Effecting System Change in the Real World: Implementing and Sustaining Trauma-Informed Practices in a Stressed Child Welfare System

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The New Hampshire Partners for Change Project was a 5-year initiative funded by the Department of Health and Human Services (DHHS), Administration for Children and Families, Children's Bureau, from 2012 to 2017 and one of 20 grantees nationwide tasked with implementing trauma-informed care (TIC) in their state or tribal child welfare systems. The grant was awarded to Dartmouth College in partnership with the New Hampshire Division for Children, Youth and Families (NH DCYF). The overall aim was to improve the well-being of children and families served by NH DCYF by installing TIC practices. Prior to the start of this project, child protective services and juvenile justice services had been collapsed into the same Division (DCYF). Because they shared common leadership, and there was strong interest in closely aligning these systems in their values and practices, we decided to implement our TIC activities in both service systems.

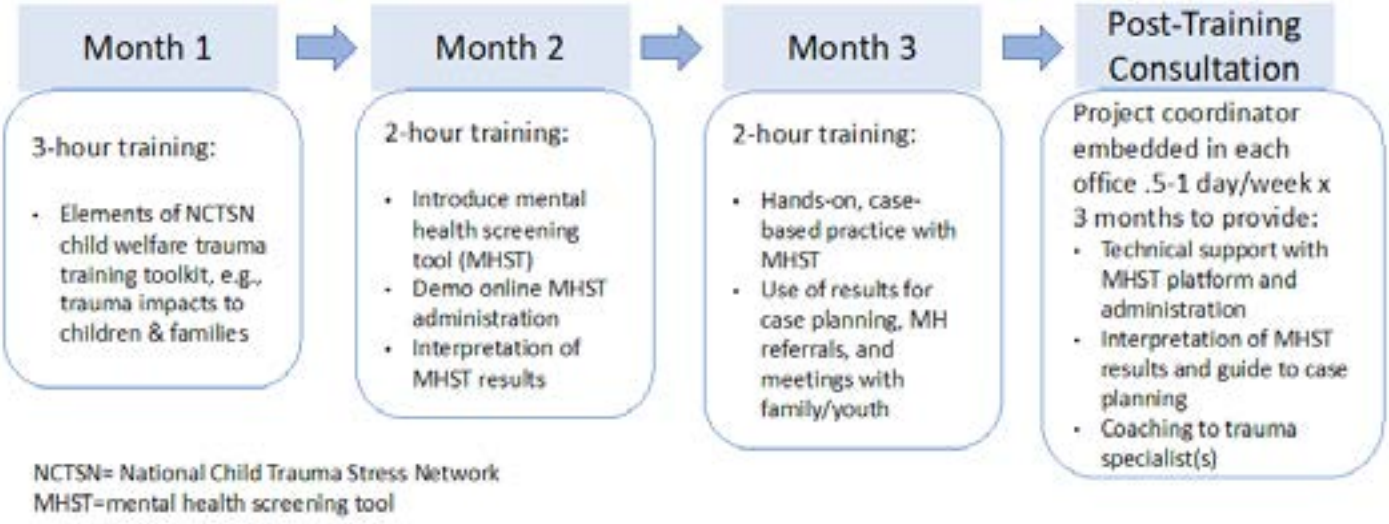
The specific objectives of the Partners for Change initiative included the following: (1) installation of universal screening for trauma exposure, posttraumatic symptoms, and well-being needs of all adjudicated children and youth, (2) data-driven case planning informed by trauma screening results, (3) enhanced progress monitoring through re-screening and increased coordination between child welfare and mental health sectors, (4) increased trauma-focused competencies among child welfare staff, (5) increased collaboration between child welfare and community-based behavioral health services, (6) psychotropic medication monitoring, (7) use of evidence-based trauma treatments by mental health providers, and (8) service array realignment strategies. We implemented the project statewide across 11 DCYF district offices and in the associated mental health agencies that serve these offices.

The child welfare portion of the intervention targeted all DCYF staff and supervisors representing child protection and juvenile justice services in the 11 districts. It focused on providing training in trauma-informed care principles and use of a new screening tool, with ongoing consultation and support to follow. The specific measures in our screening battery varied by age (we had four different batteries based on age of child) but consisted of measures of trauma exposure, posttraumatic stress disorder (PTSD) symptoms, and broad-based mental health and well-being (strengths and difficulties). Additional information about specific measures is available from the first author.

Figure 1 presents the main components of the child welfare intervention. Each district office identified from one to three trauma specialists, direct service staff who were tasked with providing ongoing local support for staff around implementation of trauma-informed practices, with particular emphasis on implementation and interpretation of screening, as well as making informed referrals, including

consulting with workers about how to advocate for trauma-informed mental health services with partner agencies. As part of the intervention, we also worked with DCYF administrators and field staff to establish formal protocols and policies for integrating the TIC activities within the larger operational structure of the child welfare system.

Figure 1. Partners for Change Child Welfare Intervention Components and Timing.



The Change Project also targeted the mental health sector by building and extending capacity statewide for two evidence-based trauma treatment models, trauma focused-cognitive behavioral therapy (TF-CBT), designed for children ages 4–18, and child parent psychotherapy (CPP), developed for children ages 0–6 and their caregivers. We invited clinicians from community-based mental health agencies across the state who worked with DCYF-involved children and youth to be trained in TF-CBT or CPP, or both. We provided face-to-face training and, in the case of TF-CBT, web-based training as well as consultation calls with certified trainers lasting 9 months for TF-CBT or 12 months for CPP.

Challenges

The most significant challenge to implementation, uptake, and sustainability of our change project has been navigating what has seemed a constant stream of stressors and competing priorities in our child welfare system that have occurred simultaneously with the project. We do not implement these projects in a vacuum; crises and competing demands arise simultaneously, often in ways that are not anticipated and understood when planning a project, but yet have major impacts. Stressors that have affected us most significantly are as follows: a burgeoning opioid crisis in New Hampshire, higher than usual rates of staff turnover along with a concomitant workforce shortage in our state causing multiple staff and provider vacancies, a shift to 24/7 coverage at DCYF, and leadership instability at the highest levels of the agency triggered in part by political changes and heightened media scrutiny.

During the past 4 years, our state has experienced a devastating opioid crisis that has put unprecedented demands on child welfare and other social service systems. New Hampshire has one of the highest rates in the country of opioid-related deaths per capita. (New Hampshire Information and Analysis Center, 2017). Deaths resulting from fentanyl-related overdoses increased by over 1,600% from 2010 to 2015 (Meier et al, 2017). In 2012, 31% of new cases at DCYF were associated with a substance misuse allegation; by the end of 2017, this number had climbed to 51%. Although there had been a slight downward trend in the number of children requiring foster care through 2013, between 2014 and 2016 the number of children entering foster care increased by 40%. All ages of children have been affected, but the biggest increase has been in the number of infants and children under age 2 coming into care with evidence of parental

substance misuse (NH DCYF data).

The opioid crisis has increased both the demand for assessments and the caseloads of family service workers who provide the ongoing case management of children in care. This comes at a time when NH DCYF and the state overall have been experiencing a significant human services workforce shortage. Historically, NH DCYF has had a fairly stable workforce, yet over the past several years, it has experienced an unusually high level of turnover, especially among assessment workers and been compounded by a dearth of applicants to fill vacant positions. In 2015 and 2016, some offices had vacancies as high as 40%–50%. As a result, remaining staff were often covering more than one position and carrying higher than normal caseloads (e.g., 13 cases with an average of 60 children, youth, and families served per caseworker in a typical month).

These staffing issues presented a barrier for uptake of the trauma-informed practices in two ways: (1) difficulty in keeping up with training needs associated with a "revolving door" of staff—some with training who left DCYF prematurely and those newly hired requiring training, and (2) remaining staff who were so busy covering the caseloads of those who had left that they did not have sufficient time or attention to fully adopt the new trauma-informed practices. Morale among staff was also low during this time. Project evaluation data (e.g., surveys, focus groups) showed that DCYF workers experienced an increase in their own stress levels as well as increased stress and pressure in their district offices during the project's timeframe. This stress was due in part to higher caseloads and other division stressors of media scrutiny and leadership turnover, as well as concerns about the lack of trauma-informed mental health services for children, particularly the youngest children, in most regions of the state. To add to the staffing issues, the New Hampshire legislature passed into law during the project period that NH DCYF would need to provide 24/7 coverage, leading to the creation of new staffing positions. Not only were these positions difficult to fill but also the situation led to more stress on the workforce because staff were concerned about what it would mean for their own positions and whether they would be required to be available for crisis coverage even more than they currently were.

Finally, a number of leadership changes occurred over the course of the 5-year project, including four DCYF director changes, multiple major DCYF bureau administrator changes, and changes in the Commissioner of Health and Human Services and Governor of the State. Moreover, at least one leadership change was highly publicized and portrayed this leader and the agency in an unfairly negative light. The lack of continuity in leadership at the highest levels and negative publicity presented several barriers for the Partners for Change Project. Although we were fortunate that each DCYF director (and interim director) was supportive of this project, each had his or her own leadership style and priorities. It was difficult for the project team to create traction, continuity, and follow through with the trauma-informed practices due to nearly constant change in leadership. In addition, each leader change carried enough uncertainty that it created anxiety in the field and concern over system stability, which took attention and focus away from adopting new practices. Moreover, despite our best efforts to get new leaders up to speed, we inevitably experienced some loss of institutional knowledge. New leaders brought their own priorities, personality, leadership style, and in some cases, staff. Field staff, as well as our team, had to expend a significant amount of energy toward "reading" the new leader, energy, and focus that otherwise could have gone to continued TIC implementation.

Strategies to Mitigate Stressors

Although these challenges were daunting and at times seemed insurmountable to achieving our goal of instituting TIC practices into our child welfare system, overall we have been fairly successful in installing and maintaining many of the new practices. In the face of each of these competing demands or priorities for the agency, we (i.e., project team and our primary partners from DCYF) strategized and developed a plan for how to best maintain focus and buy-in with the project and adherence to practice change. We used every opportunity to emphasize the relevance of adopting a trauma lens to staff members in their work to manage

the impact of the opioid crisis. Children affected by the opioid crisis are at high risk for experiencing trauma and neglect. Therefore, increasing numbers of children entering the system because of parental opioid misuse created a greater imperative for workers to be trained in trauma and its effects, screening for trauma-related symptoms, and collaborating with the mental health sector to facilitate referrals for trauma-focused treatments. We continued to emphasize to staff at every level that although practice change is difficult when a system is (and staff are) stressed, naming trauma and addressing trauma with one's cases might actually lessen the stress.

We also recognized that the cumulative effect of all these stressors on the system was essentially traumatic for staff. At the same time that we were asking staff to address trauma with their cases, these workers were embedded in a system that also was experiencing trauma. We chose not to implement a formal intervention around secondary traumatic stress (STS) because of concerns that if introduced at the height of the stress in the agency, it would be received as simply one more initiative demanding staff attention and participation and likely would not be well received. Instead, we integrated STS principles and practices into trainings and consultation provided at the district office level and to trauma specialists. Our project coordinator, who was embedded in the district offices, provided considerable support and informal STS training to staff. Furthermore, she was available to provide consultation to workers, particularly around screening and interpreting screening results. In this way, she was a welcome extra resource for district offices that were short staffed.

During changes in leadership, we were fortunate that with the exception of our latest director, all prior directors were known to us. Each was ultimately supportive of the agency becoming more trauma-informed. We also had two child welfare partners (a head bureau administrator and a program specialist) who were with us for the tenure of the project. They were able to provide some continuity and advocate for maintaining project activities throughout all the higher-level leadership changes. We continued to have monthly leadership team meetings despite all the change, in which we tried (and were mostly successful) to have the DCYF director as well as head bureau administrators join calls and participate in key decision making. As established directors and bureau administrators left and new ones came on board, we quickly got new ones up to speed and advocated for maintaining continuity of practice. The entire team regrouped several times, reviewing "one pager" documents and providing an overview and history of the trauma projects. The monthly team meetings became a mix of education about the projects and a discussion about the larger next steps and sustainability. In some ways, the leadership change provided an opportunity to pull out the most salient "lessons learned" and determine sustainability plans earlier than we had originally planned.

Our goal, albeit unspoken and probably not even fully conscious at the time, was to "stay the course"; convey a sense of purpose, confidence, and calm; to be able to ride out the storm. Evaluation activities also provided opportunities to gather staff input to project activities, feedback on barriers and facilitators to uptake, and recommendations from the field to sustain this work. Aggregated evaluation results were shared annually with all DCYF and district office leadership and more frequently with members of the project joint leadership team to inform decisions and examine intermediate outcomes.

Lesssons Learned

A major lesson learned from steering this project through so many system stressors is that contextual factors and their impact must be considered at every phase of a project from planning and design to implementation and sustainability. Although we did plan for certain contextual issues, including changing budgetary climate, differences in culture across district offices, and competing training initiatives, we had not anticipated the extent and impact of the opiate crisis and the consequent increase in number of intakes, assessments, and children entering care; the unprecedented turnover in the agency's workforce; and the number and frequency of leadership changes. The fact that these issues could not have been anticipated when we designed and began this project raises questions about how to optimally address such major

challenges and barriers.

Challenging as it may be, project design must take into account the dynamic nature of many system challenges and pressures while building in sufficient flexibility and responsiveness to the inherent changes in any system, especially one with as much complexity as a state child welfare agency.

Key Sustainability Factors

This project is now in the sustainability phase after a new DCYF director arrived 8 months ago. Over the past year, we have been meeting with a leadership team to transition from project staff to DCYF staff and contracted training partners taking responsibility for oversight and implementation of TIC activities. Although our plan is focused on how to sustain practices established through this project, we are increasingly more cognizant of the fact that changes within the system will arise and present new (and old) obstacles to maintaining these practices. We have advocated for sustaining the full array of TIC practices, but we also have been identifying "bottom line" needs, that is, which resources are absolutely necessary to maintain key practices.

The key factors that have allowed us to have success even in the face of so many obstacles are as follows:

(1) strong, trusting relationships between our university-based team and our state child welfare partners. We have worked together on multiple projects for nearly a decade, and our child welfare leaders were open to, and even solicitous of, our feedback and suggestions on how to maintain and sustain effective TIC practices. The director and leaders higher up in DHHS have seen the need and benefit for TIC and are working collaboratively with our university-based team to commit resources to ensuring sustainability of at least essential practices (e.g., screening).

(2) the need for TIC, despite many barriers. Staff members may have felt overwhelmed and burdened at times with the new and additional demands associated with our TIC activities, but they recognized how traumatized their children and families were and the need for having a systematic approach to addressing trauma in their practice.

(3) taking a very flexible approach to implementation, anticipating obstacles, and trying to identify core ingredients and practices and how to maintain those even in the face of inevitable contextual stressors.

Commentary

Anthony Camelo, MS

Over the last five years or so, NH DCYF and its child protection and juvenile justice field staff have experienced a number of practice changes throughout the agency. One of the changes included the Partners for Change Project, which is a collaborative effort between NH DCYF, Mental Health Provider Community, and the Dartmouth Trauma Interventions Research Center. As a Juvenile Probation and Parole Officer, I was intimately involved in this project from the initial pilot phase to the end that focused on evaluation and sustainability.

My experience with TIC and general impression after several discussions with many field workers across New Hampshire is that we are more informed today about trauma than we were prior to the Partners for Change Project. As part of the project, the team at Dartmouth facilitated quality training, consultation, and support. DCYF staff members are passionate about helping children and families who enter the child welfare system.

A goal of the project was to administer a mental health screening tool on all relevant child protection and juvenile justice cases. The results provided important information about a child's emotional and behavioral health, which could lead to a more comprehensive mental health evaluation and appropriate treatment if needed. Having this information also allowed field staff to have informed discussions with the child and family. We then would re-assess to monitor outcomes to determine if symptoms were getting better or worse. Finally, completing the screening tool allowed us to advocate for the child/parent(s) with other community partners (e.g., law enforcement, court, attorneys,

CASA, community providers, and school officials).

Throughout the project, and much like in other organizations that experience major changes in practice, there have been challenges, which include but are not limited to the following:

- The mechanics of the how and when the screening tool is used may not be effective for every applicable case. For example, in some cases, asking about trauma when first meeting the child and family and before developing a relationship could trigger a strong behavioral response, or they could refuse to answer or not answer honestly.
- If the results yield a positive screen for mental health or PTSD symptoms, field staff are concerned that there is a lack of mental health services to make appropriate referrals.
- Some field staff feel uncomfortable talking about trauma and upsetting events with the child/parent(s) when they feel unqualified to do so.
- Lack of ongoing training offered for field staff and supervisors on TIC.
- With staff turnover and demanding caseloads, it is difficult managing all of the required tasks and case related activities.

Despite these challenges, these are a few solutions to consider:

- Redesigning how and when the screening tool is used. For example, before the screening tool is administered it makes greater sense if the case is expected to stay open longer than 90 days, to wait and administer later when more trust has developed between the client (child/parent) and juvenile probation and parole officer (JPPO) or child protection social worker (CPSW).
- Providing sustainability work committees on a consistent basis with DCYF administration support. If committees are formed to address sustainability efforts on trauma-informed care, then supervisors and administrators need to insure there is consistent representation from JPPOs and CPSWs and other assigned DCYF appointees to do this work.
- Ongoing training and education for all field staff, supervisors, and administrators. DCYF should have a plan that addresses trauma-informed care training and education for all employees (e.g., field staff, supervisors, program specialists, and administrators).
- Developing and implementing a process for DCYF field staff and mental health and community service providers to collaborate at the local and regional levels.
- Creating a TIC "specialist" position with DCYF support that is highly experienced and knowledgeable about the New Hampshire mental health system and particularly about trauma-informed care.
- Developing a TIC plan with DCYF support that addresses how field staff will incorporate trauma-informed practices into its daily work load and secondary trauma stress.

As a child welfare agency, we have certainly experienced some challenges with this project, but we have also learned a great deal about TIC practices. NH DCYF employs a great workforce of people who are passionate about helping children and families to meet their needs. If we as an agency consider some of these proposed solutions, I believe that we can be only better prepared and functional in meeting our goals to be trauma informed.

About the Authors

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Interested in another perspective on this study? Check out this issue's Research to Practice Brief on page 93 for another author's view on this content.

References

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Meier, A., Moore, S. K, Saunders, E. C., Metcalf, S. A., McLeman, B., Auty, S., & Marsh, L.A. (2017) *National drug early warning system hotspot report: Understanding opiod overdoses in New Hampshire.* Retrieved from: http://ter.ps/NDEWSHotSpot

New Hampshire Information and Analysis Center. (2017). NH Drug Monitoring Initiative overview report (NHIAC Product # 2018-3235). Retrieved from https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-2017-overview.pdf