations should focus on answering the following questions:

- Does the setting serve a sufficient number of youth in foster care for the planned implementation?
- Can youth in foster care be easily identified and accessed at the target setting?
- Does the setting have facilities where the CBITS/SSET sessions can be conducted on a weekly basis?
- Are clinical staff available to conduct the CBITS/SSET sessions?
- If the sessions are being conducted in a school setting, is the district and/or school leadership staff (e.g., superintendents, principals, and teachers) on board with plans to implement CBITS/SSET in the schools?

Identify Potential Partners. Potential partners for the implementation of CBITS/SSET with youth in foster care include groups that have legal authority to make decisions on behalf of youth in foster care. In addition, some of the groups advocate for the best interests of youth in foster care, and some provide direct services to these youth. Each group would have a keen interest in the implementation of CBITS/SSET with this population. They include

- local school districts
- local CPS agency
- local mental health agency
- juvenile dependency court
- attorneys for the youth (if applicable—not all youth in foster care are represented by attorneys)
- CBITS experts who can provide training and clinical consultation
- clinical staff to implement CBITS
- local community-based organizations
- advocacy agencies
- foster/kin/biological parents
- foster care alumni.

Initiate Contact with Each Potential Partner. Once the potential partners have been identified, the next step is to attempt to reach agreement that the target population may benefit from participating in CBITS/SSET. If everyone agrees to move forward with the program, then determine the role of each partner and identify the main point of contact within the group. In addition, ascertain which group(s) will serve as the primary leader(s) of the program.

Some key tasks to consider when implementing CBITS/SSET include

- educating stakeholders about trauma and its effects on learning (see below)
- identifying youth (see Step 2)
- securing necessary permissions from groups who have decisionmaking authority for the youth (see Step 2)
- gaining consent from individuals responsible for making decisions for the youth (see Step 2)
- gaining the assent of youth and screening them (see Step 2)
- preparing youth for the program (see Step 3).

Each partner should determine which of the aforementioned tasks he or she will complete.

Establish Formal or Informal Partnership Agreements. After the partners are in agreement about their roles, formal or informal agreements should be established. Partner agreements should include a clear delineation of each partner's roles and responsibilities. In addition, since youth in foster care are a highly protected population, it can often be difficult to share information about them across groups. Thus, agreements should address information-sharing and confidentiality limitations.

Schedule Ongoing Project Planning and Implementation Meetings. Once the partnerships have been created, the next step is to develop a schedule for regular meetings to discuss planning and implementing the program.

Educate Stakeholders About Trauma and Its Effect on Youth in Foster Care

It is also important to educate stakeholders about trauma and its effects on children and about the specific issues that youth in foster care have regarding maltreatment and access to mental health services. The National Child Traumatic Stress Network has compiled information for educators on trauma and its effects on children (www.nctsn.org). The LAUSD Treatment Services Adaptation Center for Schools has also developed materials on trauma and learning and tools for implementing CBITS (www.tsaforschools.org).

Establish a Clear Staffing, Training, and Consultation Plan

The next task is to develop a clear staffing, training, and consultation plan. First, determine who will be responsible for facilitating the CBITS/SSET sessions. Typically, there is one group facilitator per 4–6 youth. If the plan is to conduct groups with 7 or more youth, consider using a second facilitator for the large group or creating a separate group for the additional youth.

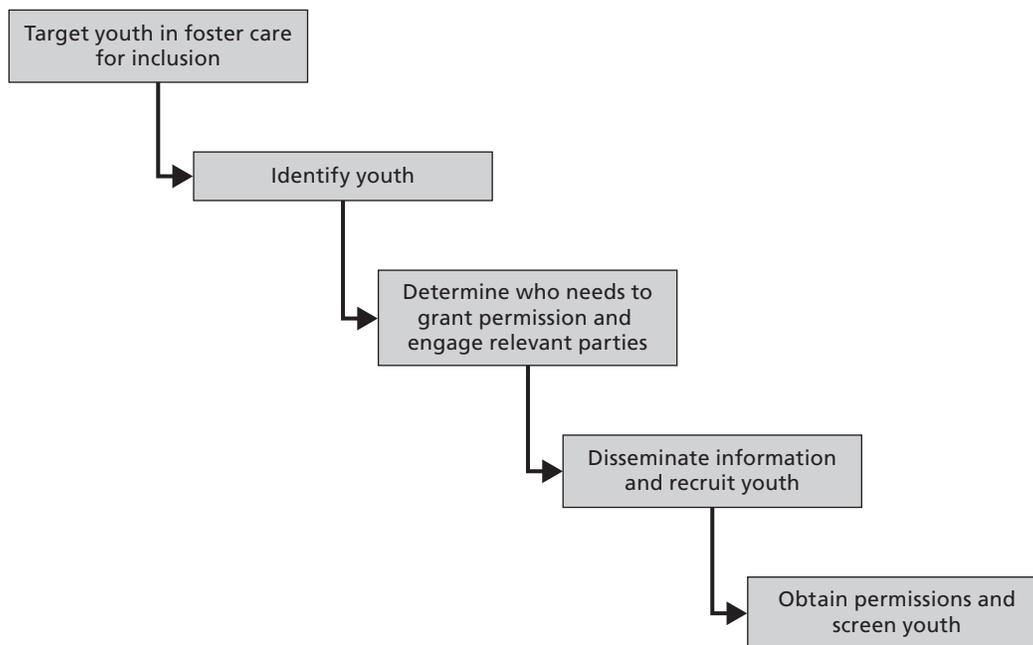
Second, identify the requisite number of trainers to train the facilitators. In previous implementations of CBITS, facilitators completed 16 hours of training on conducting CBITS. Training sessions should include ample opportunities for the facilitators to practice their new skills. Training for SSET is similar to CBITS.

Finally, identify CBITS experts who can provide regular clinical consultation to the group facilitators. LAUSD's Trauma Services Adaptation Center for Schools and Communities Web site has a variety of materials and resources related to CBITS (www.tsaforschools.org). Often, clinical consultation consists of one-hour, weekly, in-person group meetings between the facilitators and the consultant throughout the implementation period. Clinical consultation provides the facilitators with an opportunity to share lessons learned, discuss challenges they may be having, and obtain additional training as needed. Once the CBITS or SSET session leaders and experts are identified, establish a schedule for the training session(s) and develop a plan for ongoing clinical consultation during the implementation of the program.

Step 2: Prepare to Deliver Services to Youth in Foster Care

A series of preparatory activities should occur before services can be provided to youth in foster care (see Figure 4). These steps are relevant when the CBITS/SSET groups being planned are made up of only youth in foster care. For groups with both youth in foster care and others, it may be necessary to address some of these issues only with the participants who are in foster care. The first step is to target youth in foster care for inclusion in the group by considering the criteria for participation in CBITS/SSET. The second step is to identify the youth. The third step is to determine who needs to grant permission for youth in foster care to participate in CBITS/SSET and to make the appropriate notifications to relevant parties. The permission discussed in this step refers to permission for the youth in foster care to participate in both the screening and the CBITS/SSET program. In prior work with CBITS/SSET, the permissions and consents were obtained in different ways in different projects—sometimes with two stages of permission (one for screening/eligibility determination, one for the CBITS/SSET program) and sometimes with just one stage (for the whole process of screening and CBITS/SSET participation if eligible.) In working with youth in foster care, the single permission process may be most expeditious, since several layers of permissions and consent may be required. The next step is to disseminate information and recruit youth for the program. The final step is to obtain permissions and conduct the screening. Each step is described in more detail below.

Figure 4—Preliminary Steps Before Providing Services



Target Youth in Foster Care for Inclusion

There are three primary considerations for targeting a group of youth in foster care for screening and the program: age, placement and location. In terms of **age**, CBITS/SSET is appropriate for middle school–age youth (aged 10–15). It has been used with older children as well but never tested. Work is under way to adapt the program for younger children. To date, most CBITS/SSET groups have been conducted in middle schools with students in one or two of the grades.

The second eligibility criterion is related to the youth’s **placement** situation. Since there is a caregiver component to the program, it is important to determine the youth’s current placement status. CBITS/SSET is appropriate for most youth in formal out-of-home placements, including

- legal guardians
- foster family homes
- relative or nonrelated extended family member
- adoptive placement homes.

While parent/caregiver participation for other populations is difficult, it may be even more challenging for youth who have out-of-home placements—especially those placed in group homes. Youth in group homes may also participate in CBITS/SSET, but the program would lack the caregiver component (two caregiver group sessions and caregiver involvement in the youth group session homework). Thus, youth in group-home settings may not receive support to complete homework assignments and practice skills from the group sessions. Some youth are also in informal guardianship arrangements that mirror other out-of-home placements. In many cases, these youth are living with relatives and have had experiences similar to those of children in formal kinship care through the CPS agency. Including youth in informal guardianship arrangements would provide a needed service to a population that is often underserved. The screening process described below would be able to screen out those without the same degree of exposure or symptoms.

The third eligibility criterion relates to **location**. For a group to be formed, there needs to be some commonality among the youth identified to participate. CBITS and SSET were designed for the school setting, but it is possible to offer the group sessions at another location, such as a foster family agency, CPS agency office, or community agency. However, it will be more challenging to form a group in one of these settings due to issues in scheduling, transportation, and the like.

Identify Youth

There are several ways to identify youth in foster care for CBITS/SSET screening, and each of them presents challenges. Currently, many school data systems do not track the identity of youth who are in foster care. In addition, although CPS data systems are able to identify youth who are in foster care, they may not contain information about the schools that the youth attend. The considerations listed in Table 3 are important for identifying youth in foster care through the school or CPS.

Table 3—Considerations for Identifying Eligible Youth

Source of Information	Consideration
School	<p>If the school enrollment information includes any indication of the youth's placement status, it may be possible to use enrollment records to find youth in foster care at a particular school.</p> <p>While this may be a starting place to find youth in foster care, caregivers may not have provided information on the youth's placement status when enrolling the child at school.</p> <p>In many instances, schools will not have a systematic way to track whether students are involved with the child welfare system.</p> <p>If the enrollment information is not included in the school database, there may be a social worker, guidance counselor, mental health provider, or someone else at the school who is aware of which students are in foster care and who can help identify them for possible participation in CBITS/SSET.</p>
Child Protective Services	<p>Some CPS agencies have electronic databases that include information about which school a youth currently attends. For these agencies, a search by school can generate a list of youth.</p> <p>However, even if the electronic database includes a field for the current school, the electronic database is often not updated frequently enough to make the information useful.</p> <p>If the information is not available within the electronic database, then it may be possible to query the agency's caseworkers and ask them to help identify youth in foster care attending a particular school. The caseworker should have the most up-to-date information about which school the youth currently attends.</p>

Regardless of the approach, there are some feasibility issues related to identifying youth in foster care:

- **Mobility of youth.** Youth in foster care change placements quite often. Even for those who remain with the same caregiver, the population is quite mobile. School records may not have accurate information about where the youth currently resides. Similarly, the CPS agency's electronic database may not have the youth's current placement. Without the ability to rely on electronic records, it may be necessary to contact the youth's CPS social worker to determine the youth's current school and placement.
- **Changes in caregiver.** In the process of changing placements, youth also may change caregivers. For CBITS, it is important to know who the youth's current caregiver is and how to reach that person during the program. Again, the CPS social worker should have the most up-to-date information about the youth's current caregiver.
- **Inaccurate contact information.** As mentioned above, school and CPS records may not accurately reflect the youth's current placement and living situation. Further, there may not be accurate contact information for the person who must grant permission for the youth to participate in the program. Without the ability to contact this person, it will be difficult to enroll the youth in CBITS.

- **Identity of the person who needs to give permission is unknown.** It may be challenging to determine who needs to give permission for a youth in foster care to participate in CBITS/SSET, particularly if it is someone other than the current caregiver.
- **Whereabouts of person who needs to give permission is unknown.** If the person who needs to give permission for a youth in foster care is the biological parent, it can be challenging to find the parent to ask his or her permission for the youth to participate in CBITS.

Determine Who Needs to Grant Permission and Engage the Relevant Parties

Permissions. In preparing to conduct CBITS/SSET with youth in foster care, the next step is to identify and contact the person who is responsible for granting permission for each youth to participate in the program. This is the person who is able to grant permission for the youth to receive mental health services at school. You cannot recruit youth to participate in the program without first getting permission from the responsible person. The identity of this person will vary depending on the jurisdiction, but it might be the CPS agency social worker, foster parent/caregiver, biological parent, or someone else, such as the education rights holder. For example, in California, the education rights holder is the person who has legal authority to represent the youth's educational interests, consent to education programs and services, and make education-related decisions, including granting permission for participation in CBITS/SSET. The education rights typically remain with the biological parents unless the court specifically removes those rights and assigns them to someone else.

To determine who needs to grant permission for youth in foster care to participate in CBITS/SSET in your jurisdiction, it will be necessary to do the following:

- Check with the local CPS agency to see who has authority to make medical and mental health decisions for youth in foster care.
- Check with the local school district to determine who needs to grant permission for youth in foster care to receive mental health services at school.

In some cases, a youth in foster care may not be living with the person who needs to grant permission for him or her to participate in CBITS/SSET. Often, school systems do not maintain information about foster care status, including the identity of the person who can make education-related decisions for the youth. This information may be available in the CPS database, although it is possible that the data are incorrect or missing, since often there is no requirement to collect or maintain this information. There are also potential issues related to gaining permission from biological parents who have perpetrated the trauma through abuse or neglect. Biological parents are often transient and difficult to locate, given their life circumstances and challenges. In addition, as a result of child victimization, the judicial system may have placed restrictions on the frequency and type of communication between the biological parents and their child. Limited contact between the parent and child may negatively influence the parent's decision to grant permission for the youth to participate in the program.

Once the person who needs to grant permission for the youth in foster care to participate is identified, contact him or her directly. When approaching this person, it is important to be prepared to address any concerns about the youth's participation in CBITS/SSET. We present some possible concerns and responses in Table 4.

Table 4—Concerns About Participation in CBITS/SSET and Responses

Concern	Response
What if my child has already sought counseling with a psychiatrist, psychologist, or counselor or participated in a similar program?	CBITS is not meant to replace any individual counseling that your child might have received. Even though your child has already received some treatment, he may still be having difficulties. The screening survey will determine whether he might need the CBITS/SSET program.
What if my child is already involved in too many extracurricular activities and does not have the time to participate?	The CBITS/SSET sessions are usually held during the school day, so the schedule should not interfere with any after-school activities.
Why does my child have to miss classes to participate?	Usually, CBITS/SSET uses a rotating schedule so that students miss a different class each week. This rotation allows students to participate in CBITS/SSET without missing the same class more than once or twice during the ten-week session. We do not want to pull a child out of class because that is important. In the event of a test, special assignment, field trip, teacher request, etc., a student can miss CBITS/SSET and make up the session individually with the social worker.
How do you think that you are going to help my child?	CBITS/SSET has been shown to help children learn how to handle stressful situations. CBITS/SSET teaches skills that children can then use when stressful things happen. The group is intended to help children manage their feelings around stressful events so they can cope with them better.

The person who needs to grant permission for the youth to participate might offer several different reasons for not allowing the youth to participate:

- The person discussed CBITS/SSET with the youth and the youth made the decision not to participate.
- The person has been the youth's caregiver for an extended period of time (e.g., since birth or an early age) or is a close relative of the youth (e.g., grandmother or aunt). In these circumstances, this person might feel that the youth was not living out of the home and thus was not dealing with any stressors related to being removed from his/her biological parent(s). The youth might also feel this way and feel less of a need to participate.
- The person is in a dispute with the youth's social worker or CPS and is unwilling to participate.

Engage Relevant Parties. In addition to the person who needs to grant permission for the youth to participate in the program, youth in foster care often have multiple agencies and parties involved in their lives, including a CPS agency social worker, attorney (if applicable), person who needs to grant permission for participation, and caregiver. It is important to engage all of the relevant parties in the delivery of CBITS/SSET to youth in foster care. This section provides strategies for engaging different parties.

1. CPS agency social worker and attorney. Since the youth's care is under the purview of the CPS agency, it is necessary to notify the youth's social worker and attorney about their

possible participation in CBITS/SSET. Contacting the social worker early on to tell him or her about the program can help gain access to the youth, caregiver, and education rights holder, who may need to grant permission for the youth to participate. The social worker can make phone calls, send letters, or discuss the program in person with the youth, caregiver, or education rights holder during regular visits, which might help engage all relevant parties and help obtain consent. Likewise, the youth's attorney can be a source of support for the program. The attorney can help determine who needs to grant permission, identify who holds the education rights, and change the education rights holder if necessary to allow the youth to participate.

When approaching social workers and attorneys, it is important to address possible concerns about their client's participation in CBITS/SSET (Table 5). The social workers and attorneys can also discuss the program with the youth and then recommend whether or not to proceed with offering it based on the youth's response.

2. Caregiver. It is also necessary to notify the youth's current caregiver. This may be the person who needs to grant permission for the youth to participate in the program. Even if someone else needs to grant permission for the youth to participate, the youth's caregiver should be notified about the youth's participation. Caregivers may also raise concerns regarding the youth's participation in CBITS/SSET. Some possible concerns and responses are shown Table 6.

Table 5—Concerns of Social Workers and Attorneys and Responses

Concern	Response
Will the youth be able to participate in a group dynamic given the youth's current mental and functional status?	The social worker or attorney can help determine whether CBITS/SSET is appropriate given the circumstances.
Will a youth who is expected to be reunited with biological parent(s) or who has been recently reunited benefit from CBITS/SSET?	CBITS/SSET is designed for children who are experiencing stress and anxiety. The screening survey is used to determine whether or not CBITS/SSET might help, regardless of the youth's current placement situation.
Will a youth receiving other mental health services be able to participate in CBITS/SSET?	Yes, CBITS/SSET can complement ongoing mental health services. It is not meant to substitute for these services.

Table 6—Concerns of Caregivers and Responses

Concern	Response
Why does my child have to miss classes to participate?	See response on Table 4.
What do I have to do to participate?	For parents or caregivers, CBITS/SSET participation involves two optional group sessions to learn about trauma and common reactions to stress or trauma. In addition, there are some homework assignments that involve the youth's parent or caregiver.

Disseminate Information and Recruit Youth

Once permission has been obtained and the appropriate notifications made, a dissemination strategy should be developed to increase awareness of the intervention and recruit participants. There are several possible ways to get the word out and recruit youth to participate in the program. The strategies used will depend on the implementation setting. Possible options include

- distributing flyers to the target population
- asking individuals who work directly with youth, including CPS social workers and school social workers, to invite them to participate
- conducting community meetings to share information about the program.

Obtain Permissions and Screen Youth

Determining the procedures for obtaining permission for the program is an important part of the planning process. As described earlier, the process sometimes involves two stages of permission (one for screening/eligibility determination, one for the CBITS/SSET program) and sometimes just one stage (for the whole process of screening and CBITS/SSET participation if eligible). Since several layers of permissions may be required for youth in foster care, the single permission process may be most expeditious. Some additional considerations include the following:

- If working in schools, it is important to incorporate the normal district or school procedures for obtaining consent for mental health services.
- For youth in foster care, the education rights holder may need to provide the consent for the youth's participation. As outlined above, there are sometimes challenges to finding the education rights holder.
- Even if a one-step permission process is used, there will be a need for continued contact with the relevant parties over time (e.g., to inform them of the results of the eligibility determination or changes in status, such as drop-outs from the group or the end of the group).

After the youth have been identified, the relevant parties have been notified, and permission has been obtained from the appropriate person, it is also necessary to ask permission from the youth to participate in the screening and program. Information about obtaining the youth's permission and the screening process can be obtained from the CBITS developers and trainers (www.tsaforschools.org) or in the SSET manual (Jaycox, Langley, & Dean, 2009).

Step 3: Prepare Youth for CBITS/SSET

Once a youth has screened positive for distress related to exposure to trauma, it is important to prepare the youth for the CBITS/SSET group sessions. The group facilitator should arrange an individual meeting with the youth prior to starting the CBITS/SSET sessions. The individual meeting provides an opportunity to discuss the youth's situation and their responses to the screening survey. Further information about the individual meeting can be found in the SSET manual available at http://www.rand.org/pubs/technical_reports/TR675/. For youth in foster care, there are additional considerations that should be addressed before the first group session.

Select the Trauma

The individual meeting provides an opportunity for the group facilitator to help the youth select the traumatic event that is currently the most distressing or the one interfering the most with daily life. Youth in foster care may also pick their removal from home as the traumatic event bothering them the most. Given the psychological impact that removal has on children, it is possible to use the removal as the trauma exposure and to focus on the attachment and grief issues surrounding the separation from family.

Particularly for youth in foster care, it is important to make sure that the trauma selected is appropriate for group work. For example, if the youth has experienced sexual abuse, the group facilitator should consider whether to help the youth pick a different trauma to work on in the group, since working on sexual abuse in a mixed-gender group at school is generally not seen as helpful. The skills learned in CBITS can generalize somewhat to help the student with the sexual abuse experience as well, but the student will probably also need a referral to work on that issue individually. If sexual abuse is the only trauma, then the youth should be excluded from the group and referred for individual therapy.

Discuss Confidentiality

During the individual meeting, it is important for the group facilitator to carefully introduce the group composition, discuss confidentiality, and review the rules for the group sessions. The youth should understand that the issues and feelings discussed during the group are private and should not be shared outside of the group. Youth in foster care have particular concerns related to stigma and confidentiality, so they may not want to be identified as foster care youth and/or be associated with other foster care youth. In a pilot of CBITS for a group of youth in foster care, the students who participated did not know each other beforehand but did not appear to have a problem being in a group solely for youth in foster care.

During this individual meeting, the group facilitator should also inform the student that mandated reporting is required when students disclose neglect, physical or sexual abuse, and/or domestic violence that is not already known to CPS.

Assess the Youth's Appropriateness

During the individual meeting, the group facilitator should consider the youth's appropriateness for the group format. For youth in foster care, clinical judgment should be used to determine if other factors, such as the youth's current placement status, may prevent successful participation in CBITS/SSET. In these cases, carefully consider an appropriate referral and help the youth link up with those resources.

Step 4: Review Adaptation Materials for Youth in Foster Care

Youth in foster care often experience trauma on several levels, from the stress of being separated from their family of origin to the uncertainty of multiple out-of-home placements. In many cases, these young people do not receive the mental health services that they need. CBITS was developed to reduce symptoms of distress and to build skills to improve children's abilities to

handle stress and trauma in the future. The program addresses the known risk factors for developing chronic disturbances following trauma, including cognitive factors, poor coping skills, and low levels of social support.

For youth in foster care, CBITS/SSET offers several advantages over traditional community-based, individual-level treatment models. First, with its focus on trauma, CBITS has been shown to influence PTSD, depression, and behavior, making it an ideal means to target the diverse problems that foster care youth face. Second, unlike traditional community mental health services, CBITS/SSET is most often provided in a school setting, making it possible to keep youth in place to receive the program rather than pulling them away for clinic-based treatment. Third, the group format of CBITS/SSET offers further advantages because it broadens the reach of the treatment, making it possible to serve more youth than a traditional individual-based therapy model.

Although CBITS has been established as an effective intervention for youths exposed to violence in the general child population, it has not been conducted in a strictly foster care population. In this section, we provide some general tips for implementing CBITS/SSET with youth in foster care and for troubleshooting problems that might be encountered during group sessions. In addition, we provide some specific tips and ways to adapt the examples and activities for each session, including the ten group sessions, two individual session, caregiver sessions, and teacher session. Since some of the standard CBITS/SSET materials, examples, and activities may include potential triggers, concerns, or issues for youth in foster care, these adaptations have been developed to aid group facilitators who are working with groups that include only youth in foster care. However, they can also be helpful for groups that include both youth in foster care and other youth. As noted earlier, this toolkit is a supplement to the CBITS or SSET manual. Please refer to the manual for more details on each session.

- Tips for addressing logistic issues:
 - Work closely with the caregiver, biological parent, or trusted person as appropriate to involve them in helping youth in foster care address their trauma symptoms.
 - Keep track of the youth’s placement situation throughout the course of the sessions.
- Tips for increasing a sense of privacy:
 - Demonstrate an understanding of the stigma that youth in foster care feel because of their living situation by using appropriate terms.
 - Use “placement” instead of “foster care.”
 - Avoid using “home.”
 - Use “trusted person” instead of “parent.”
 - Show sensitivity for the uncertainty and loss of control that comes with being in foster care.
 - Focus on the strengths of youth in foster care.
 - Help youth in foster care feel secure and safe in the group by emphasizing confidentiality and privacy to the whole group.
 - Use examples from the experiences of youth in foster care.
 - Focus on common problems experienced by youth in foster care (e.g., aggression, peer rejection, defiance, and poor school behavior) by using these problems as examples in group discussions.
 - Teach CBITS/SSET skills to youth in foster care by using examples from their experiences.

- Tips for addressing the traumatic event(s)
 - Understand that being in foster care is itself traumatic and that many of these youth have had multiple traumatic experiences.
 - Involve foster youth in their treatment by accepting them as the experts in how to address what is happening in their lives.
 - Avoid examples that might trigger memories of very serious traumatic events (e.g., examples involving beds, lying down, or bathtubs may trigger memories of sexual abuse).

Table 7 presents tips for each session type. An example Hot Seat exercise for use with Group 3 and Group 4 follows.

Table 7—Helpful Tips for the Group, Individual, Caregiver, and Teacher Sessions

Session	Additional Ideas for Working with Youth in Foster Care
Group 1: Introduction	<p data-bbox="444 793 740 821">Lengthen the first session:</p> <ul style="list-style-type: none"> • Remind the group that some youth in the group may be living away from home right now. • Stress issues of confidentiality by developing group rules that reinforce the important things, such as respect and privacy, particularly as they relate to youth in foster care, who may feel sensitive about their living situation. • Differentiate this intervention from other interventions or therapies that youth in foster care may be involved with. • Plan for group closure. <p data-bbox="444 1094 1276 1148">Consider additional confidentiality examples that are more specific to this population:</p> <ul style="list-style-type: none"> • “Let’s say that there is a boy named Joe in this group. If Joe were to tell everyone in the group that there was a lot of fighting at home and he couldn’t live there, would it be okay to tell a classmate at school that he said that? Why not?” • “Let’s say there is a girl named Angela in this group. If Angela tells everyone in the group why she is not living at home, would it be okay to tell a classmate at school who Angela is and why she is in the group?” • “Let’s say there is a girl named Tasha in this group. If Tasha tells everyone in the group that her foster mom was not feeding her, would it be okay to tell a classmate at school?” • “Let’s say there is a boy named Derrick in this group. If Derrick tells everyone in the group that he has been abused by his foster parent, would it be okay to tell classmates at school?” <p data-bbox="444 1562 1386 1738">Discuss the selection of a “trusted person” to help with the homework activities. The trusted person should be someone who can support the youth during their participation in CBITS/SSET. It could be a caregiver, teacher, coach, or other person the youth feels comfortable talking with about issues that may be bothering them. Revise the goal worksheet and parent letter to refer to a “trusted person” since the youth may not be living with his or her parent.</p>

Table 7—Continued

Session	Additional Ideas for Working with Youth in Foster Care
Group 2: Education and Relaxation	<p>Youth in foster care may not have a parent, caregiver, or significant person that they would like to engage in the activities. Make sure the youth understand that they should not be worried about this. The activity for this session is just meant as something that might help them but is not required.</p> <p>There also may be issues with engaging the parent or caregiver in the activity for this session. Remember that sometimes youth have a contentious relationship with their caregiver. In the absence of an available trusted person, be prepared to work closely with the student yourself to complete the activities.</p>
Group 3: Introduction to Cognitive Therapy and Group 4: Combating Negative Thoughts	<p>Consider the following examples of things that might make youth in foster care upset:</p> <ul style="list-style-type: none"> • I have to go to court. (Note: Students may be afraid that the judge will tell them that they can't ever see their parents again.) • I got a summons to go to the office at school. (Note: Students may have been picked up from school by the police and/or social worker when they were taken away from their biological parents.) • I am starting a new school (again). • Someone finding out that I don't live with my biological parents.
Group 5: Introduction to Real Life Exposure	<p>Consider referring to the "Fear Thermometer" as a "Feeling Thermometer." Use the adapted Hot Seat exercise example at the end of this section.</p> <p>Review the questions in the "Construction of Fear Hierarchy" activity to determine if any of them may be especially upsetting for the specific youth in the group, knowing their histories and sensitivities.</p> <p>Youth may have some complicated fears and thoughts related to being moved to foster care or may experience instability with permanency plans and the court process. Group facilitators should work with youth to identify one or two situations that do not cause them overwhelming distress to focus on during the CBITS sessions. This will help them address the more manageable concerns first.</p> <p>Consider separation from family as a traumatic event. In some instances, the traumatic event will be separation from family members and not a classic experience of trauma exposure. Exercises for this session may need to be adjusted to account for separation as a traumatic event.</p> <p>Consider additional examples of things that may make youth in foster care feel afraid or nervous:</p> <ul style="list-style-type: none"> • seeing my biological parents or siblings • letting my foster parents get close to me • going to court or school • making new friends or trying new things. <p>Youth in foster care may not have a parent, caregiver, or significant person whom they would like to engage in the activities. Make sure the youth understand that they should not be worried about this. The activity is just meant as something that might help them but is not required.</p> <p>There also may be issues with engaging the parent or caregiver in an activity. Remember that sometimes youth have a contentious relationship with their caregiver. In the absence of an available trusted person, be prepared to work closely with the student yourself to complete the activities.</p> <p>Revise the Facing Your Feeling instructions and the letter to refer to a "trusted person," since the youth may not be living with his or her parent.</p>

Table 7—Continued

Session	Additional Ideas for Working with Youth in Foster Care
Group 6: Exposure to Stress or Trauma Memory	Youth may have some complicated memories related to their experiences in foster care. Make sure the students do not share too much detail about specific events during group discussions. Instead, help them to focus on what they are feeling and thinking.
Group 8: Introduction to Problem Solving	<p>Review the examples in the “Thoughts and Actions” activity to determine if any of them may be especially upsetting for the specific youth in the group, knowing their histories and sensitivities.</p> <p>Use the experiences of youth in foster care in the group to develop alternate examples for this activity.</p> <p>There may be some challenges related to social situations based on what has happened to these youth. For example, youth may raise problems related to living in homes with multiple foster children, or they may have challenges with changing homes and schools regularly and not feeling comfortable engaging with peers. Make sure the students slow down their thought processes and think of several options for how to act.</p>
Group 10: Relapse Prevention and Graduation	<p>Provide youth in foster care with resource information so that they know where to go if they have a particular problem.</p> <p>Let youth in foster care in the group know that their parent, caregiver, education rights holder, attorney, and social worker will be notified by letter about their completion of the program (if applicable).</p>
Individual 1 & 2: Imaginal Exposure to Stress or Trauma	<p>Discuss the youth’s experience during individual meeting to help identify the trauma they will work on for the CBITS group. If the youth has experienced sexual abuse, consider whether to help the youth pick a different trauma to work on in the group, but still work on the sexual abuse during individual sessions. The skills learned in CBITS can generalize somewhat to help the student with the sexual abuse experience during the individual session, but the student may also need a mental health referral to work specifically on that issue.</p> <p>Youth may have some complicated memories related to their experiences in foster care. Help them focus on the most upsetting moments instead of what might be a long and complicated set of experiences.</p>
Caregiver 1 & 2: Caregiver Education	<p>Consider inviting both the youth and caregiver or trusted person to the session to allow for better communication.</p> <p>For the caregiver session for youth in foster care, use the Hot Seat examples at the end of this section.</p>
Teacher: Teacher Education	Remind teachers that youth in foster care often do not want their peers to know that they are not living with their biological parents.

**For use with Group 3: Introduction to Cognitive Therapy and
Group 4: Combating Negative Thoughts**

Name: _____ Date: _____

Hot Seat Exercise (Example)

In the box, write something that happened to you that made you upset. Then write down some of the thoughts you had under “Negative Thoughts.” Use the questions on the “Hot Seat Activity” worksheet to find new ways of thinking about what happened. Refer to the “Hot Seat Exercise Example” to see how to complete your own worksheet.

Revised Example 1:

What happened?	
<i>I stayed up late because I didn't want to fall asleep.</i>	
Negative Thoughts	Helpful Thoughts
<i>If I fall asleep, I'll have nightmares.</i>	<ul style="list-style-type: none"> • <i>I don't have nightmares every night, so I might not have them tonight</i>
	<ul style="list-style-type: none"> • <i>Nightmares aren't real, they can't hurt me.</i>
	<ul style="list-style-type: none"> • <i>I need to get some sleep for school tomorrow, even if it means I have nightmares.</i>
<i>If I fall asleep, something bad will happen.</i>	<ul style="list-style-type: none"> • <i>I'm safe in my house and my bed. My family is here to protect me.</i>
	<ul style="list-style-type: none"> • <i>If something bad happens, I'll wake up and be able to deal with it then.</i>
<i>Trying to fall asleep makes me feel nervous.</i>	<ul style="list-style-type: none"> • <i>I can practice my relaxation if I feel nervous.</i>
	<ul style="list-style-type: none"> • <i>I can remind myself that I am safe.</i>
	<ul style="list-style-type: none"> • <i>It's okay to feel nervous for a little while; eventually, I'll fall asleep.</i>

New Example 2:

What happened? <i>My social worker called to say that s/he would be coming by in 30 minutes.</i>	
Negative Thoughts	Helpful Thoughts
<i>My social worker is coming to move me to another placement.</i>	<ul style="list-style-type: none"> • <i>My social worker comes to visit me every month just to see how I'm doing.</i> • <i>My social worker would tell me over the phone if s/he were going to move me.</i> • <i>I can ask her why she's visiting as soon as she gets here and figure out how to deal with it then.</i>
<i>Something bad happened to my biological family.</i>	<ul style="list-style-type: none"> • <i>If something bad happened, my social worker will help me to deal with it.</i> • <i>It's unlikely that something bad happened to my family. It's probably just a normal visit.</i> • <i>It's possible she has something good to tell me. I'll have to just wait and see.</i>

Step 5: Follow Up and Track Youth in Foster Care

There are two issues to consider when youth complete CBITS/SSET: (1) notifications of program completion to relevant stakeholders and (2) care continuity planning.

Notifications to Stakeholders

Many individuals are responsible for youth in foster care and thus must receive information about the progress of that child on an ongoing basis. Specifically, the child's attorney, social worker, and foster parent should be apprised of the youth's completion of the program. If the biological parent has retained educational rights, that parent also should be informed that his or her child has completed the program. The details of youth progress are not appropriate to share with all stakeholders due to issues of privacy, but these individuals must have the CBITS/SSET completion information to ensure that it is placed in the child's record.

As described earlier, consent may be required from the attorney and social worker in addition to the foster and/or biological parent. Therefore, the communication pathway should have been established prior to the start of CBITS/SSET. Following the completion of CBITS/SSET, a formal letter to each of these stakeholders should address this notification issue.

Care Continuity

Many youth who participate in CBITS/SSET may be in the process of receiving ongoing individual or group mental health services through another agency (e.g., Department of Children, Youth, and Families). Because CBITS/SSET addresses such mental health issues as PTSD, depression, anxiety, and general stress, it is critical that progress with CBITS/SSET be reported to the mental health clinician of record. The clinician would benefit from general progress notes on the youth (see case summary form) and information about CBITS/SSET, if he or she is unfamiliar with the tenets and goals of the intervention. This information will aid the clinician in developing treatment plans that build on or complement the CBITS/SSET efforts.

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