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In This Issue

Trauma-Informed Care

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The Partners for Change Project is a collaboration between the Dartmouth Trauma Interventions Research Center (DTIRC) and the New Hampshire Division for Children, Youth, and Families (NH DCYF), with a shared goal of improving the social and emotional well-being of children served by the state's child welfare agency. Implementation involved training child welfare staff on the use of screening and assessment to inform case planning, coordination of trauma-informed services, and resource parent training in trauma. Our target population included youth from both child protection and juvenile justice sectors. Our most striking challenge has been contending with a cascade of contextual stressors including a devastating opioid crisis, staff shortages and leadership instability. We discuss how we navigated these stressors to optimize project uptake, offer a DCYF staff member's perspective on enacting these practices in a system "under siege," and present "lessons learned".

page 15 ***Lessons From an Evaluation of a Trauma-Informed Care Initiative in Child Welfare* | *Jessica Dym Bartlett***

Evaluating trauma-informed care (TIC) initiatives in child welfare (CW) is a complex undertaking. Numerous challenges emerge throughout the evaluation process, from defining and operationalizing the construct of TIC, to assessing the effectiveness of intervention components separately and in aggregate, to detecting associations between TIC and child, family, and system outcomes. This article highlights lessons learned through a mixed method, multi-source, longitudinal evaluation of the Massachusetts Child Trauma Project (MCTP). While results indicated positive outcomes across intervention domains, we also encountered a number of evaluation challenges along the way. We describe three particular issues that emerged—measuring TIC outcomes, lack of consistent engagement among service providers and families, and turnover among providers—as well as our strategies for addressing them.

page 22 ***Placing Strengths at the Center: Implementing a Trauma-Informed, Collaborative Case Planning Process for Children and Youth in Foster Care Using the Child and Adolescent Needs and Strengths (CANS) Tool* | *Abigail Hemenway, Alison Krompf, Janine Beaudry, Cheryle Bilodeau Wilcox, Cassie Gillespie, Dillon Burns, Brenda Gooley, Belinda Bessette, Shabnam Cota, Jessica Strolin-Goltzman***

The following article provides a practice perspective on the Initial Implementation stage (Fixsen, Blasé, Timbers, & Wolf, 2001) of a collaborative case planning protocol between child welfare and mental health agencies using the Child and Adolescent Needs and Strengths (CANS) tool. Woven throughout the article is a fictional case example used to highlight barriers and illustrate potential solutions to cross-sector implementation. Although some barriers have been quickly and easily overcome, others present ongoing challenges. Nonetheless, many key staff at the local and state level are engaged, supportive, and committed to this implementation and the state continues to make steady progress toward trauma-informed, collaborative case planning around the CANS. Indeed, as barriers arise, they continue to be addressed and resolved using the same innovative and collaborative spirit that is at the heart of the CANS protocol itself. The fictional case exemplifies how collaborative teaming, when using the CANS to its full potential, can support the needs of children who have experienced trauma and maltreatment, as well as the adults who care for them.

page 33 ***Implementation of Trauma Screening in Three Tribal Communities** | Ashley Trautman, Maegan Rides At The Door, Gaynell Realbird, Marilyn Zimmerman*

Implementation of a trauma-screening instrument into child welfare practice is one component of engaging in trauma-informed practice (Klain & White, 2013). The results of trauma screening can be used to enhance trauma-informed service delivery by responding to the unique needs and challenges faced by youth who have experienced trauma. The Transforming Tribal Child Protective Services project, a collaboration between of the National Native Children's Trauma Center and Bureau of Indian Affairs (BIA) Rocky Mountain Region, selected, adapted, and began implementation of a trauma-screening instrument in three tribal communities. This article details the process by which the project approached implementation of a screening instrument as well as the challenges faced along the way. Importantly, these findings and lessons learned include commentary from BIA project partners regarding their experience of selecting, adapting, and implementing trauma screening into their practice. Steps for moving forward with implementing trauma screening into tribal child welfare practice are discussed.

page 39 ***Challenges and Strengths in One State's Effort to Screen and Support Resource Parents' Family Functioning** | Rebecca R. Parton, Erin R. Barnett, Catherine E. Meister, M. Kay Jankowski*

New Hampshire's child welfare system introduced family-level screening tools to assess attachment, belongingness, caregiver commitment, and caregiver ability to reflect on one's own and the child's experiences. The caregiver screens were done in conjunction with child-level screens capturing trauma exposure, PTSD, and well-being installed through a related project, along with other practice improvements targeting child welfare and mental health staff. Project leaders were challenged by slow uptake of the family functioning screens compared with the child-level screens, and few families were identified as having needs. To better understand the potential barriers to uptake and potential solutions, the team plans to analyze the screening tool data and conduct additional focus groups with staff and parents.

page 44 ***Screening for Mental Health Needs in Child Welfare: Do We Also Need to Screen for Trauma?** | Andrea L. Hazen, Brent R. Crandal, Jennifer Rolls Reutz*

Children involved in the child welfare system have high rates of mental health and trauma-related problems, yet many children with an identified need do not receive mental health services. In California, a recent initiative resulting from a class action lawsuit established the requirement for all counties statewide to implement screening procedures to identify mental health needs among children involved with child welfare services in order to increase access to mental health assessment and treatment services. In this article, we describe results from the implementation of a screening approach in a county child welfare agency in California to highlight the importance of screening for trauma-related concerns in conjunction with screening for general mental health needs. Implications for the delivery of services for children involved in the child welfare system are discussed.

page 49 ***What Is Foster Parents' Role in Trauma-Informed Child Welfare Practice?** | Erika Tullberg*

Although foster parents are the cornerstone of the foster care system, they often lie outside of formal structures and decision-making processes at both the child and agency level. This can cause problems when agencies seek to implement trauma-informed practices, which are intended to support the care of children but can instead be experienced as burdensome. This article provides examples of how foster parents were actively involved in the planning and implementation of trauma-informed practices in New York City-based Treatment Family Foster Care programs, discusses challenges and benefits of foster parent involvement in such activities, and provides recommendations for deeper foster parent engagement and collaboration in the design and implementation of trauma-informed child welfare practices

page 55 ***Enhancing Understanding of the Mental Health Needs of Children and Youth in Foster Care: Validity of Foster Parents as Reporters and Progress Monitoring** | Suzanne E. U. Kerns, Barbara J. Putnam, Jedediah H. Jacobson, Michael D. Pullmann, Jacqueline A. Uomoto, Lucy Berliner*

In response to concerns that foster parents' reports on child mental health symptoms within the first 30–60 days post-placement may not be valid, the Washington State Creating Connections project team conducted a cross-informant study of the interrater reliability of a key screening measure, the Pediatric Symptom Checklist—17. Additionally, in an effort to gather information about how child mental health status changes over time when children remain in care, we initiated a centrally managed "ongoing mental health screening program" to re-assess children and youth who remain in the system for six months or longer. Results indicated that youth self-report ratings were slightly more associated with their foster parents' ratings than biological parents' for internalizing and externalizing subscales. Between baseline and 6-month follow-up, approximately 31% of children and youth showed improvement, 10% deteriorated, 25% remained consistently below clinical criteria, and 34% remained consistently above clinical criteria. We conclude with lessons learned and implications for the field. Commentary is provided by project partners at the Washington State Department of Social and Health Services, Children's Administration.

page 63 ***Leadership Change Within a System During an Implementation Effort: Considerations After Implementing Trauma-Informed Care in Child Welfare and Behavioral Health Systems* | *Brent R. Crandal, Jennifer A. Rolls Reutz, Charles Wilson, Andrea L. Hazen***

One of the most daunting challenges of creating system-level change is maintaining progress over time and through leadership transitions. However, during multi-year implementation projects for child-serving social service systems, such as child welfare and children's behavioral health, leadership change is the norm. These changes can create shifts in priorities, perceptions, and decision making, often creating new currents for the organizational context in which the change is implemented. With very limited research to guide policy makers, system leaders, and implementation intermediaries, there is a great deal still to understand about this frequent occurrence and how it serves to facilitate or hinder implementation progress. As an initial step to further explore this topic, we propose a model for considering crucial contributing factors for an implementation project when leadership change occurs. We then offer a case study based on a multi-year, trauma-informed care project implemented within several child welfare and behavioral health systems to apply the model and explore the outputs in the model. Finally, we discuss next steps for implementation intermediaries, policy makers, and social service system leaders to address the impact of leadership change.

page 75 ***Policy Change to Support Trauma-Informed Care in Child Welfare* | *Kimberly Campbell, Jason M. Lang, Bethany Zorba***

Although research on trauma-informed care in child welfare is increasing and guidelines have been developed to help agency administrators design trauma-informed organizational cultures and services, very little is known about creating internal trauma-informed policies and procedures and how they can support and sustain practice components of trauma-informed care. This article describes the challenges created by lack of information about trauma in a public child welfare agency's internal policies and procedures at the beginning of a statewide initiative to implement trauma-informed care principles into practice. An additional challenge was created by lack of a defined agency process to develop policies and procedures or modify existing ones. Using guidelines established for designing trauma-informed child welfare systems, the authors describe the planning and implementation process for developing trauma-informed child welfare policies to support the implementation of trauma-informed care in a state child welfare agency. They present results of a 3-year process that included the review and modification of 23 major child welfare policies and procedures to support practice changes being simultaneously implemented. Lessons learned are described and recommendations made for developing policies and procedures to support trauma-informed care in child welfare.

page 90 ***Creating Trauma-Informed Systems of Care: Reflections on the Special Issue* | *J. Bart Klika***

Few would disagree that the abuse and neglect of our nation's children is truly one of the most concerning public health problems of our time. The physical, emotional, psychological, and economic burdens of abuse and neglect are staggering, yet are also preventable. Building coordinated systems of care for family support, inclusive of early intervention services (e.g., home visitation), are key to moving upstream to ensure that abuse and neglect never occur. Creating systems and processes for transitioning children and families across the service continuum (and at various levels of intensity) depending upon need is essential in our pursuit of preventing trauma and adversity.

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Introduction to the Issue: Creating Trauma-Informed Systems of Care

J. Bart Klika, MSW, PhD

Children and youth in the United States are exposed to preventable violence, trauma, and adversity on a daily basis. Adverse Childhood Experiences (ACEs) are those experiences that lead to chronic stress and may result in a child presenting with a complex set of trauma symptoms (e.g., aggressive behavior, sleep problems). ACEs include, but are not limited to, child physical abuse, sexual abuse, emotional abuse, neglect, exposure to intimate partner violence, and being raised by a parent with a significant mental health or substance abuse problem. Research shows that these experiences rarely occur in isolation but instead cluster together in what some have termed "polyvictimization" (Finkelhor, Turner, Hamby, & Ormrod, 2011) or "multi-type maltreatment" (Herrenkohl & Herrenkohl, 2009; Higgins & McCabe, 2001). The accumulation of ACEs have been linked to a number of negative life-course health outcomes, including risky health behaviors (e.g., smoking, alcohol use), mental health problems (e.g., depression, PTSD), and physical health complications (e.g., heart disease, cancer) (Felitti et al., 1998; Anda et al., 1999; Dong et al., 2004). Emerging science continues to show us, however, that it is not just the mere count of adversities a child experiences that determines long-term prognosis but the particular combinations of adversity (Lanier, Maguire-Jack, Lombardi, Frey, & Rose, 2018), the timing of adversity (Dierkhising, Ford, Branson, Grasso, & Lee, 2018), and the presence of protective factors at the time of the adversity (Hambrick, Brawner, & Perry, 2018).

After a number of years of rate decline, the number of children being placed into the foster care system as a result of abuse or neglect has risen steadily since 2012 (United States Department of Health and Human Services [USDHHS], 2017). In 2016, nearly 274,000 children entered the foster care system, up from approximately 251,000 children in 2012. Not all children who experience ACEs,however, will come to the attention of child and family services but may be identified through other systems in society such as juvenile justice, education, or healthcare. Regardless of the specific entry point into one of the many systems of care in place to support children and families, it is imperative that agencies and their staff understand the deleterious effects of trauma and diverse presentations of trauma symptoms.

In recent years, our field has seen the proliferation of strategies and approaches implemented in practice using the findings and framework of the Adverse Childhood Experiences study. These strategies and approaches include increased efforts to screen children and parents for trauma, the creation of trainings to inform professionals and communities about the effects of trauma, and greater call for organizations to become "trauma-informed." Although definitions vary (see Hanson & Lang, 2016, for a comparison of definitions), a *trauma-informed system* can be defined as

> … one in which all parties involved recognize and respond to the varying impact[s] of traumatic stress on children, caregivers, families, and those who have contact with the system. Programs and organizations within the system infuse ... knowledge, awareness, and skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery. (Chadwick Trauma-Informed Systems Project, 2013, p. 11)

The area of trauma-informed care is in its infancy in regard to operationalization, implementation,

and evaluation. As such, Hanson and Lang (2016) co-edited a special edition of the journal *Child Maltreatment* (*CM*) to explore and address many of the definitional, conceptual, and empirical shortcomings of this body of scholarship (see "Special Focus Issue: A Critical Look at Trauma-Informed Care Among Agencies and Systems Serving Maltreated Youth and Their Families"). The articles in this special issue of the *APSAC Advisor* expand on the *CM* special issue and represent emerging science and thinking on the implementation of complex change initiatives to create trauma-informed systems of care for children involved in child welfare. The contributors to this special issue of the *APSAC Advisor* were all involved with research initiatives funded by the USDHHS, Administration for Children and Families, Children's Bureau. Although the specific aims for each cohort of grantees were slightly varied, all grantees were tasked with the following:

- Building system capacity through training of child welfare workers, resource parents, and other community professionals on the topic of trauma
- Implementing trauma screening in child welfare
- Creating referral pipelines to mental and behavioral healthcare systems for children who screen positive for trauma
- Training and implementation of evidence-based and evidence-informed trauma treatments in mental health and behavioral health settings.

Jankowski, Butcher, and Barnett begin the special issue by framing many of the challenges (internal and external) of implementing change initiatives across multiple state systems, highlighting common themes experienced by many of the contributing cohorts. Bartlett then describes the complex challenges of evaluating trauma-informed care initiatives. Next, a series of papers explores the topic of screening. This section begins with an article by Hemenway et al., who use a case study to underscore the need for teaming in the implementation of the Child and Adolescent Needs and Strengths (CANS) assessment in the case planning process. Trautman, Rides At The Door, Zimmerman, and Realbird highlight some of the commonalities and uniqueness of implementing trauma screening in tribal child welfare systems. Parton, Barnett, and Jankowski describe their process of implementing family functioning screens with foster and relative caregivers. Next, a number of critical questions are raised in relation to screening, including what should we screen for (Hazen, Crandal, & Rolls-Reutz) and who is the best reporter of trauma symptoms (Kerns, Pullmann, Uomota, Jacobson, Berliner, & Putnam). Following the papers on screening, Tullberg discusses the need to include foster parents, the "forgotten front-line," in the case planning process. Crandal, Rolls-Reutz, Wilson, and Hazen dig deeper into the process of sustaining momentum of change initiatives in the context of leadership changes in large state systems. In closing, Campbell, Lang, and Zorba describe their process and framework for embedding trauma-informed policies and procedures into agency practice. Together, these articles explore the challenges, successes, and lessons learned in the process of implementation of complex trauma-informed care initiatives.

About the Guest Editor

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References

Introduction to the Issue: Creating Trauma-Informed Systems of Care

Anda, R. F., Croft, J. B., Felitti, V. J., Nordenberg, D., Giles, W. H., Williamson, D. F., & Giovano, G. A. (1999). Adverse childhood experiences and smoking during adolescent and adulthood. *JAMA, 282*(17), 1652-1658.

Chadwick Trauma-Informed Systems Project. (2013). *Creating trauma-informed child welfare systems: A guide for administrators* (2nd ed). San Diego, CA: Chadwick Trauma-Informed Care Project.

Dierkhising, C. B., Ford, J. D., Branson, C., Grasso, D. J., & Lee, R. (2018). Developmental timing of polyvictimization: Continuity, change, and association with adverse outcomes in adolescence. *Child Abuse & Neglect*. Advance online publication. doi.org/10.1016/j.chiabu.2018.07.022

Dong, M., Anda, R. F., Felitti, V. J., Dube, S. R., Williamson, D. F., Thompson, T. J., . . . Giles, W. H. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect, 28*, 771-784.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258.

Finkelhor, D., Turner, H., Hamby, S., & Ormrod, R. (2011). *Polyvictimization: Children's exposure to multiple types of violence, crime, and abuse*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Hambrick, E. P., Brawner, T. W., & Perry, B. D. (2018). Examining developmental adversity and connectedness in child welfare-involved children. *Children Australia, 43*, 105-115.

Hanson, R. F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child Maltreatment, 21*, 95-100.

Herrenkohl, R. C., & Herrenkohl, T. I. (2009). Assessing a child's experience of multiple maltreatment types: Some unfinished business. *Journal of Family Violence, 24*, 485-496.

Higgins, D. J., & McCabe, M. P. (2001). Multiple forms of child abuse and neglect: Adult retrospective reports. *Aggression and Violent Behavior, 6*, 547-578.

Lanier, P., Maguire-Jack, K., Lombardi, B., Frey, J., & Rose, R.A. (2018). Adverse childhood experiences and child health outcomes: Comparing cumulative risk and latent class approaches. *Maternal and Child Health Journal, 43*, 288-297.

United States Department of Health and Human Services (USDHHS), Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. (2017). *Trends in foster care and adoption: FY2007-FY2016*. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/trends_fostercare_adoption_07thru16.pdf

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

M. Kay Jankowski, PhD
Rebecca L. Butcher, MS, MPH
Erin R. Barnett, PhD
With Commentary by Anthony Camelo, MS

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.

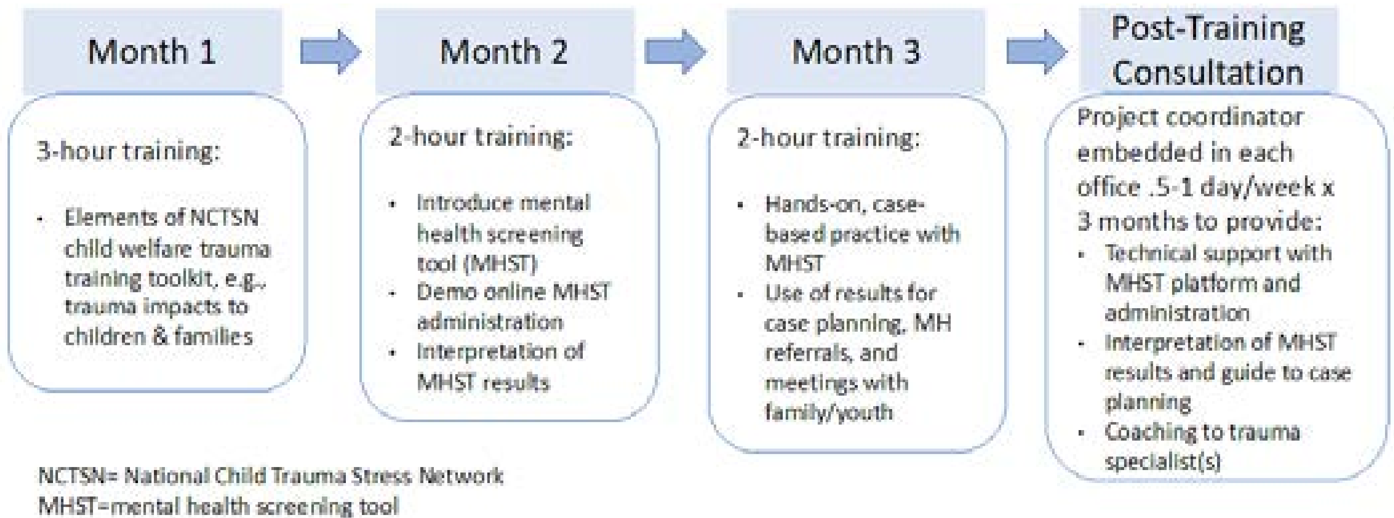
The specific objectives of the Partners for Change initiative included the following: (1) installation of universal screening for trauma exposure, posttraumatic symptoms, and well-being needs of all adjudicated children and youth, (2) data-driven case planning informed by trauma screening results, (3) 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.

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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

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

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

Lessons From an Evaluation of a Trauma-Informed Care Initiative in Child Welfare

Jessica Dym Bartlett, MSW, PhD

Growing public awareness of the prevalence of child trauma, the potential disruption of children's development and lifelong well-being it poses, and the unique treatment needs of children who experience it, have led to important innovations in trauma-informed care. The term *trauma-informed care* (TIC), often used interchangeably with a *trauma-informed approach* and a *trauma-informed system*, generally refers to a service system "in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers" (National Child Traumatic Stress Network, 2012). The child welfare (CW) system, which exclusively serves children who have experienced trauma (i.e., child abuse and neglect, at minimum), is a natural setting for implementing TIC. Accordingly, the U.S. Department of Health and Human Services has invested in such efforts (e.g., the National Child Traumatic Stress Initiative, Substance Abuse and Mental Health Services Administration [SAMHSA]; the Children's Bureau cooperative agreements on integrating trauma-informed practice into child protective service delivery, Administration for Children and Families [ACF]). These initiatives have provided fertile ground for implementing and testing a range of TIC approaches in CW.

TIC in CW takes multiple forms, but an essential element is an expansion of the system's concerns beyond children's physical safety and permanence. It also attends to children's psychological safety; attempts to address trauma-related needs by promoting the well-being and resilience of children, families, and service providers; treats children and families as partners in their own care; and collaborates with other relevant agencies and systems (Chadwick Trauma-Informed Systems Dissemination and Implementation Project, 2013). A strong commitment to evaluation generally has accompanied public TIC efforts (SAMHSA, 2014). The Massachusetts Child Trauma Project (MCTP), a 5-year project in CW and mental health (MH), exemplified the TIC approach.

The Massachusetts Child Trauma Project

MCTP was a 5-year collaboration among Department of Children and Families (DCF), two behavioral health agencies (LUK, Inc., and the Trauma Center at Justice Resource Institute), and two large, urban medical centers (Boston Medical Center and the University of Massachusetts Medical School) designed to integrate TIC into CW and MH services statewide. Specifically, it was meant to (a) improve identification and assessment of children exposed to complex trauma; (b) build capacity within MH services to deliver trauma-specific, evidence-based treatments and practices in community agencies serving children and families involved in CW; (c) increase referrals of children to trauma treatment; and (d) increase caregivers' awareness and knowledge of child trauma.

MCTP integrated TIC into CW and MH during the implementation period (2012–2016) using three major strategies: trauma training in CW, dissemination of evidence-based and evidence-informed trauma treatments and practices (EBTs/EBPs), and development of Trauma-Informed Leadership Teams (TILTs), which were teams of CW staff and

community service providers with freedom to develop any TIC activities to meet the specific needs of their communities.

The evaluation of MCTP reflected the ambitious, complex nature of the intervention itself, including a mixed method, multi-informant, multi-measure implementation and child outcome study. This study was well-planned and executed in many regards, anticipating many possible stumbling blocks; nonetheless, we encountered methodological and practical challenges for which there were only partial "fixes." In the service of advancing dialogue and improving both TIC efforts and their evaluations, we identify three particularly vexing issues—(1) difficulties in measuring TIC outcomes; (2) lack of consistent engagement among service providers and families; and (3) turnover among providers—and our approach to solving these issues. Additional detail about MCTP implementation and outcomes is provided elsewhere (Bartlett et al., 2016; 2018; Barto et al., 2018; Fraser et al., 2014).

Measuring Outcomes in TIC-CW

Although researchers have been studying trauma for decades, the evaluation of TIC is arguably in its infancy. Little guidance exists on how to define, operationalize, and measure TIC; how to assess components, both individually or in aggregate; or how to identify which components lead to intended outcomes (DeCandia & Guarino, 2015; Hanson & Lang, 2016; Sullivan, Murray, & Ake, 2016). There is no well-specified theory of change, in part because approaches to TIC vary so widely. Moreover, the field lacks valid, reliable, and culturally relevant measures to comprehensively assess its impact.

Evaluating TIC has challenges comparable to studying other systems, which include accounting for the operation of its parts, the interactions of its subsystems, and its functioning as a whole, which theoretically offers more than the sum of its parts (Foster-Fishman, Nowell, & Yang, 2007; Hargreaves, 2010). Systems are inherently complex entities with a multitude of moving parts and shifting conditions; they do not operate in a linear or even a bi-directional way. Trauma-informed care, like other systems initiatives, endeavors to change patterns of behavior across the system by changing its dynamics, structures, and conditions. Current research (Eoyang, 2007; Hargreaves, 2010) underscores the necessity to include those system-related elements in ongoing evaluations.

The MCTP evaluation effectively employed a number of methods to investigate system change. We conducted both an implementation study and an outcome study, allowing us to thoroughly examine intervention activities and processes. We also used a mixed method design to ensure that any information not captured quantitatively was collected qualitatively through key informant interviews, focus groups, and open-ended questions on surveys. Finally, we collected information from multiple types of informants (i.e., CW leadership, staff, and resource parents; MH leadership, supervisors, clinicians, parents/caregivers, and youth). Taken together, these strategies enabled us to triangulate findings, highlighting both commonalities and disparities among the experiences of project participants in system components. For example, focus groups with TILTs, MH providers, and CW leadership included questions about the nature and quality of their work within their agencies, with one another, with other community service providers, and with the state CW system as a whole. Qualitative data collection revealed essential elements of TIC we would not have otherwise identified. For instance, participants in focus groups in both CW and MH systems emphasized that developing a shared language around child trauma was a critical foundation of successful collaboration, and one that did not previously exist. As one TILT leader explained:

> It was identified very early on that the language the Department speaks and the language the clinician speaks are completely not in the same world…and people are getting excited about speaking the same language.

We also used surveys on the MH system's readiness to adopt EBTs and changes in trauma-related agency policies and practices, though identifying instruments that had undergone comprehensive psychometric testing was nearly impossible given the nascence of TIC measurement in the field of child trauma. Indeed, findings suggested burgeoning system changes in TIC, including uptake of trauma-informed policies,

practices, and knowledge among service providers and resource parents, increased referrals to EBTs/EBPs, and a shared understanding of child trauma and how to address it collectively (Fraser et al., 2014; Bartlett et al., 2018).

Despite these successes, we encountered considerable difficulties in key areas of measuring TIC. A primary example was the challenge of linking positive child outcomes to changes in the system. The original evaluation plan approved by the state CW agency included an experimental design comparing children in CW offices participating in MCTP with those receiving services as usual. However, concerns from CW leadership about simultaneously increasing awareness of child trauma while unevenly distributing related services (e.g., increasing capacity of communities to refer to and provide EBTs/EBPs) led us to use a less rigorous design. Eventually we agreed upon a quasi-experimental design in which we compared children involved in CW who lived in areas of the state participating in MCTP with those in areas of the state in which MCTP had not yet been implemented. The results showed that MCTP reduced the likelihood of child maltreatment recurrence by 15% and increased the likelihood of adoption by 21% (Barto et al., 2018). This was a particularly encouraging finding because it reflected the effects of TIC as a whole, given that fewer than 300 of the 91,253 children in the sample received an EBT/EBP through the project that year. Nevertheless, we were not able to determine which elements of TIC were most important to these outcomes, either alone or in combination.

Overall, we learned several lessons from this experience. First, the goals of the evaluation are not always compatible with the goals of an institution; or, in this instance, they may be in-sync at one point in time but not another. Second, changes in any one system component can have tangible reverberations for evaluators. Third, TIC system components and contexts can be expected to change in unexpected ways, and evaluations must be nimble enough to accommodate the shifting tides. Finally, some institutions may not be able to accommodate optimal TIC evaluation designs, and even when they can, quality measures may not be available—standardized tools for assessing trauma-informed are practically nonexistent (DeCandia & Guarino, 2015). Regardless, we believe MCTP made key inroads in the measurement of TIC and we are optimistic that our efforts will contribute to the field's progress in this area.

Engagement of Service Providers and Families

Another challenge that arose during the MCTP evaluation was limited engagement among some participants in the initiative. There is general consensus among researchers, practitioners, and policymakers that "buy-in" at all levels of a system is essential to ensuring successful implementation of social service interventions (Fixen, Naoom, Blase, Friedman, & Wallas, 2005). Engagement in evaluation is no exception to the rule, and this can be further impeded when participant engagement in the intervention itself wanes or fails to develop fully in the first place. While the MCTP evaluation nearly reached its goal to enroll 900 children in treatment (842 enrolled), rates of attrition were considerable—approximately 40% of the sample completed or provided data from discharge assessments with children. In addition, only 54% of MH providers who completed a baseline survey completed an exit survey one year later. Statistical techniques (we used Full Information Maximum Likelihood) helped us address missing data in some instances; however, we postulate that our findings suffered from selection bias, at the very least (Legerski & Bunnell, 2010). It is difficult to determine the origin of the problem, though likely a number of problems with engagement were at play (e.g., family drop-out of services or the evaluation; provider turnover; discontinued use of study measures; omissions in data entry).

To support participant engagement, MCTP evaluators selected clinically relevant measures (several were required for certification or rostering in EBTs/EBPs) and conducted in-person trainings on study measures and data entry with MH providers and their supervisors, including role-plays, video clips, and written materials showing effective ways to engage families in the evaluation. We also maintained regular contact with them through a designated email

and EBT/EBP consultation calls, followed up with clinicians with missing data, and requested assistance from the Project Director, who encouraged senior leaders to comply with the evaluation requirements. These techniques were useful in decreasing missing data, but ultimately could not solve some of the quintessential problems in the fields of MH and CW, such as provider turnover.

Provider turnover. One of the most often cited challenges to successful implementation of MCTP by MH and CW providers was provider turnover. Turnover is common in MH agencies, with average rates ranging from 25% to 50% per year (Aarons, Sommerfeld, & Willging, 2011; Eby & Rothrauff-Laschober, 2012; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). In MCTP, approximately 27% of MH workers trained in MCTP dropped out. This was a conundrum for evaluators, who were not in a position to decrease burnout and turnover among service providers in either system given larger system challenges related to poor compensation, heavy caseloads, and stressful work conditions in the professions of CW and MH (DePanfilis & Zlotnick, 2008; Morse et al., 2012). In MCTP, provider turnover reduced the number of MH workers prepared to offer treatment once children were referred—particularly very young children for whom there was already an existing shortage of EBT/EBP providers. In response to this challenge, MCTP designed and evaluated a second wave of EBT/EBP training to replenish teams at agencies from prior cohorts who lost staff. We also allowed providers who moved to a different agency to continue participating in the evaluation.

Turnover in CW is also high in the United States, estimated to be between 20% and 60%, annually (National Child Welfare Workforce Institute, 2011). In Massachusetts, turnover rates were higher than usual during the evaluation period, with the opioid epidemic taking hold and a number of high-profile child maltreatment deaths leading to especially challenging working conditions. For the evaluation, this presented innumerable challenges. For example, while our survey response rate among CW managers appeared sufficient at first glance—85% completed both a baseline and follow-up survey 2 years later—we determined that the vast majority of the sample comprised different individuals at the two time points. Perhaps this helps explain the finding that there were no significant improvements in trauma-informed practices or policies reported by child welfare leaders; or perhaps not, and this would have been the case regardless; we will never know the answer. In addition, after the first 2 years, the Principal Investigator (PI) at the CW agency changed multiple times (there were eight PIs during the project period). These changes required much time and attention from the agency and were accompanied by waning prioritization of TIC.

Were child protection work more highly valued and compensated, perhaps the workforce would stabilize and this turnover problem, ubiquitous across state CW agencies, would decrease. That "fix," which obviously would help evaluators as well, was far outside our influence. We did what we could, however, to generate the best quality data from informants available to us. For example, because we had planned to use multiple informants and methods, we shifted our investments of time and energy to conducting interviews with those who had weathered the storm and could speak to changes in TIC over time. Of course, there are drawbacks to this approach, given that the remaining sample was self-selected and may well have had distinct characteristics from those who left the agency. We also continued to evaluate trainings for each new cohort of MH providers and resource parents, who made significant improvements in their knowledge and practices in TIC. Mental health providers reported more trauma-informed individual and agency practices, as well as more trauma-informed agency policies, and resource parents used more trauma-informed parenting strategies, were better able to tolerate their foster children's difficult behaviors, and experienced more parenting efficacy (Bartlett et al., 2016; 2018).

Final Thoughts

Our experiences with MCTP suggest the obvious—that a sound evaluation design and a commitment to its faithful execution are "necessary but not sufficient" conditions for conducting useful TIC-CW evaluation. Other critical attributes include the flexibility to adjust to continually changing conditions

in multiple systems at once, perseverance and creativity in establishing and maintaining participant engagement over time, and acceptance of imperfect but "good enough" methods (e.g., measures, designs) when the "real world" intrudes. Trauma is a complex form of assault on children that includes a broad range of types, etiologies, and consequences. It is not surprising, then, that both the systems interventions meant to ameliorate those consequences as well as the evaluations that strive to document intervention processes and outcomes must acknowledge and reflect that complexity.

Nevertheless, TIC evaluators are in the enviable position of making meaningful contributions, both to the knowledge base on successful trauma interventions and to the operations and effectiveness of TIC-CW. They can be catalysts for improving interventions, not simply by articulating and translating outcomes but also by investigating TIC processes and mechanisms, helping interventions clarify theories of change, offering feedback in an iterative manner, and highlighting the need for course corrections in implementation along the way.

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References

Lessons From an Evaluation of a Trauma-Informed Care Initiative in Child Welfare

Aarons, G. A., Sommerfeld, D. H., & Willging, C. E. (2011). The soft underbelly of system change: The role of leadership and organizational climate in turnover during statewide behavioral health reform. *Psychological Services, 8*(4), 269281.

Bartlett, J. D., Barto, B., Griffin, J. L., Fraser, J. G., Hodgdon, H., & Bodian, R. (2016). Trauma-informed care in the Massachusetts Child Trauma Project. *Child Maltreatment, 20*(2), 101–112.

Bartlett, J. D., Griffin, J. L., Spinazzola, J., Fraser, J. G., Noroña, C. R., Bodian, R., . . .Barto, B. (2018). The impact of a statewide trauma-informed care initiative in child welfare on the well-being of children and youth. *Children and Youth Services Review, 84*, 110–117.

Barto, B., Bartlett, J. D., Von Ende, A., Bodian, R., Noroña, C. R., Griffin, J., . . . Todd, M. (2018). The impact of a statewide trauma-informed child welfare initiative on children's permanency and maltreatment outcomes. *Child Abuse & Neglect, 81*, 149–160.

Chadwick Trauma-Informed Systems Dissemination and Implementation Project. (2013). *Creating trauma-informed child welfare systems: A guide for administrators*. Retrieved January 1, 2018, from https://ctisp.org/

DeCandia, C. J., & Guarino, K. (2015). Trauma-informed care: An ecological response. *Journal of Child and Youth Care Work, 25*, 7–31.

DePanfilis, D., & Zlotnik, J. (2008). Retention of front line staff in child welfare: A systematic review of research. *Children and Youth Services Review, 30*, 995–1008.

Eby, L. T., & Rothrauff-Laschober, T. C. (2012). The relationship between perceptions of organizational functioning and voluntary counselor turnover: A four-wave longitudinal study. *Organizational Dynamics Within Substance Abuse Treatment, 42*(2), 151–158.

Eoyang, G. (2007). Human systems dynamics: Complexity-based approach to a complex evaluation. In B. Williams & I. Imam (Eds.), *Systems concepts in evaluation: An expert anthology* (pp. 123–139). Point Reyes Station, CA: EdgePress: American Evaluation Association.

Fixen, D. L. Naoom, S. F. Blase, K. A. Friedman, R. M., & Wallas, F. (2005). *Implementation research: A synthesis of the literature*. Tampa: University of South Florida Louis de la Parte Florida Mental Health Institute, The National Implementation Research.

Foster-Fishman, P., Nowell, B., & Yang, H. (2007). Putting the system back into systems change: A framework for understanding and changing organizational and community systems. *American Journal of Community Psychology, 39*, 197–215.

Fraser, J. G., Griffin, J. L., Barto, B. L., Lo, C., Wenz-Gross, M., Spinazolla, J., . . . Bartlett, J. D. (2014). Implementation of a workforce initiative to build trauma-informed child welfare practice and services: Findings from the Massachusetts Child Trauma Project. *Children and Youth Services Review, 44*, 233–242.

Hanson, R. F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child Maltreatment, 21*(2), 95–100.

Hargreaves, M. (2010, April). *Evaluating system change: A planning guide*. Cambridge, MA: Mathematica Policy Research. Retrieved January 20, 2018, from https://www.mathematica-mpr.com/our-publications-and-findings/publications/evaluating-system-change-a-planning-guide

Institute for Healthcare Improvement. (2003). *The Breakthrough Series: IHI's collaborative model for achieving breakthrough improvement* [IHI Innovation Series white paper]. Boston: Institute for Healthcare Improvement. Available at www.IHI.org

Legerski, J., & Bunnell, S. L. (2010). The risks, benefits, and ethics of trauma-focused research participation. *Ethics & Behavior, 20*(6), 429–442.

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health, 39*(5), 341–352.

References, cont.

National Child Traumatic Stress Network.(2012). *Creating trauma-informed systems.* Retrieved July 29, 2018, from https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems

National Child Welfare Workforce Institute. (2011). *Child welfare workforce demographics (2000-2010): Snapshot of the frontline child welfare caseworker*. Albany, NY. Retrieved January 20, 2018, from https://www.ncwwi.org/files/Workforce_Demographic_Trends_May2011.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *Trauma-informed care in behavioral health services: Treatment improvement protocol series 57*. U.S. Department of Health and Human Services Publication No. (SMA) 13-4801. Rockville, MD: Author.

Sullivan, K. M., Murray, J. J., & Ake, G. S. (2016). Trauma-informed care for children in the child welfare system: An initial evaluation of a trauma-informed parenting workshop. *Child Maltreatment, 20*(2), 147–155.

Placing Strengths at the Center: Implementing a Trauma-Informed, Collaborative Case Planning Process for Children and Youth in Foster Care Using the Child and Adolescent Needs and Strengths (CANS) Tool

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Meet AJ: *AJ is a fictional youth who entered foster care at the age of 7 for physical abuse and neglect related to parental opioid use disorder. He experienced four foster home placements in 2 years, and each time the foster caregiver cited unmanageable behaviors as the reason for the move. AJ was angry and scared and did not have the skills to help him express these intense emotions appropriately. Fortunately, with the collaboration of a dedicated social worker and a team of professionals and caregivers, AJ was provided with the support he needed to begin to heal past trauma and build skills alongside his caregivers, which led to his adoption at 11 years old. AJ is now 17 and on his way to college, making him one of the few youth who were involved in child welfare to go on to receive a post-secondary education (Day, Riebschleger, Dworsky, Damashek, & Fogarty, 2012).*

Though his story is fictional, his voice represents the true potential of all children and youth to thrive when given the collaborative supports that meet their identified needs, and the opportunity to build on their strengths, talents, and interests. The goal of CANS implementation is to help realize this potential.

Background

Across the nation, approximately 250,000 children entered foster care in 2016 (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau [USDHHS], 2017). In a way similar to AJ, too many children in foster care nationwide experience placement instability beyond initial removal from their homes (Pecora, 2010; Rubin, O'Reilly, Luan, & Localio, 2007). On average, a child or youth experiences more than three placement

moves during each stay in foster care (Child Welfare Information Gateway, 2017).

Research shows that frequent placement changes are often highly stressful for children and can impact brain development (Northern California Training Academy, 2008; Pecora, 2010) and long-term outcomes (Pecora et al., 2005). For example, a large body of literature suggests a relationship between placement instability and children's well-being, including social-emotional skills and behaviors (e.g., Newton, Litrownik, & Landsverk, 2000; Pecora et al., 2005), drug and alcohol use (e.g., Herrenkohl, Herrenkohl, & Egolf, 2003), and school stability and success (e.g., Herrenkohl et al., 2003; Pecora et al., 2006). In addition, the literature shows a consistently negative relationship between externalizing behaviors and placement stability (Koh, Rolock, Cross, & Eblen-Manning, 2014; Rubin et al., 2007), whereby children with a greater number of home placements tend to have more negative behaviors perceived by caregivers and professionals, suggesting the potential for a vicious cycle.

Although research-based trainings and interventions have been linked to improvements in placement stability (Northern California Training Academy, 2008), there is little research investigating the effectiveness of trauma-informed, collaborative, system-level interventions. Placement data point to the critical need for cross-system collaboration between families, child welfare, education, mental health, and other providers toward the early identification of children's strengths and needs (Ko et al., 2008), a process referred to as "teaming" throughout this article. By improving teaming between providers and families, it may be possible to recognize the strengths and needs of a child as soon as she or he enters foster care, and to address trauma and behavioral health needs across life domains such as school and home.

AJ's Story, Part I: Before heading off to college, AJ agreed to participate in a foster youth panel. This is his response to the statement "Tell us about your experience when you first entered DCF custody."

> *Going to college is a dream that I didn't think would come true for me…but to tell you how I got here I have to start from the beginning. So I guess I'll start with my birth mother who had me when she was 19 years old. I came into custody when I was 7 because she was struggling with opioids and couldn't take care of me. She was so young but was already alienated from her whole family, and all her friends were using, too. By the time I was 8, I had gone 6 months without seeing her and her parental rights were terminated. By that time, I had also been in three different foster homes in as many towns. My foster parents said things such as, "He's just a monster," "He's completely out of control," and, "I'm afraid of what he might do!" I was only 8 years old! I must have been a mess. I don't remember much of it, but imagining it makes me sad for me and my birth mother.*
>
> *I remember walking into second grade in a brand new town, not knowing anyone. I went to the shelf and picked up a toy, but another boy grabbed it out of my hands. I yelled and jumped on him and hit him. I don't remember anything else, but I know that my teachers thought I was out of control and was not "available to learn." Before I got through half the year, I was off to foster home number four in another town with another school. That fourth school was a big turning point for me.*
>
> *I had four social workers by the time I was 9! Thankfully, Amy was my last. She's the only one I remember. And she made all the difference. She understood the school system and worked with the local mental health agency using something called the Child and Adolescent Needs and Strengths (CANS) tool. The CANS was a new tool that her agency had just started using, and she really thought it would help my "team" figure out what I needed and how each of them could support me, since no one seemed to really know me or each other. . . .*

Child and Adolescent Needs and Strengths (CANS)

The CANS is a tool that brings together the voices of all of the important and influential adults in a child's

life to identify his or her unique combination of needs and strengths across contexts, thus facilitating strength-based case planning, caregiving, and targeted service provision (Praed Foundation, 1999, 2016). Furthermore, the CANS provides a format for effective communication of these strengths and needs, thereby improving communication and collaboration between cross-system service providers and caregivers (Praed Foundation, 1999). Any provider with a bachelor's degree can be certified to administer the CANS by annually completing an online training through the Praed Foundation (https://praedfoundation.org/training-and-certification/); however, there is additional education, training, and experience needed for "CANS super users" and those using "more complex versions" of the tool (Praed Foundation, 2016, p. 6). It is important to note that the CANS is a descriptive, data gathering tool that is not intended to determine, evaluate, or diagnose the *cause* of particular challenges. Rather, the tool allows for effective communication across all levels of the system. Ideally, it is completed every 6 months so that a child's progress over time can be illustrated, allowing opportunities to celebrate successes and promptly address needs (Praed Foundation, 2016).

The CANS (Praed Foundation, 1999) is organized into five domains, each of which houses several specific items related to a child's and caregiver's well-being:

1. Child Behavioral/Emotional Needs
2. Life Domain Functioning
3. Child Strengths
4. Caregiver Needs and Strengths
5. Child Risk Behaviors

Each item has been included in the CANS because it is "relevant to service/treatment planning" (Praed Foundation, 1999, p. 3). These items are scored on a 0-3 scale so that "Immediate/Intensive" needs and "Centerpiece Strengths" can be easily identified and addressed (Praed Foundation, 1999, p. 4), helping teams focus on effective, strengths-based planning.

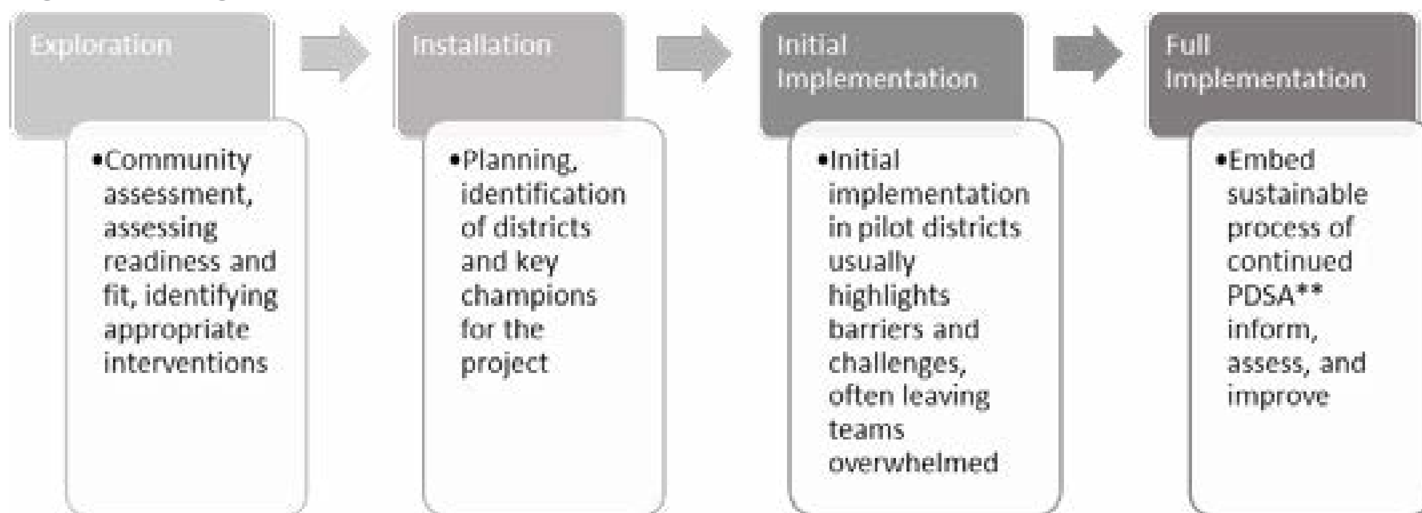
Pilot research studies conducted by CANS developers demonstrate both the reliability and validity of the CANS (Lyons, 2009; Praed Foundation, 2016), as well as the potential for improved placement stability for children in state custody (Lyons, 2009, p. 113; Lyons, 2014). These data support the potential efficacy of the CANS as a collaborative case planning tool, and one that serves the ultimate goals of all human services agencies: improving child outcomes and overall well-being.

AJ's Story, Part II: *...Amy said that the most important thing that the CANS tool allowed my "team" to do was talk with me and each other about what I seemed to need the most and what was already working well. It was clear to everyone that I needed some support in school, and that I needed a family to commit to me. I didn't trust anyone and was so angry and alone. I don't remember much, but I remember thinking and feeling that I was nobody and no one cared or understood. My "team" included Amy, my child welfare social worker, my mental health clinician, my school counselor, and my foster mom, Renee. Renee kept a notebook with my schedule and habits and what made me angry and what I did when I was mad. This helped my school counselor, Drake, notice similar patterns at school. Seeing the same aggressive behaviors across settings helped my team realize that I was having "fight or flight" responses. They gave me tools for self-regulating and recommended ways that I could have the extra help I needed at school. The CANS also identified resilience as a strength and helped everyone on my team realize that art and exercise were important outlets for me that could also be used to manage my emotions. Most important, this led to finding my forever family.* . . .

Implementation Science

Implementation of new practice initiatives, such as teaming around the CANS, demands collaboration and commitment to arrive at a successful and productive practice. According to Fixsen, Blasé, Timbers, and Wolf (2001), there are four stages in implementation: Exploration, Installation, Initial Implementation, and Full Implementation. Each stage brings unique activities, challenges, and rewards (see Figure 1).

Figure 1. Stages of Implementation*.



*Based on work by Fixsen et al., 2001.

Initial implementation, which is the focus of this article, is the stage during which a new practice is first implemented and the biggest challenges arise. The National Implementation Research Network (NIRN) provides the following description of the initial implementation phase:

> During the Initial Implementation Stage, the new practice is first put into place and made available to consumers. The key focus of this stage is on continuous improvement. In Initial Implementation, staff are attempting to use newly learned skills (e.g., the evidence-based program) in the context of an organization, that is itself just learning how to change to accommodate and support the new ways of work. This is the most fragile Stage where the awkwardness associated with trying new things and the difficulties associated with changing old ways of work are strong motivations for giving up and going back to comfortable routines (business as usual). (2013-2017, para 1)

Initial Implementation of the CANS in a Northeastern State

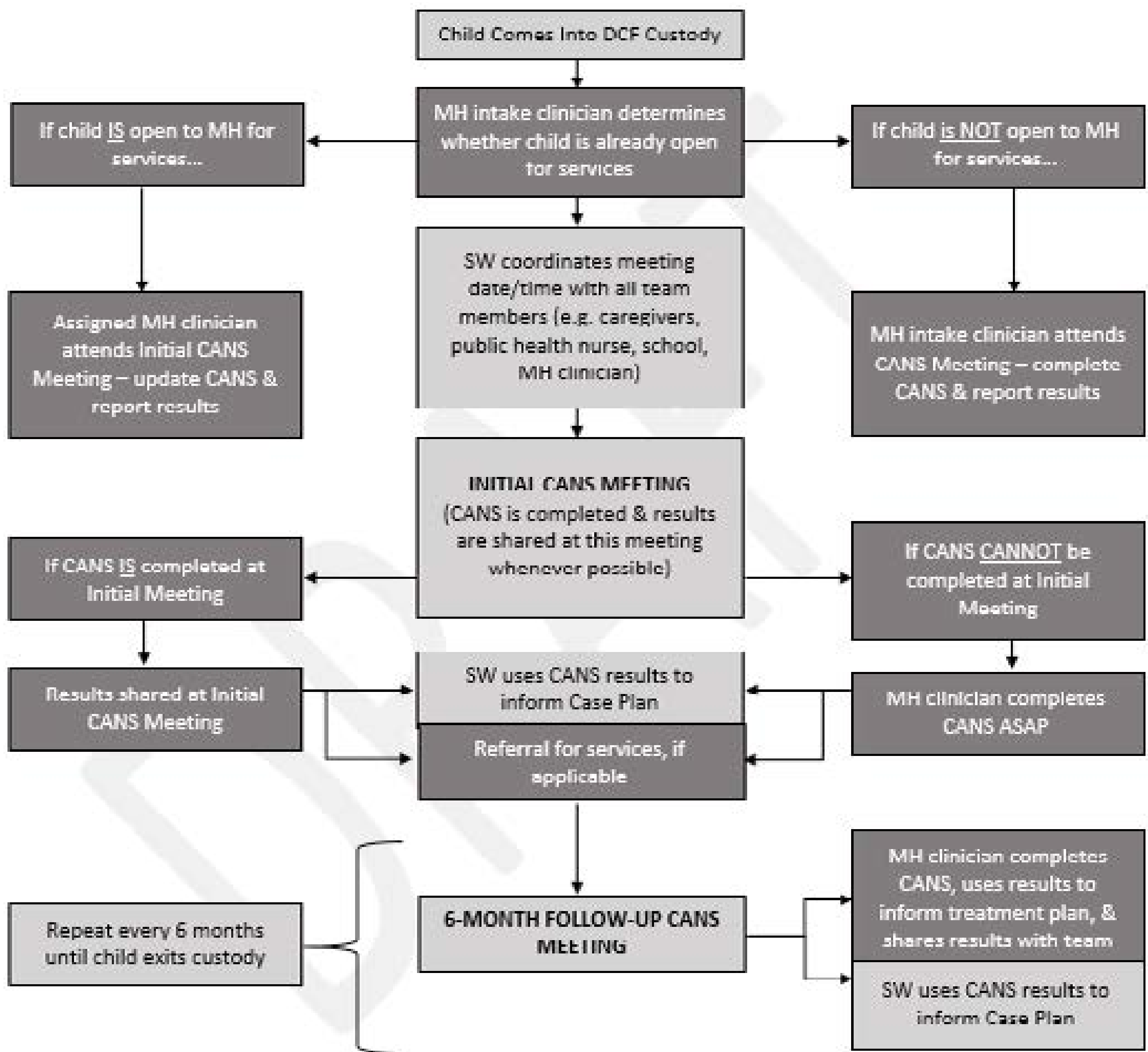
Implementation of the CANS in a Northeastern state began in 2014 with the State-Level Planning and Implementation Team, a 15-member, multidisciplinary team of local and state providers including community mental health, child welfare, and schools, which came together to identify a tool that could be utilized across disciplines to support a longstanding collaboration statute in the state. After thorough research and dialogue, the team decided to move forward with the CANS. There were a number of reasons for selecting this tool, including alignment with the state's system of care values, which emphasize a strengths-based approach to clear, cross-disciplinary communication. Ongoing leadership and oversight for implementation and fidelity of the CANS across many regions and agencies has continued to be supported by this cross-disciplinary team.

Children in state custody were quickly identified as one population that could benefit from supported implementation of the CANS, with the aim of improving placement stability through collaborative teaming and early, trauma-informed identification of needs and strengths, which informs service provision. The state has higher than average placement instability rates (USDHHS, 2013), and preliminary evidence suggests that the CANS may be a particularly powerful tool with which to improve placement stability (Lyons, 2009, 2014; Praed Foundation, 2016).

As a result, one district is piloting a cross-system collaborative case planning process using the CANS. In this district, the local implementation team comprises supervisors and clinicians from the community mental health agency, supervisors and directors in the district Family Services Division (FSD) office, and an implementation support team.

The implementation support team was funded through a 5-year federal grant that aims to improve placement stability and permanence for children and youth, by enhancing their social and emotional well-being. This goal is supported through the implementation of trauma-informed, evidence-based services and supports, such as the CANS. In this district, implementation support persons are working collaboratively alongside child welfare and mental health agencies to create a team-based CANS protocol that addresses the needs and barriers perceived across systems, while building on existing inner- and inter-agency strengths and teams. Prior to initial implementation, child welfare and mental health agencies in this district collaborated as part of a state pilot project aimed at bolstering system-level infrastructure for children, youth, and family services by supporting a continuum of integrated and consistent services for families.

Figure 2. Overview of the CANS Meeting Protocol, Working Draft.



Though the CANS protocol is still in the iterative phase of initial implementation (Fixsen et al., 2001), the flow of activities is depicted in Figure 2 (a working draft of the protocol) and outlined here, using AJ as an example. As Amy, AJ's social worker, prepared to write his case plan, she scheduled a CANS Meeting with his team, including a CANS-certified mental health clinician from the local community mental health agency, AJ's foster mother, school guidance counselor, and public health nurse. The team met to discuss AJ's strengths and needs. The clinician facilitated this conversation as she scored the CANS, using input from all of AJ's providers and caregivers. She was able to complete the CANS and share the results then and there, including recommendations for mental health service referrals. (Whenever possible, the CANS is completed at that Initial Meeting and the results are discussed with the entire team, including service recommendations; however, this is not always possible (e.g., a service provider is unable to attend the meeting and must be consulted by the clinician at a later time).) With release forms in place, a hard copy of the CANS report was shared with AJ's social worker. This report was used to inform AJ's case plan; his needs were addressed through referrals to trauma-informed services such as counseling, and his strengths were built upon by enrolling him in after-school art classes and allowing him to join the school's soccer team. Approximately five months later, Amy reached out to the team to schedule a follow-up meeting, during which an updated CANS would be completed, allowing the team to monitor AJ's progress over time and update his case and treatment plans.

Implementing any new protocol can be challenging; however, implementing cross-system practices can present multiple overlapping barriers that require the ongoing support of agency leadership (Aarons, Hurlburt, & Horwitz, 2011), as well as a committed and consistent implementation team who can flexibly adapt the protocol and support implementation efforts (NIRN, 2013-2017). Though the team continues to work toward a sustainable model, three recurring barriers have arisen during initial implementation of the CANS in this district, which have been creatively and collaboratively solved: (1) seeking input from education and healthcare providers (see Table 1), (2) workforce turnover and workload overload in both child welfare and mental health (see Table 2), and (3) lack of understanding of other professions' roles and responsibilities (see Table 3). These barriers, and the solutions addressing them, are detailed in the following three tables.

Table 1. Bringing Education and Healthcare Providers Together.

Specific Barriers	Solutions
Initial Implementation coincided with summer vacation for many schools, which may have hindered the implementation team's attempts to communicate with teachers and administrators regarding the new process of collaboration around the CANS.	The implementation team coordinated with the DCF leadership team to write and distribute a letter explaining the new initiative to teachers, and school and district leaders.
The heavy workload of pediatricians, in particular, may have precluded them from attending collaborative meetings.	Based on feedback from child welfare social workers, the protocol was revised so that the public health nurse now attends collaborative meetings, rather than each child's individual primary care physician.
In an earlier draft of the protocol, the implementation team was responsible for inviting providers to collaborative meetings; however, team members were frequently unable to gain access to the needed information prior to a child's first collaborative meeting after coming into custody.	The protocol was revised so that the child welfare social worker managing the case is responsible for inviting both school personnel and the public health nurse, as the caseworker has access to the needed information promptly after a child comes into custody.

Table 2. Workforce Turnover and Workload Overload in Child Welfare and Mental Health.

Specific Barriers	Solutions
Child welfare services and the local mental health agency experienced high staff turnover in conjunction with the onset of *Initial Implementation*.	Team leaders in the Child Protective Services (CPS) unit integrated the CANS protocol into regular training of new social workers. The mental health agency developed a CANS training for new employee orientation, and an ongoing consultation group to get mental health clinicians up to speed.
Due to a staffing shortage in the local mental health agency, only one clinician was conducting all of the CANS for new clients early in *Initial Implementation*, which resulted in a delay in CANS completion and teaming around the results.	The local mental health agency was able to increase staffing so that the assigned intake clinician is able to attend collaborative meetings and share CANS results in a timely manner. The right technology was also put in place so that CANS summary reports are now available immediately at the end of a CANS meeting.
Perhaps in part due to this delay in CANS completion, child welfare caseworkers reported that the collaborative process was not providing the information needed to inform case planning or support cross-context teaming.	The implementation team has created a "cross-walk," demonstrating the key areas of overlap between the CANS and an Initial Case Plan. Furthermore, feedback from both mental health and social workers is being monitored as CANS are completed more promptly and there are opportunities to observe change over time using a second CANS 6 months after the first.

Table 3. Lack of Understanding of Other Professions' Roles and Responsibilities.

Specific Barriers	Solutions
In early versions of the protocol, it was unclear whose role it was to initiate teaming for children who were already active clients of the local mental health agency.	The protocol was revised with this detail more clearly specified: Upon notification that a child has entered custody, the lead agency coordinator of the mental health agency collaborates with FSD supervisors to connect the social worker and assigned clinician.
At the onset of *Initial Implementation*, there was no existing mechanism for sharing this type of data regularly across agencies, nor was there a mechanism for sharing data with the implementation team that would allow for progress-monitoring. Mental health information-sharing was constrained by HIPAA protections for sharing youth substance use disorder and caregiver mental health information.	This barrier is being addressed in two stages: a) The protocol was revised to specify that all necessary parties will sign release forms before CANS results are shared with a child's team, with redaction practices in place when necessary. b) Currently, a data-sharing system is being designed and tested, which will allow child welfare and mental health agencies to share information on a child's CANS, as well as related services and outcomes, including placement stability. Furthermore, this system will allow the implementation and research team's access to de-identified data for the purposes of ongoing efficacy research

Conclusion

As depicted here, barriers to implementation have crossed systems, arising in child welfare, mental health, healthcare, and education. Yet teaming around the CANS is being used to support the work of service providers by aiding in identification of the strengths and needs of children and youth who have experienced trauma and maltreatment, as well as the adults who care for them, in order to promote the ultimate goal of improving placement stability, well-being, and positive lifetime outcomes for child welfare-involved children, youth, and families. Though there have been ongoing barriers throughout Initial Implementation, these barriers have been addressed using the same collaborative spirit that is at the heart of the implementation protocol itself. Indeed, as the team works to hone the protocol and move towards a sustainable implementation model, all members continue to approach the process with creativity, flexibility, and true collaboration. CANS implementation has helped to identify, measure, and celebrate *assets* in a way that supports the values of the state's system of care, while deepening its commitment to building resiliency and other strengths. With this powerful approach, we hope to support children like AJ who enter foster care feeling angry, scared, and alone, so that they may, with the help of trauma-informed, evidence-based services and supports, address their own barriers to happiness and success.

AJ's Story, Part III: *My forever mom was a local art teacher who had been a foster parent for many years and was ready to adopt a child of her own. Based on my identified strengths and interest in art, my team thought that we might be a good fit. Based on my needs, the team recommended that Mom attend a training on understanding and working with kids who have experienced a lot of trauma, called the Resource Parent Curriculum (Grillo, Lott, & Foster Care Subcommittee of the Child Welfare Committee, National Child Traumatic Stress Network, 2010), and that I start seeing a counselor to help me deal with my trauma. With the support of my team, Mom was able to really make a difference for me, and she knew that she wanted to be my Mom forever. The rest is history!*

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References

Placing Strengths at the Center: Implementing a Trauma-Informed, Collaborative Case Planning Process for Children and Youth...

Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(1), 4-23.

Child Welfare Information Gateway. (2017). *Foster care statistics 2015.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubs/factsheets/foster/

Day, A., Riebschleger, J., Dworsky, A., Damashek, A., & Fogarty, K. (2012). Maximizing educational opportunities for youth aging out of foster care by engaging youth voices in a partnership for social change. *Children and Youth Services Review, 34*(5), 1007-1014.

Fixsen, D. L., Blasé, K. A., Timbers, G. D., & Wolf, M. M. (2001). In search of program implementation: 792 replications of the Teaching-Family Model. In G. A. Bernfield, D. P. Farrington, & A. W. Leschied (Eds.), *Offender rehabilitation in practice: Implementing and evaluating effective programs* (pp.149-166). New York, NY: Wiley.

Grillo, C. A., Lott, D. A., & Foster Care Subcommittee of the Child Welfare Committee, National Child Traumatic Stress Network. (2010). *Caring for children who have experienced trauma: A workshop for resource parents—Facilitator's guide*. Los Angeles, CA: National Center for Child Traumatic Stress.

Herrenkohl, E. C., Herrenkohl, R. C., & Egolf, B. P. (2003). The psychosocial consequences of living environment instability on maltreated children. *American Journal of Orthopsychiatry, 73*(4), 367-380.

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., . . . Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice, 39*(4), 396-404. doi: http://dx.doi.org/10.1037/0735-7028.39.4.396

Koh, E., Rolock, N., Cross, T. P., & Eblen-Manning, J. (2014). What explains instability in foster care? Comparison of a matched sample of children with stable and unstable placements. *Children and Youth Services Review, 37*, 36-45. doi: https://doi.org/10.1016/j.childyouth.2013.12.007

Lyons, J. S. (2009). Communimetrics: A communication theory of measurement in human service settings. New York, NY: Springer.

Lyons, J.S. (2014). *Use of the* Child and Adolescent Needs and Strengths (CANS) *in child welfare in the United States: Report prepared for the Ohio Assoication of Child Caring Agencies, Inc.* Retrieved from http://www.oacca.org/wp-content/uploads/2014/03/CANS-in-child-welfare-report.pdf

National Implementation Research Network (NIRN). (2013-2017). *Module 4: Implementation stages. Topic 5: Initial implementation stage*. The National Implementation Research Network's Active Implementation Hub. Retrieved from http://implementation.fpg.unc.edu/module-4/topic-5-initial-implementation-stage

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect, 24*(10), 1363-1374.

Northern California Training Academy, University of California—Davis, Extension, Center for Human Services. (2008, August). A literature review of placement stability in child welfare services: Issues, concerns, outcomes, and future directions. Retrieved from http://www.childsworld.ca.gov/res/pdf/PlacementStability.pdf

Pecora, P. J. (2010, Spring). Why should child welfare focus on promoting placement stability? In T. LaLiberte & E. Snyder (Eds.), CW360˚: A *comprehensive look at a prevalent child welfare issue: Promoting placement stability* (pp. 4-5). Retrieved from http://cascw.umn.edu/wp-content/uploads/2013/12/CW360_2010.pdf

Pecora, P. J., Kessler, R. C., O'Brien, K., White, C. R., Williams, J., Hiripi, E.,…Herrick, M. A. (2006). Educational and employment outcomes of adults formerly placed in foster care: Results from the Northwest Foster Care Alumni Study. *Children and Youth Services Review, 28*(12), 1459-1481.

Pecora, P. J., Kessler, R. C., Williams, J., O'Brien, K., Downs, A. C., English, D.,…Holmes, K. (2005, March 14). *Improving family foster care: Findings from the Northwest Foster Care Alumni Study*. Retrieved from https://www.casey.org/northwest-alumni-study/

Praed Foundation. (1999). *Child and Adolescent Needs and Strengths (CANS) [state]: Comprehensive multisystem assessment for children and youth 5 years–22 years*. Retrieved from http://ifs.[State].gov/content/child-and-adolescent-needs-and-strengths-cans-0

Praed Foundation. (2016). *[State] Child and Adolescent Needs and Strengths ages 0–5 (CANS 2.0)*. Retrieved from http://ifs. [State].gov/content/child-and-adolescent-needs-and-strengths-cans-0

Rubin, D. M., O'Reilly, A. L., Luan, X., & Localio, A. R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics: Official Journal of the American Academy of Pediatrics, 119*(2), 336-344.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (USDHHS). (2013). *The AFCARS report: Preliminary FY2012 estimates as of November 2013, (No. 20).* Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport20.pdf

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (USDHHS). (2017). *The AFCARS report: Preliminary estimates for FY2016 estimates as of Oct 20, 2017, (No. 24).* Retrieved from *https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport24.pdf*

Implementation of Trauma Screening in Three Tribal Communities

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The Transforming Tribal Child Protective Services (TTCPS) project was funded by the Administration for Children and Families and designed to respond to the important issues of abuse and neglect in tribal communities. Though not specific to the tribal communities involved on this project, 2016 statistics on rates of maltreatment published by the U.S. Department of Health and Human Services (USDHHS) show that American Indian/Alaska Native youth served by state Child Protective Services had the highest rate of victimization at 14.2 per 1,000 children of the same race/ethnicity (USDHHS, 2018). American Indian children are more likely to be identified as victims of neglect (65.5%) and less likely to be identified as victims of physical abuse (7.3%) than children of any other race or ethnicity (The Pew Charitable Trusts & National Indian Child Welfare Association [NICWA], 2007). The high rate of neglect speaks to the important contextual factors such as poverty and substance use that must be considered when evaluating statistics such as these and when working toward the development of trauma-informed systems of care.

The TTCPS project was the result of a collaboration between the National Native Children's Trauma Center (NNCTC) at the University of Montana and the Rocky Mountain Region Bureau of Indian Affairs (BIA), Social Services Department. Project activities were implemented with three tribal communities in the Rocky Mountain West (NNCTC, 2011). These tribal communities are rurally located and span large geographic areas. Each tribe has its own unique culture, traditions, strengths, and challenges. In addition, though each partnering tribal community has social service programs operated by the Bureau of Indian Affairs, other important ancillary services such as behavioral health are provided by a mix of federal, state, and tribal agencies. Given this framework of service delivery, key partners on the project, in addition to NNCTC and BIA, included Indian Health Service (IHS) behavioral health clinicians and two nonprofit statewide mental health agencies.

The overarching goal of the TTCPS project was to create trauma-informed tribal child welfare systems. The two main goals of the project were to implement (1) trauma screening, referral procedures, and trauma-specific treatment for American Indian children involved in the BIA social service system and (2) trauma treatment by Indian Health Service Behavioral Health clinicians (NNCTC, 2011). Each goal had corresponding objectives that were designed as benchmarks and a guide to implementation activities. Although the project resulted in various successes, the piloting of a trauma screening instrument in a tribal community was a particularly innovative strategy. Therefore, this article details the challenges, lessons learned, and next steps for implementing trauma screening in tribal communities.

Strengths and Challenges of Trauma Screening Implementation

Strengths and barriers to implementation of trauma screening resulted in important lessons learned for the project. One strength of this process was a consequence of the selection and adaptation of the screening instrument, which was guided by the project's Steering Committee. The Steering Committee, comprising project partners from BIA, NNCTC, and IHS, completed a literature review of trauma screening instruments, contrasted and compared these instruments, engaged in an iterative process of adapting the chosen screening instrument, and employed mechanisms, such as regular check-ins with workers, to collect feedback on implementation of the screening instrument in order to best fit the policies, practices, and needs of each partnering site.

Although none of the reviewed instruments was designed for use in Indian Country, the following were considered for implementation: Trauma Symptom Checklist for Children (Briere & Lanktree, 1995), Trauma Symptom Checklist for Young Children (Briere et al., 2001), Connecticut Trauma Screen (Lang, Cloud, Stover, & Connell, 2014); Child and Adolescent Needs and Strengths (Lyons, 1999), Child Welfare Trauma Referral Tool (Taylor, Steinberg, & Wilson, 2006), and Southwest Michigan Children's Trauma Center Assessment Screening Checklist (Henry, Black-Pond & Richardson, 2010). The Southwest Michigan checklist was piloted by project partners and selected for implementation. This particular screen was chosen because it captured all necessary information and workers were able to complete the document in a relatively short amount of time.

Adaptations were made to the screen to support its efficient use by workers, ensure its relevancy to the organization, and facilitate referral mechanisms between agencies. These adaptations included adding information for traumatic stress reactions common in youth ages 6–18 to expand the applicability of the screen to a greater population of children, the bolding of certain text in the traumatic experiences section (e.g., physical and sexual abuse, exposure to domestic violence, and suicidal ideation) that would trigger an automatic referral to behavioral health, a decision tree for easy calculation of scores and efficient decision making by workers, and a brief referral form to accompany the screen and provide basic information (e.g., reason for child welfare involvement, medication, and allergies) helpful to the behavioral health clinician.

One of the most consequential factors influencing implementation of the screen was the existence of competing demands BIA social service workers must balance. Namely, BIA social service workers, unlike some state child welfare workers, are responsible for coordinating all human service activities in addition to their role as investigators and case managers in cases of child maltreatment (U.S. Department of the Interior [USDI], n.d.-b). It is not uncommon for BIA social service workers to carry responsibilities in the areas of child protection, adult protection, welfare assistance, and Individual Indian Money accounts management. In addition to this broad set of responsibilities, BIA social service workers are tasked with responding to incidents located on reservations with exterior boundaries that encompass up to one million acres of land (USDI, n.d.-a). Responding to the needs of individuals located within such a large land mass, combined with high caseloads and chronic shortage of staff, means that BIA social service workers have become, as one worker described, "emergency responders" (Realbird, personal communication, 2017). Within the context of this work load, feedback during implementation included that some workers felt the trauma screen added another task and piece of documentation to an already heavy workload and paperwork burden.

Additionally, uptake of trauma screening practices was influenced by perceptions held by some social service workers. For example, feedback during implementation from a select number of local social service workers included a concern that labeling a child with a mental health diagnosis may be more likely as a result of screening. Workers remained concerned that certain mental health diagnoses attached to youth was problematic due to potential stigmatization. Furthermore, due to high rates of turnover and staff shortages at IHS behavioral health

units, some social service workers questioned the utility of screening given the limited number of licensed mental health professionals available to conduct trauma assessments and receive referrals.

These findings, which were noted in the TTCPS project evaluation, are consistent with national dialogue regarding the potential limitations of screening for Adverse Childhood Experiences (ACEs). For example, Finkelhor noted the need to understand potential negative outcomes of ACE screening without first understanding important factors, such as whether current treatments are effective at treating high ACE scores in children (2017).

In addition, findings from the TTCPS evaluation revealed commonalities with other similar projects. Barriers around trauma screening in other child welfare systems and those experienced during the TTCPS project included common systemic challenges, such as the size of staff within any given office, the number of responsibilities each worker was required to balance, high caseloads, staff and supervisor turnover, and the number of clinicians who can provide evidence-based trauma treatments (Lang et al., 2017). As a result, maintaining the consistency of implementation was a challenge.

Lessons Learned and Solutions

The lessons learned through the TTCPS project have provided a framework for moving forward with solutions. An important success of the project, and perhaps the reason why trauma screening activities progressed as they did, was due to the strength of collaboration among project partners and their voice and choice in the decision-making process. In addition to providing selection, adaptation, and planning for implementation of the trauma screening instrument, Steering Committee meetings offered an opportunity for dialogue regarding challenges and finding solutions to these challenges.

After the project concluded, some members of the Steering Committee continued collaborative efforts toward building trauma-informed BIA child welfare systems, broadly, and implementation of the trauma screen, specifically. To respond to worker concerns regarding potential labeling of children who are screened and to reinforce the purpose of trauma screening, BIA Regional-level supervisors and local champions continue to work toward regular and consistent trauma trainings as a component of professional development for all new staff. These trainings, when they occur, provide a context for workers around the importance of screening for trauma. As a result, BIA leadership has noted a change in the language used by workers and their corresponding referral practices. Specifically, one member of BIA leadership commented that when discussing a case, consideration is given to the impact of trauma on a child. As she noted, “We’re using the word *trauma*. We wouldn’t have used that word before.”

Though a lack of behavioral health providers to accept referrals continues to be a challenge, BIA social service workers are circumventing this barrier by reaching out to non-tribal mental health agencies who provide services to tribal communities. Additionally, one site found it helpful to have an IHS behavioral health clinician ask the screening questions with the worker over the phone. This allowed the clinician to obtain helpful information about the client to be referred and shifted the burden of completing the screen so that it was shared between the worker and the clinician. A similar process could be replicated at other sites.

Finally, refinement and adaptation of the trauma screening tool continues to occur in order to best fit the needs of each site. For example, workers are finding the screening tool to be useful in an expanded capacity to support care for the newborns on their caseloads. In these cases, the screening tool has been a foundation for gathering a more comprehensive picture of each family, building safety plans, and assessing the support system for caregivers. Based on the results, the worker is able to determine appropriate services for the child and family.

Though no concrete plans have been made to formally evaluate the adapted screen for validity, informal conversations and efforts to understand the impact of screening implementation continue. Emerging themes from these conversations illustrate that workers, seeing its usefulness, help maintain movement toward consistent use of the screen in practice.

Next Steps for Trauma Screening Implementation

Moving forward, BIA social services will continue to lean on the strength of collaborative relationships and local champions to support the implementation of trauma screening. Modeling the use of trauma screening has resulted in a growing shared understanding of the impact of trauma on children. Workers have learned to be curious about what treatments mental health providers are using and that it is best for treatment to be trauma specific when possible. Screening activities have also led to cross pollination into other systems such as shelter care and are beginning to achieve goals toward systemwide trauma-informed service delivery. This cross-agency collaboration, in addition to institutionalized and regular professional development training, is the focus of work to come. Replicating components of the TTCPS project such as trauma training and trauma screening with other BIA regions has also occurred and continued efforts in this area are ongoing. Currently there are no special projects to report, however. Ultimately, though the TTCPS project experienced both unique and common challenges compared with other systems implementing trauma-informed practices, the successes and considerable strength of each community yielded a strong framework on which to build.

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References

Implementation of Trauma Screening in Three Tribal Communities

Briere, J., & Lanktree, C. B. (1995). *The Trauma Symptom Checklist for Children (TSCC): Preliminary psychometric characteristics*. Unpublished manuscript, Department of Psychiatry, University of Southern California School of Medicine.

Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., et al. (2001). The Trauma Symptom Checklist for Young Children (TSCYC): Reliability and association with abuse exposure in a multi-site study. *Child Abuse & Neglect, 25*, 1001-1014.

Finkelhor, D. (2017). Screening for adverse childhood experiences: Cautions and suggestions. *Child Abuse & Neglect*. doi: 10.1016/j.chiabu.2017.07.016

Henry, J., Black-Pond, C., & Richardson, M. (2010). *Children's Trauma Assessment Center (CTAC) trauma screening checklist: Identifying children at risk*. Western Michigan University, Southwest Michigan Children's Trauma Assessment Center. Retrieved from https://wmich.edu/traumacenter/referral.

Lang, J. M., Ake, G., Barto, B., Caringi, J., Little, C., Baldwin, M. J., . . . Connell, C. M. (2017). Trauma screening in child welfare: Lessons learned from five states. *Journal of Child and Adolescent Trauma, 10*, 405-416. doi: 10.1007/s40653-017-0155-y

Lang, J., Cloud, M., Stover, C. S., Connell, C. M. (2014). *Connecticut Trauma Screen*. Funded in part through the Department of Human Services, Administration for Children and Families, Children's Bureau, Grant #0169.

Lyons, J. S. (1999). *The Child and Adolescent Needs and Strengths for children with mental health challenges and their families*. Chicago: Northwestern University.

National Native Children's Trauma Center (NNCTC). (2011). *Transforming tribal child protective services*. Unpublished grant application. University of Montana, Missoula.

The Pew Charitable Trusts, & National Indian Child Welfare Association (NICWA). (2007). *Time for reform: A matter of justice for American Indian and Alaska Native children*. Retrieved from http://www.pewtrusts.org//media/legacy/uploadedfiles/wwwpewtrustsorg/reports/foster_care_reform/nicwareportpdf.pdf

Taylor, N., Steinberg, A., & Wilson, C. (2006). *Child Welfare Trauma Referral Tool*. San Diego: Chadwick Center for Children and Families.

U.S. Department of the Interior (USDI), Division of Human Services, Bureau of Indian Affairs. (n.d.-a). *Agencies offices in the Rocky Mountain region*. Retrieved from https://www.bia.gov/regional-offices/rocky-mountain/agencies

U.S. Department of the Interior (USDI), Division of Human Services, Bureau of Indian Affairs. (n.d.-b). *Division of Human Services mission*. Retrieved from https://www.bia.gov/bia/ois/dhs

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Challenges and Strengths in One State's Effort to Screen and Support Resource Parents' Family Functioning

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Approximately one third of youth in the United States foster care system exit the system each year through adoption, guardianship, or placement with relatives (National KIDS COUNT, 2017). Unfortunately, a case plan of adoption or legal adoption does not secure permanency. A significant proportion (10%–25%) of pre-adoptive placements disrupt before adoption, and 1%–5% of legal adoptions dissolve (Child Welfare Information Gateway, 2012). There is no question that placement disruptions negatively impact children and families. The interplay of trauma, attachment, and behavioral difficulties, along with ensuing placement disruption, is complicated. The experience of trauma is found to be a significant barrier to the child's ability to form attachment relationships with caregivers, which in turn, affects placement security and the child's mental health functioning (Leathers, Spielfogel, Gleeson, & Rolock, 2012).

To prevent such disruptions, and to improve child and family well-being, the New Hampshire Division for Children, Youth and Families (DCYF) partnered with the Dartmouth Trauma Interventions Research Center (DTIRC) on two Administration for Children and Families grants aiming to improve outcomes for children and families through trauma-informed practices. The first grant, funded in 2012, focused on all children involved with the NH Child Welfare and Juvenile Justice systems, and among other things, introduced child-level screening for trauma exposure, PTSD symptoms, and well-being. The second grant, New Hampshire Adoption Preparation and Preservation (NHAPP), was funded one year later, and this time, the focus was more narrowly on children with a case plan goal of adoption and their families. Alongside other workforce and family initiatives, the NHAPP project implemented family-level screening tools to measure family and caregiver constructs identified in the literature that influence placement stability. The constructs we chose to measure included caregiver commitment and sense of belonging in a family (Leathers, Falconnier, & Spielfogel, 2010; Leathers, Spielfogel, Gleeson, & Rolock, 2012), as well as caregivers' ability to reflect on their own and their child's experiences (Bouchard et al., 2008; Luyten, Mayes, Nijssens, & Fonagy, 2017; Sharp & Fonagy, 2008; Slade, 2005). We used the following tools: Protective Factors Survey, Foster Home Integration Scale, Abbreviated Parental Reflective Functioning Questionnaire (ages 0–6), and the Belonging and Emotional Security Tool (ages 7–21). These tools were chosen because their goal is to identify barriers to permanency for each family system and encourage child welfare staff to intervene early to address these barriers. Some of the recommended action steps after screening are referrals to additional child welfare support, foster parent support groups, mentoring with other foster/relative caregivers, family therapy, and specific training.

Framing the Problem

Family-level screening is new for New Hampshire and rare across other state child welfare agencies. In this article, we describe the unique challenges associated with implementing family-level screening in our project, listing several barriers uncovered thus far by our evaluation team. We also name the barriers specific to the content of the tools and implementation processes.

Content Barriers

- Family-level screening asked caregivers to report on their own or their family's functioning, rather than the child's as is traditionally done. Caregivers must reflect on their feelings toward the child, their parenting strategies, and their commitment to the child. During evaluation focus groups, Child Protection staff expressed concern that caregivers may worry that their answers would reflect poorly on them, that they would be judged for their answers, or that their comments might even lead to placement changes. Our evaluation team plans to ask more about this in future focus groups.
- The chosen screening tools did not have existing data to indicate appropriate cut-off scores. Cutoffs were therefore selected by the project team, and some measures lacked reliability or validity testing. It is unknown whether the current scoring system is effective and whether reliability/validity is interfering with successful use of the tools.
- The constructs measured in the screening tools were based on literature identifying family-level risks for placement disruption and then narrowed down to what constructs we could measure change in over time. It is unknown whether these are the most important constructs for our population specifically.
- In a 2017 survey of child welfare staff and supervisors, 52 reported using the Family Functioning Screen (FFS) tool at least once (55%; total n=95; the other 43 respondents indicated that using the FFS was not part of their job). Among these respondents, more than a third (38%; n=20) reported that the results obtained through the FFS were only slightly useful or not at all useful for doing their job. When asked about their assessment of how well the FFS scoring system matched up with their own assessment of resource families' needs, 35% (n=35) of the 100 respondents to this survey item reported that the scoring did not match up with their own assessment(s) of a resource family's needs in those same areas. This matches what we have heard anecdotally.

Implementation Barriers

- Family-level screening required a time commitment on the part of the caregiver, as opposed to the child. Family-level screening may have been seen as "additional paperwork" by the family, and it was not mandatory, as are other forms.
- The screening process and data entry were cumbersome. We developed an online customized dashboard, placed outside of SACWIS, for staff to enter data and see screening results in real time. Workers were required to enter into a separate web-based portal to administer, score, and print the screening results. Workers reported that the dashboard is more complicated for the family-level screening, and staff were more likely to need follow up training compared with the child-level screens implemented in the first project.
- Workers experienced initiative fatigue and system crises. The child-level screening tools were rolled out about a year before the family-level screening tools. DCYF administrative support was more visible with the child-level tools, and more internal supports were in place. System crises (e.g., opioid epidemic, staff and administrator turnover) were also ramped up at the time when family screens were introduced.
- The process for tracking and eligibility was not clearly defined from the outset, and because the data entry system took place outside of the state SACWIS, this situation impeded internal tracking. Instead, Dartmouth personnel

conducted the tracking. Internal meetings were used as an anchor to attempt to track the use of the screening tools, but this was not consistent across offices/regions and therefore was only moderately effective. Compared with the child-level screens, the criteria for eligibility was more nuanced (based on how many months a child had been in care and the date the office got trained) and more reasons were available to rule out eligibility (e.g., children are in residential treatment; they are about to reunify; they have just changed placements).

Strategies to Address the Content and Implementation Barriers

Content Strategies

To address the usefulness of the screening tools, the project team tried several approaches. First, the Adoption Unit at DCYF was trained on how to interpret the screening tool results and for a 6- month period, provided written feedback on every case screened. The goal was to increase the comfort of field staff with the content of the tools. Second, the Project Coordinator traveled to every District Office and participated in regular internal Permanency Planning Team (PPT) meetings to offer guidance and feedback about the screening tools. The Project Coordinator gave case-based consultation during scheduled unit meetings. Only some offices utilized this opportunity. The Project Coordinator also developed a "cheat sheet" for staff to interpret scoring results and determine what steps to take post-screening. Further, in a beginning effort to look at the scoring rubric developed by the team, project staff hand-reviewed screening data for 23 families to examine, broadly, whether or not positive screens were associated with more services. In this initial review, they found no correlation between positive screens and the amount or type of services being provided.

Implementation Strategies

To simplify the process of eligibility and tracking, the project team announced that every child who had been in foster care or relative placement for 6 months was eligible to be screened. First, a specific point person in each office, the Permanency Worker, was asked to track the screening tools and track them during regular internal PPT meetings. Second, project staff presented at statewide supervisory meetings on a semi-regular basis, providing updates and sharing results from surveys and focus groups with field staff. At the same time, DCYF leadership provided support and guidance to field staff, encouraging them to complete the screening tools. The third intervention was a change in administration of the tool. The project team created a fillable PDF that could be emailed to families to be completed and emailed or mailed back in. The Project Coordinator simultaneously trained support staff in many offices on how to enter the screening tools, in an effort to reduce the paperwork burden on staff. This was helpful in that it reduced barriers for the staff, but it also kept them one step away from the data and may have reduced the utility of the screening. This combination of interventions led to an increase in screening tools being completed, from 36 total in the first year to 97 in a 6-month period. Data from the 2017 staff survey shows mixed results about the impact of the described interventions. Among respondents who provided an answer to this item in the survey (n=34), 18% of respondents (n=6) reported completing the tool electronically while meeting with a family (the original intention). Another 18% reported using the fillable PDF or mailing/emailing the screening tool to families to be completed, or both. Nevertheless, the majority, 65% (n=22) reported completing it on paper with a family during a visit and entering it into the system later.

Next Steps

We plan to conduct additional child welfare and family focus groups and interviews to better understand what tools and practices have been most useful, what tracking and daily practices have been done independently, and how to make our work more effective. The project team plans to do more comprehensive data mining to examine the effectiveness of the scoring rubrics as additional screening data become available to support statistical analyses. In addition, we will continue finding ways to reduce the paperwork and time burden on staff

and examine the most efficient workflow to promote these practices. One consideration is to incorporate, with skip logic, the family-level screening into the current child-level trauma-screening tool, so there are no separate sections within the platform. Finally, the project team will develop online training and curriculum for DCYF to be able to use after the end of the project to promote implementation processes. This includes training about the screening tool, interpretation and referrals, and the impact of trauma on children and families, particularly in the context of adoption and permanency.

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References

Challenges and Strengths in One State's Effort to Screen and Support Resource Parents' Family Functioning

Bouchard, M., Target, M., Lecours, S., Fonagy, P., Tremblay, L., Schachter, A., & Stein, H. (2008). Mentalization in adult attachment narratives: Reflective functioning, mental states, and affect elaboration compared. *Psychoanalytic Psychology, 25*(1), 47-66.

Child Welfare Information Gateway. (2012). *Adoption disruption and dissolution*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Leathers, S. J., Falconnier, L., & Spielfogel, J. (2010). Predicting family reunification, adoption, and subsidized guardianship among adolescents in foster care. *American Journal of Orthopsychiatry, 80*, 422-431.

Leathers, S. J., Spielfogel, J. E., Gleeson, J. P., & Rolock, N. (2012). Behavior problems, foster home integration, and evidence-based behavioral interventions: What predicts adoption of foster children? *Children and Youth Services Review, 34*, 891-899.

Luyten, P., Mayes, L, Nijssens, L., & Fonagy, P. (2017). The Parental Reflective Functioning Questionnaire: Development and preliminary validation. *Public Library of Science (PLOS ONE), 12*(5), e0176218.

National KIDS COUNT. (2017). Children exiting foster care by exit reason. Baltimore, MD: Annie E. Casey Foundation. Retrieved from http://datacenter.kidscount.org/data/tables/6277-children-exiting-foster-care-by-exit-reason

Sharp, C., & Fonagy, P. (2008). The parent's capacity to treat the child as a psychological agent: Constructs, measures, and implications for developmental psychopathology. *Social Development, 17*(3), 737-754.

Slade, A. (2005). Parental reflective functioning. *Attachment and Human Development, 7*, 269-281.

Screening for Mental Health Needs in Child Welfare: Do We Also Need to Screen for Trauma?

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Introduction to the Project

From 2012 to 2018, the California Screening, Assessment, and Treatment (CASAT) Initiative was administered by the Chadwick Center for Children and Families at Rady Children's Hospital-San Diego with funding from the Department of Health and Human Services, Administration on Children, Youth and Families (DHHS). One of the central activities of the CASAT Initiative was building infrastructure across individual counties in California to create comprehensive systems for screening social and emotional strengths and needs among children involved with child welfare services. In this article, we describe results from the project's collaboration on the implementation of a screening approach in a county child welfare system to highlight the importance of screening for trauma-related concerns in conjunction with screening for general mental health needs.

Major Issue

Children involved in the child welfare system are particularly vulnerable to having experienced potentially traumatic events including physical and sexual abuse, neglect, and exposure to violence (e.g., Freeman, 2014). The impact of these experiences can be far-reaching and have long-lasting consequences on development across domains of well-being.

Findings from a nationally representative study of cases investigated by child welfare services indicated that 41.4% of children were at risk for behavioral or emotional problems, but of those with identified risk, only 42.5% of children 1.5-10 years and 51.9% of children 11-17 years received mental health services in the preceding year (Ringeisen, Casanueva, Smith, & Dolan, 2011). Recognition of the gap between rates of mental health and trauma-related needs and use of mental health services has led to the development of guidelines calling for comprehensive screening in child welfare to identify and refer children with potential concerns for further assessment (e.g., Hunter Romanelli et al., 2009). Specific congressional guidance now includes the recommendation that children in the child welfare system receive trauma-focused screening in conjunction with screening for general mental health concerns (e.g., Child and Family Services Improvement and Innovation Act, 2011).

In California, an initiative resulting from a class action lawsuit settled in 2011 (*Katie A v. Bonta*, 2006, 2007) sought to improve the delivery of mental health and other supportive services for children and youth in, or at risk of placement in, foster care. This case established the requirement for all counties statewide to implement screening procedures to identify mental health needs among children involved with child welfare services. California's 58 counties are state-supervised but county-administered, each with its own child welfare and mental health systems. Beginning in 2012, the CASAT project partnered with a county

child welfare agency that was seeking to implement a screening approach to meet state requirements and to improve its practice with regard to identification of children with potential mental health and trauma-related needs in order to increase access to mental health assessment and treatment services. The collaborating county that is the focus of this article is classified as a medium-sized metro county (Ingram & Franco, 2014; population ≈ 450,000; 15% of residents living in rural areas). In 2014, there were 870 case openings in the county's child welfare system, and 651 entries to foster care, which represents an incidence of 4.5 per 1,000 children (Webster et al., 2018). In 2013–2014, 33.2% of eligible children in foster care had at least one visit for specialty mental health services in the county mental health system (California Department of Health Care Services, 2017).

Prior to its collaboration with the CASAT project, the county had not been conducting any formal mental health screening of children involved with the child welfare system. Through implementation support and technical assistance provided by the CASAT project, the county began screening for child mental health and trauma-related concerns using the Strengths and Difficulties Questionnaire (Goodman, 1997) and the Traumatic Stress Disorder Scale of the Screen for Child Anxiety Related Emotional Disorders (Muris, Merckelbach, Korver, & Meesters, 2000). The Strengths and Difficulties Questionnaire (SDQ) is a 25-item mental health screening tool that assesses emotional symptoms, conduct problems, hyperactivity-inattention symptoms, peer problems, and prosocial behavior. In the partner county, the parent/caregiver report version was used for children ages 3-10 years and the self-report version was used for youth ages 11 years and older. The Traumatic Stress Disorder Scale of the Screen for Child Anxiety Related Emotional Disorders (SCARED-PTS) is a youth self-report screening tool consisting of four items that inquire about posttraumatic stress-related symptoms (e.g., I have scary dreams about a very bad thing that once happened to me). Youth ages 7 and older responded to the SCARED-PTS. To screen for trauma symptoms in younger children, the tool was adapted for parent/caregiver report for children ages 3-6 years.

Information is reported on 991 children who had an SDQ and SCARED completed in 2013–2014. Screening was conducted on existing cases as well as new cases entering the child welfare system because the county was interested in ensuring that children already active to child welfare services would be screened in the initial phase of implementation. The mean age of the children was 9.6 years (sd = 4.5). Forty-seven percent were males.

On the SDQ, the *total difficulties* score was classified as not elevated, borderline, and abnormal based on established cutpoints. Similarly, the SCARED-PTS score was classified as *not elevated*, *somewhat concerning*, and *concerning* according to recommended cutpoints. Results shown in Table 1 indicate the extent to which potential concerns were identified on each screening tool and the extent to which indication of potential concerns overlapped on the tools.

On the SDQ, 11.6% of children fell into the *borderline* category and 22.3% fell into the *abnormal* category. On the SCARED-PTS, 12.1% of children were classified in the *somewhat concerning* category and 10.5% in the *concerning* category. Collapsing across the two

Table 1. Screening Results (n = 991).

		Traumatic Stress Disorder Scale of the Screen for Child Anxiety Related Emotional Disorders (SCARED-PTS)	
		Not Elevated	Somewhat Concerning/Concerning
Strengths and Difficulties Questionnaire (SDQ)	Not Elevated	57.6%	8.5%
	Borderline/Abnormal	19.8%	14.1%

categories indicating potential concerns on each tool, 14.1% had elevated scores on both the SDQ and SCARED-PTS, while an additional 19.8% had elevated scores on the SDQ alone and 8.5% had elevated scores on the SCARED-PTS alone.

Perhaps most important was that, overall, 42.4% of children had an identified concern on either or both tools, and 8.5% identified only with the trauma-specific screener. These findings suggest that, with relatively little added burden, the use of a trauma-specific screener has the potential to identify a sub-group of children who otherwise might not be identified for referral to mental health services if a general mental health screener were used alone.

The partner child welfare system had a strong commitment to advancing trauma-informed practices, and it readily opted to implement universal screening for both mental health and trauma-related concerns utilizing standardized tools completed by caregivers and youth. Implementation challenges were encountered, but they were not specific to screening for trauma-related concerns. They included difficulties with supporting consistent use of the screening tools across child welfare caseworkers and with data tracking to monitor metrics such as screening rates and outcomes. By the end of the CASAT project, efforts to address these challenges led to the reorganization of the screening approach, and responsibility for screening and referral shifted to a specialized unit of child welfare staff.

Screening is but the first step in identifying trauma-related and mental health needs and should be followed by a thorough, trauma-informed assessment. The CASAT project has developed a framework for assessment in this area called the Trauma-Informed Mental Health Assessment Process (TI-MHAP; California Screening, Assessment, and Treatment Initiative, 2017) which outlines an approach for gaining a thorough understanding of a child, his or her family, and the social environment, based on the ultimate goal of helping the child resolve issues surrounding potentially traumatic events. TI-MHAP operates with the understanding that every child comes to treatment with a unique history, unique family system, and unique level of developmental, cognitive, and emotional functioning. Cultural factors at the child, family, and community level are also considered. TI-MHAP utilizes standardized assessment measures and assessment-based treatment to help guide decisions made throughout the course of the process. It allows for decisions regarding assessment and treatment interventions to be tailored to the individual needs of each child.

Next Steps

Screening for trauma-related concerns is considered a central component of trauma-informed care in child welfare systems and has been promoted through initiatives sponsored by the following offices: Administration on Children, Youth and Families (e.g., Lang et al., 2017) and the Substance Abuse and Mental Health Services Administration National Child Traumatic Stress Network (e.g., Child Welfare Committee, National Child Traumatic Stress Network, 2013). Yet many child welfare systems are not routinely screening children for trauma-related needs. An examination by the CASAT Initiative of California's efforts to implement screening in child welfare systems following settlement of the *Katie A v. Bonta* (2006, 2007) class action lawsuit revealed that most counties opted to utilize tools focused on broad mental health concerns, and few targeted trauma-related concerns in their screening approach, despite the fact that the initiative included an emphasis on the importance of trauma-informed care (Crandal, Hazen, & Rolls Reutz, 2017). Additional support and consultation could promote wider-scale implementation and sustainment of trauma-informed screening practices in child welfare systems. Only when closely linked with a thorough trauma-informed assessment and subsequent trauma-informed, evidence-based treatments can a screening system be implemented effectively. The challenge raised by this need for coordinated services highlights the path ahead for further work in child welfare systems to support the children, youth, and families impacted by maltreatment.

The Chadwick Center for Children and Families is currently embarking on a project that builds on the work of the CASAT Initiative. The Advancing California's Trauma-Informed Systems (ACTS)

Initiative has been developed to utilize resources and lessons learned from CASAT to first consolidate and refine key trauma-informed system-level practices and then help organizations adopt those practices with gradually decreasing technical assistance. In this way, the CASAT Initiative has provided a foundation upon which next steps for advancing trauma-informed care can be built.

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References

Screening for Mental Health Needs in Child Welfare: Do We Also Need to Screen for Trauma?

California Department of Health Care Services. (2017). *Performance Outcomes System children in foster care county report*. Retrieved from http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

California Screening, Assessment, and Treatment Initiative. (2017). *Trauma-Informed Mental Health Assessment process resource guide.* Retrieved from http://www.chadwickcenter.com/wp-content/uploads/2017/09/TIMHAP-merged-toolkit_FinalVersion_101317.pdf

Child and Family Services Improvement and Innovation Act, Pub. L. No 112-34, 120 Stat. 513, 125 Stat. 369-383 (2011).

Child Welfare Committee, National Child Traumatic Stress Network. (2013). *Child welfare trauma training toolkit: Comprehensive guide* (3rd ed.). Los Angeles & Durham, NC: National Center for Child Traumatic Stress.

Crandal, B. R., Hazen, A. L., & Rolls Reutz, J. (2017). Identifying trauma-related and mental health needs: The implementation of screening in California's child welfare systems. *Advances in Social Work, 18*(1), 335-348.

Freeman, P. A. C. (2014). Prevalence and relationship between adverse childhood experiences and child behavior among young children. *Infant Mental Health Journal, 35*(6), 544-554.

Goodman, R. (1997). The strengths and difficulties questionnaire: A research note. *Journal of Child Psychology and Psychiatry, 38*(5), 581-586.

Hunter Romanelli, L., Landsverk, J., Levitt, J. M., Leslie, L. K., Hurley, M. M., Bellonci, C., … the Child Welfare-Mental Health Best Practices Group. (2009). Best practices for mental health in child welfare: Screening, assessment, and treatment guidelines. *Child Welfare, 88*(1), 163-188.

Ingram, D. D., & Franco, S. J. (2014). 2013 NCHS urban–rural classification scheme for counties. *Vital and Health Statistics, 2* (166), 1-73. Retrieved from https://www.cdc.gov/nchs/data/series/sr_02/sr02_166.pdf.

Katie A v. Bonta, 433 F.Supp. 2d 1065 (C.D. Cal. 2006); 481 F. 3d 1150 (9th Cir. 2007).

Lang, J. M., Ake, G., Barto, B., Caringi, J., Little, C., Baldwin, M., . . .Connell, C. M. (2017). Trauma screening in child welfare: Lessons learned from five states. *Journal of Child and Adolescent Trauma, 10*(4), 405-416.

Muris, P., Merckelbach, H., Körver, P., & Meesters, C. (2000). Screening for trauma in children and adolescents: The validity of the Traumatic Stress Disorder Scale of the Screen for Child Anxiety Related Emotional Disorders. *Journal of Clinical Child Psychology, 29*(3), 406-413.

Ringeisen, H., Casanueva, C., Smith, K., & Dolan, M. (2011). *NSCAW II baseline report: Children's services*. OPRE Report #2011-27f, Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation.

Webster, D., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., . . . Lee, H. (2018). *CCWIP reports*. Retrieved from http://cssr.berkeley.edu/ucb_childwelfare

What Is Foster Parents' Role in Trauma-Informed Child Welfare Practice?

Erika Tullberg, MPA, MPH

Introduction

Although foster parents are the cornerstone of the foster care system, they often lie outside of formal structures: They are recruited, trained, certified, and paid by agencies but are not considered staff, and they are caretakers but are not considered family members. As a result, there can be ambiguity around their role that leaves them outside of decision-making processes at both the child and agency level. This can cause particular problems when agencies seek to implement trauma-informed practices, which are conceptually designed to support foster patents in their care of children but instead may feel like an additional requirement that is imposed without a clear rationale or needed support and reinforcement.

Based on the available literature, it appears that it is rare for the implementation of new foster care practices to actively involve foster parents at any stage of the process: planning, training, application or evaluation (Cohen & Canan, 2006; Mahoney & Wiggers, 2007; Smith & Donovan, 2003). Additionally, traditional program implementation can also overlook the fact that, like child welfare staff (Caringi & Hardiman, 2011; Sprang, Craig, & Clark, 2011), foster parents experience both primary and secondary trauma in the course of parenting traumatized children (Conrad, n.d.). Based on anecdotal evidence, unaddressed trauma can create and exacerbate conflict between foster parents and child welfare staff, and thereby contribute to children moving between homes and foster parents leaving the system.

Drawing from efforts to implement trauma-informed practices in Treatment Family Foster Care (TFFC) programs in New York City, and from the author's personal experience as a therapeutic foster and adoptive parent, this article reviews the challenges and benefits of actively involving foster parents in the implementation of trauma-focused efforts. It also discusses how doing so can result in improvements in managing children's behaviors, collaboration with agency staff, and outcomes at the child and agency level.

Trauma-Informed Child Welfare Practice

Over the last decade, child welfare has seen a movement toward trauma-informed practice (Bartlett et al., 2016; Ko et al., 2008). However, there is not complete consensus around what "trauma-informed child welfare practice" entails, and these concepts have been operationalized in different ways by entities such as the Administration for Children, Youth and Families (ACYF) and the National Child Traumatic Stress Network, public child welfare systems, and direct care providers. Some have focused more narrowly on identifying children who have trauma symptoms, referring them to appropriate services and tracking their treatment progress over time (e.g., Kerns et al., 2016), while others have taken a broader approach that includes training, support, and policy change related to trauma and secondary trauma experienced by children, caretakers. and staff (e.g., Lang, Campbell, Shanley, Crusto, & Connell, 2016).

To the point of this article, however, most available

definitions of trauma-informed child welfare practice do not implicitly or explicitly address the role of foster parents in delivering trauma-informed care, despite the fact that they are the primary service providers in the foster care system. This oversight can lead to efforts that, while well-intentioned, result in large gaps that affect the care children receive. I can speak to this from my personal experience as a foster parent when, for example, I learned from one of our caseworkers that our agency was now using a well-known trauma model. She told me about the multi-day trainings that staff attended and related changes that they were making to their internal processes—but nowhere on the list of implementation activities was anything related to foster parents. My response to her was, "How are these efforts supposed to make a difference for children if the people who care for them every day are left out of the loop?"

An Example of Foster Parent Involvement: The Atlas Project

The Atlas Project is an ACYF-funded demonstration effort focused on bringing trauma-informed care to New York City-based TFFC programs (Tullberg, Kerker, Muradwij, & Saxe, 2018). Atlas aims to infuse child welfare agencies and their mental health partners with trauma-informed care through systematic trauma screening and assessment of children, staff and foster parent training, treatment decision-making tools, and trauma-informed mental health treatment. Each Atlas site is a partnership with a TFFC program and a mental health provider; some of the mental health partners are part of the same agency (i.e., "in house") and others are community-based agencies with which the TFFC program has a close relationship.

Given foster parents' role as primary service providers to children in care, we sought to involve them in planning, implementation, and ongoing program activities as true partners, not just passive recipients of information or services. Drawing from the literature about engaging family members in program development and implementation (Shalowitz et al., 2009), we found several ways to involve foster parents in our work.

For example, during the project's planning period, we conducted focus groups with various child welfare stakeholders, such as administrators, staff, youth, biological parents, and foster parents. The purpose of these groups was to identify key concerns of each group related to existing foster care services and mental health treatment, including the coordination (or lack thereof) between service providers. In talking with foster parents, we were particularly interested in their understanding of child trauma and the degree to which they felt existing services were addressing the trauma children in their care had experienced. The primary concerns raised by foster parents focused on not receiving critical information about their children's trauma exposure and related symptoms and their lack of involvement in decision making regarding their children's care and treatment. We addressed these concerns by actively including them in the following mental health screening and treatment activities:

- As part of the Atlas Project evaluation, we completed an implementation study that included (additional) focus groups with foster parents both at the beginning of our work with each TFFC program and a year into the implementation process. The purpose of these groups was to ensure that Atlas was addressing needs expressed by foster parents, and to assess any change in practice that resulted from the implementation of the Atlas model. When foster parents expressed concerns about the functioning of their foster care programs, or their inclusion in Atlas activities, we relayed that information back to program leadership to be addressed.

  For all foster parent focus groups (both during the planning period and those that were part of our implementation study), we sought to have different perspectives represented, but because of the limitations of our project staffing, we included only English-speaking foster parents. To recruit participants, our partner sites were provided with fliers advertising the groups, and in some cases we followed up with outreach to individual parents to remind them of when the groups would be meeting. Focus group participants were provided with refreshments

and a $25 gift card for their participation.

- We also included foster parents in our training efforts and, whenever possible, trained foster parents, TFFC staff, and mental health clinicians together. In addition to ensuring that all participants were receiving the same information and learning the same concepts, we included foster parents and staff together in training to reinforce Atlas's team-focused approach and (at least temporarily) level the hierarchy between foster parents and staff. This approach was particularly powerful in trainings focused on secondary trauma, where staff and foster parents discussed the difficulties of their work in a safe space and were able to see each other not as sources of their stress, but rather as partners who were facing the same struggles.

- Following ACYF's wellbeing framework (U.S. Department of Health and Human Services, Administration on Children Youth and Families, 2012), an important component of the Atlas Project was mental health and trauma screening of all children in our partner TFFC sites. Whenever possible, TFFC or clinical staff would collect information (about children's trauma exposures and any current behaviors or symptoms) directly from foster parents as well as the child and other informants. In some cases, this process revealed important disconnects. For example, through their responses on screening forms, we learned that some foster parents did not consider being removed from one's parents or experiencing multiple moves between foster homes to be traumatic experiences for children. Although on its face, such information might be more alarming than helpful, this information created a valuable teaching opportunity that could make a vital difference in a foster parent's parenting, and in turn, a foster care agency's ability to understand and address a child's trauma.

- The Atlas Project used a team-based clinical model, trauma systems therapy (TST), that involves all of the child's caretakers and service providers in developing and implementing the child's treatment plan (Saxe, Ellis, & Brown, 2015). A main component of TST is identifying trauma triggers in the child's social environment that are contributing to the child's emotional or behavioral dysregulation, or both. For children in foster care, the foster home is a central part of the child's social environment, making it necessary to closely involve the foster parent in the assessment, treatment planning, and treatment delivery processes. To this end, in addition to eliciting information from the foster parent during home and agency visits, we encouraged our TFFC partners to actively involve foster parents in treatment team meetings whenever possible as equal members of the treatment team.

Challenges and Benefits

In our experience, several factors made involving foster parents in the Atlas screening and evaluation activities challenging. The first was logistical; many foster parents work or have childcare responsibilities and are therefore not available during the hours when meetings and trainings typically occur. Additionally, staff and foster parents typically have different levels of preparation and knowledge. Using clinical or technical language in meetings and trainings risked "losing" some of the foster parents; however, framing the concepts in a way that was more accessible to foster parents sometimes resulted in complaints from staff that the language was "dumbed down" and their experience and expertise were not being respected.

A more important factor, however, was less concrete but often more difficult to overcome: shifting the culture from one where staff members are the professionals and foster parents are service recipients, to one where information and influence are shared among equals. In some cases, foster care agency leadership was so uncomfortable having foster parents attend "their" meetings and trainings that they either asked for the idea to be revisited once their staff had more competence with the material, or rejected it altogether. However, when foster parents were at the table, whether it was during trainings or team

meetings, the depth of the conversation, and the progress that could be made, was notably different. In several instances, in fact, TFFC program leadership attributed the "saving" of a placement or improvement in a child's functioning to the foster parent's increased understanding of trauma, engagement with staff, and effectiveness in intervening with the child.

Increased understanding of trauma also influenced the *nature* of foster parent–agency partnerships. In some instances, it was clear that a foster parent's reactions to a child's behavior was contributing to the child's emotional instability, at times threatening the viability of the child's placement. Although these reactions were often unintentional, they were sometimes viewed as parental personality traits or attempts at discipline that, while not ideal, needed to be accommodated. In these situations, we encouraged our foster care agency partners to instead understand these reactions through a "trauma lens," and doing so often learned information about foster parents' own experiences of primary or secondary trauma. This led to a different kind of engagement, one focused on helping the foster parent to better understand her own reactions so that she could both get the support she needed and step back from the vicious cycle she was in with her kids. As a result, foster parents felt more respected and heard, staff felt less frustrated and helpless, and both were in a better position to effectively partner around children's care.

Taking Foster Parent Involvement to the Next Level

While we made strides in incorporating foster parents into the various components of the Atlas Project's planning and implementation, we certainly could have integrated them more fully. We might have, for example, have foster parents be involved in the initial project design and agency-specific implementation planning, had them co-deliver trainings with staff, and more actively participate in program evaluation efforts. Such efforts would have further elevated these parents' status as equal members of the project team and likely motivated other foster parents to be more actively involved in planning and caring for the children in their homes.

Although I would assert that including foster parents in every step of program implementation is good practice in general, it is particularly relevant to trauma-informed care. On an individual level, effectively addressing a child's trauma is not just about engaging him or her personally but also making adjustments in a child's environment that promotes both physical and psychological safety—and doing so is not possible without foster parents' active involvement in this process.

More broadly, at the core of trauma are the concepts of power and control, specifically the loss of power and control in the face of danger. Foster parents are on the frontline of child welfare practice and, as a result, are regularly exposed to trauma both directly and indirectly. In this context, treating foster parents solely as passive service recipients can increase their feelings of helplessness, decrease their feelings of efficacy, and make it more likely that they will ask a child to be removed from their home or choose to stop fostering altogether. Alternatively, genuine partnerships with foster parents in the development, implementation, and evaluation of agency practice can help to restore them with a sense of agency and make them more effective in both collaborating with staff and parenting children.

About the Author

Erika Tullberg, MPA, MPH*, is on the faculty of NYU's Department of Child and Adolescent Psychiatry, where her work focuses on children who have experienced maltreatment, the impact of trauma on parenting and child safety, and secondary trauma experienced by child welfare staff. Prior to coming to NYU, she worked in various leadership roles at New York City's Administration for Children's Services. She earned her MPH at the Columbia University Mailman School of Public Health, her MPA at the Columbia University School of International and Public Affairs. She is currently a doctoral student at the CUNY School of Public Health and a parent to a 28-year-old foster care alumna.*

References

What Is Foster Parents' Role in Trauma-Informed Child Welfare Practice?

Bartlett, J. D., Barto, B., Griffin, J. L., Fraser, J. G., Hodgdon, H., & Bodian, R. (2016). Trauma-informed care in the Massachusetts Child Trauma Project. *Child Maltreatment, 21*(2), 101–112. https://doi.org/10.1177/1077559515615700

Caringi, J. C., & Hardiman, E. R. (2011). Secondary traumatic stress among child welfare workers in the United States. International *Journal of Child & Family Welfare, 2*, 50–63.

Cohen, E., & Canan, L. (2006). Closer to home: Parent mentors in child welfare. *Child Welfare, 85*(5), 867–884.

Conrad, D. (n.d.). *Secondary trauma and foster parents: Understanding its impact and taking steps to protect them*. Retrieved January 14, 2018, from https://muskie.usm.maine.edu/helpkids/rcpdfs/Sec.Trauma-foster.pdf

Kerns, S. E. U., Pullmann, M. D., Negrete, A., Uomoto, J. A., Berliner, L., Shogren, D., … Putnam, B. (2016). Development and implementation of a child welfare workforce strategy to build a trauma-informed system of support for foster care. *Child Maltreatment, 21*(2), 135–146. https://doi.org/10.1177/1077559516633307

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., … Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, healthcare, juvenile justice. *Professional Psychology: Research and Practice, 39*(4), 396–404. https://doi.org/10.1037/0735-7028.39.4.396

Lang, J. M., Campbell, K., Shanley, P., Crusto, C. A., & Connell, C. M. (2016). Building capacity for trauma-informed care in the child welfare system: Initial results of a statewide implementation. *Child Maltreatment, 21*(2), 113–124. https://doi.org/10.1177/1077559516635273

Mahoney, G., & Wiggers, B. (2007). The role of parents in early intervention: Implications for social work. *Children & Schools, 29*(1), 7–15. https://doi.org/10.1093/cs/29.1.7

Saxe, G. N., Ellis, B. H., & Brown, A. D. (2015). *Trauma Systems Therapy for Children and Teens, Second Edition*. New York, NY: Guilford.

Shalowitz, M. U., Isacco, A., Barquin, N., Clark-Kauffman, E., Delger, P., Nelson, D., … Wagenaar, K. A. (2009). Community-based participatory research: A review of the literature with strategies for community engagement: *Journal of Developmental & Behavioral Pediatrics, 30*(4), 350–361. https://doi.org/10.1097/DBP.0b013e3181b0ef14

Smith, B. D., & Donovan, S. E. F. (2003). Child welfare practice in organizational and institutional context. *Social Service Review, 77*(4), 541–563. https://doi.org/10.1086/378328

Sprang, G., Craig, C., & Clark, J. (2011). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare*, 90(6), 149–168.

Tullberg, E., Kerker, B. D., Muradwij, N., & Saxe, G. N. (2018). The Atlas Project: Integrating trauma-informed practice into child welfare and mental health settings. *Child Welfare, 95*(6), 107–125.

U.S. Department of Health and Human Services, Administration on Children Youth and Families. (2012). *Promoting social and emotional well-being for children and youth receiving child welfare services.* Retrieved from https://www.acf.hhs.gov/cb/resource/im1204

Trauma-Informed Care

Enhancing Understanding of the Mental Health Needs of Children and Youth in Foster Care: Validity of Foster Parents as Reporters and Progress Monitoring

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Children and youth in the foster care system have high rates of emotional and behavioral health problems (Burns et al., 2004; McMillen et al., 2005). When unmet, these mental health needs contribute to increased placement disruptions, longer time to permanency, unsuccessful reunifications, and more restrictive placements (Akin, 2011; Horwitz et al., 2012; Iteld, 2010; James, 2004; Leathers, 2006). Mental health is integrally connected to the three primary goals of the child welfare system of safety, permanency, and child well-being. Thus, adequately addressing the emotional and behavioral health needs of children and youth in care is a priority for many child welfare systems across the country.

One widely used strategy in the child welfare system, though not often systematically applied, is the use of mental health screening tools to assist in the identification of children's strengths and needs and facilitate referrals to treatment (Hayek et al., 2014). These tools take the form of self-report surveys or structured interviews that can be administered to youth and those who know them (e.g., parents, out-of-home caregivers, and teachers). Such tools can be useful to inform initial case planning and decisions to obtain more extensive assessments, as described by Berliner and colleagues (2015). Periodic ongoing screening supports child welfare professionals to track progress and identify emerging problems. Ideally, such a strategy is accompanied by community-based high-quality, effective, and engaging treatment. When robust screening protocols are combined with first-rate mental health services, we would expect to see meaningful change at a population level (meaning that fewer children in child welfare would have unmet mental health needs). In addition to informing case planning and treatment needs at the individual level, aggregated data collected through the systematic use of screening tools can inform child welfare and community mental health planning around what types of interventions would be valuable to have in the service array.

This article describes the opportunities and challenges experienced when implementing Creating Connections (Children's Bureau Administration for Children, Youth and Families Grant #90CO1103 HHS-2012-ACF-ACYF-CO-0279). The goal of the project is to increase linkages with mental health services for children and youth in foster care through enhanced screening and progress monitoring.

Screening Context in Washington State

In Washington State, a robust screening protocol called the Child Health and Education Tracking program (CHET) has been in place since the end of 2001. Briefly, this protocol ensures that nearly all children and youth who are expected to be in foster care for 30 days or longer receive a comprehensive health, mental health, educational, social connections, and developmental screen within their first 30 days of care (see Kerns et al., 2016, for a detailed description). While the screening program was successful in completing screens, as of 2012 the screening measures did not specifically identify symptoms of traumatic stress. The funding for Creating Connections allowed for the following: (a) the planning and implementation of a screen for traumatic stress symptoms; (b) an opportunity to evaluate how the screening program was associated with mental health service receipt; and (c) a chance to examine perceptions of mental health screening from the perspectives of the screeners who administer it and the social workers who receive and use the screening results.

Key Partners and Project Goals

The Creating Connections project is a collaborative state-academic partnership managed by a core team of partners, featuring leadership and devoted project leads from the University of Washington (grantee), Children's Administration (CA), and the Division of Behavioral Health and Recovery (DBHR). The project was also advised by representative stakeholders, including a biological parent ally, foster parent, and alumna of care.

The project aimed for trauma-informed, system-level change to enhance identification of mental health symptoms, including traumatic stress, in children and youth in foster care. The purpose of identifying mental health symptoms through screening was to provide a strategy to ensure the linkage of youth to effective services to address identified concerns. Ideally, mental health services should be provided by licensed practitioners who understand the child welfare system and the unique needs of children and youth in foster care. Specific strategies employed by the grant to achieve these goals included the following: (a) adding a traumatic stress-specific measure to the statewide screening program (CHET; administered within the first 30 days in care), (b) introducing an ongoing progress monitoring program for children and youth who remain in the child welfare system for more than six months, (c) training child welfare professionals in identifying and responding to mental health needs, and (d) training mental health providers to be sensitive to the specific challenges of working with children and youth in foster care (see Kerns et al., 2016, for a description of the training approach).

Initial Considerations About Screening

Validity of Screening Within 30–60 Days of Placement

During the needs assessment phase of Creating Connections, many child welfare professionals expressed concerns about the validity of screening during the initial period of transition to foster care when foster parents may not yet know a child well enough to be accurate reporters of mental health symptoms. Further, children and youth may exhibit non-typical behaviors during the initial period of removal; some child welfare professionals indicated that there could be a "honeymoon" period, while others noted that the stress associated with removal from home could result in temporary increases in challenging behaviors. Although we have been unable to find empirical research specifically examining these potential phenomena, we had an opportunity to compare reporting by biological parents, foster parents, and the youth themselves to look for systematic differences in symptom reporting.

Ongoing Progress Monitoring: The Importance of Tracking Changes Over Time

Baseline screening is an essential starting point for identifying children and youth with emotional and behavioral health needs. Ongoing monitoring is important to ensure that children with mental health need improve and that those who develop needs over time are identified and linked to services. Changes after the first 30 days in care due to adjustment (adaptive or maladaptive), mental health symptoms

deteriorating over time, or symptoms improving over time all require attention by child welfare professionals. At the time the project began there was no systematic collection of this information.

Service Array Implications

Initial and ongoing child welfare screening results, when aggregated at the system level and combined with information about mental health diagnoses and service receipt, can provide valuable information about the existing service response. The project analyzed rates of problems youth are experiencing (e.g., internalizing vs. externalizing, trauma-related) that were stratified by age, geographic location, and receipt of and engagement with services. These variables can inform decisions about where and what types of services are needed and where they are sufficient. When these data are combined with ongoing screening, some further inferences about how services are accessed and the benefits of treatment can begin to emerge.

Solutions

Overview of Findings From PSC–17 Psychometrics Study

We compared PSC–17 scores from 2,389 children and youth as well as from self-report, foster parent report, and biological parent report (described in more detail in Parker, Jacobson, Pullmann, & Kerns, 2018). The PSC–17 provides cutoff scores for three mental health subscales and an overall score: internalizing, externalizing, attention, and total score. Scores above the cutoff are considered in the clinical range and below the cutoff are considered in the "normal" range, meaning no or minimal concerns are noted. Scores in the clinical range generally warrant a comprehensive mental health evaluation (Gardner et al., 1999).

We compared percentage agreement in scores provided by the three raters. Agreement was defined as occurring when both raters scored the youth either above or below cutoff on the PSC–17 scales. Our results indicated that foster parents and biological parents identify child symptoms similarly. The extent to which foster parents and biological parents' report of symptoms matched youth self-report was highly similar on the total score and attention subscale. Foster parents had slightly higher agreement with the youth's report on the internalizing and externalizing subscales (see Parker et al., 2018, for more specific details). Nevertheless, such agreement may not be indicative of more accurate reporting, as previous studies have found limited agreement between youth and adult reporters (Briggs-Gowan, Carter, & Schwab-Stone, 1996; Masters, Achenbach, McConaughy, & Howell, 1987). These findings, however, indicated that foster parents were roughly equivalent to biological parents as sources of information, even when they had only known the child or youth for a limited amount of time. Future research, such as use of cognitive interviewing, could help understand how foster parents and biological parents make decisions on symptom rating scales and what types of information are used to determine their perceptions of whether a youth is exhibiting symptoms.

Ongoing Mental Health Program

To enable ongoing progress monitoring, Creating Connections initiated a new program called the Ongoing Mental Health (OMH) screening program. In current practice, the OMH screening program operates with a supervisor and four full-time screeners who re-screen children and youth six months after placement into care, and at subsequent six-month intervals if ongoing mental health concerns are present. This program uses the same validated screening tools as the CHET program. The specific screening tools vary depending on the age of the child. For those under 5½ years of age, the Ages and Stages Questionnaire—Social Emotional (ASQ-SE) is administered. For those over 5½, the Pediatric Symptoms Checklist—17 (PSC–17) and, for those over age 7, the Screen for Child Anxiety-Related Emotional Disorders (SCARED) anxiety and trauma subscales are administered by telephone. In most cases, a foster parent is the sole respondent, though youth over 11 years of age are invited to complete a self-report screen. The information from the screen, including any recommendations, is communicated directly with the primary social worker and the caregiver.

Careful attention was taken to align the OMH program with existing practice (see Table 1 for alignment strategies). As can be seen in Table 1,

Table 1. Compatibility and Alignment of the OMH Program.

Philosophical	Training	Practical
The OMH Program was aligned with CA's goal of identifying and treating trauma symptoms.	OMH Screeners were easily incorporated into the existing training for CHET Screeners.	Able to mirror the CHET screening process. OMH was able to adapt existing CHET processes and documentation formats.
Staff hired to conduct the OMH Screeners had some background or knowledge of the importance of trauma screening.	OMH Screeners were centrally located at headquarters. This allowed the team to work collaboratively and receive direct supervision as needed.	IT infrastructure successfully accommodated the new trauma screening.
Management was supportive of the innovative format of the new screening program.	OMH Screeners were already experienced screening and communicating telephonically.	The OMH Screening team created user-friendly documents and processes to communicate results with staff and caregivers.

chosen strategies aligned with current structures. On a philosophical level, strategies aligned with current goals and interests in enhancing the screening program. Training and support opportunities were designed such that they did not add substantial burden within the system. Strategies and approaches with practical alignment with existing support structures were prioritized.

Data were collected via time diary to learn more about the amount of time and effort required to complete the screens. On average, full-time screeners were able to complete nearly three screens per day. While the screens themselves were relatively brief, substantial time was required to collect case information and create documentation associated with the screens. Over the course of a year and a half, the average amount of time required to complete screenings decreased slightly, indicating that the screeners improved in efficiency.

Results From the Ongoing Screening System

Between its inception in July 2014 and September 2017, the OMH screening program completed 4,314 individual screens, completed a report for each screen, and coordinated with caregivers and social workers regarding ongoing child needs.

We evaluated outcomes for a subset of 1,427 children and youth for whom we had received both the initial CHET screens and the 6-month follow-up OMH screening results. Children and youth were considered to have scored above criteria if they had scores above criteria on any screening tool and according to any rater. Four groups emerged, in order of frequency: (a) continued problems: both CHET and OMH screens were above clinical cutoff (34% of the sample); (b) improved: CHET screen was above cutoff, OMH was below (31%); (c) continued resilience: both CHET and OMH screens were below clinical cutoff (25%); and, (d) deteriorated: CHET screen was below cutoff, but OMH screen was above (10%). Of note, these

labels provide a simplistic way to characterize the groups. There may be nuances not captured by the labels. For example, some youth in the "continued resilience" group may have symptoms not identified by the screening tools. The "deteriorated" group may include youth who had mental health concerns at baseline but took some time to exhibit symptoms once placed in the new environment (i.e., the honeymoon phenomenon).

We compared screening outcomes with receipt of mental health services to determine whether OMH screening results were used to identify and address mental health needs that were not present at the time of CHET screening. Specific findings are reported in Pullmann et al. (2018). To summarize, we found that screening above cutoff at either time point was associated with a higher likelihood of receiving mental health treatment; nearly twice as many of those who screened above cutoff received services within 4 months, compared with those who screened below cutoff. One important potential confound to consider, however, is that children and youth with more substantial mental health needs are more likely to be referred to services regardless of their screening results, even if they were not screened at all (Leslie et al., 2005; Pullmann et al., 2018). However, those children and youth who initially screened below clinical cutoff, but later had a mental health concern picked up by the OMH screen (the "deteriorated" group), were more likely than any other group to initiate mental health services after the OMH screen. This finding provides some support for the hypothesis that child welfare professionals proactively use OMH screening results to guide their decisions regarding mental health referral, though we are cautious about this recommendation as there is the same potential confound that those with high levels of need may be referred regardless of screening scores.

Next Steps

The Creating Connections project enhanced the existing screening efforts and documented how screening influences receipt of needed care. The next steps are to provide the results of these studies to the screening units, child welfare professionals, and leadership. Scoring high on a screening measure is clearly associated with increased access to services. Yet, questions remain regarding the mechanisms through which screening leads to the desired outcome of children in state custody receiving needed mental health care. This is particularly important to understand given the potential for psychological impacts and economic costs associated with screening (see Finkelhor, 2017, for a thoughtful overview of key challenges). If we consider the flow between screening, referral, and service receipt as a series of "decision points," each warrants further examination. Who receives the screening? Of those who get screened, who has a clinical need identified? Of those with identified clinical needs, who gets referred to services? And of those referred to services, who ends up actually receiving a service and is that service matched to their identified needs? We know there are interpersonal, systemic, and sociocultural factors that influence each of these decision points. However, we do not yet have strategies to reliably enhance each pathway from need identification to service receipt.

Commentary

Barbara J. Putnam, MSW, LICSW

Creating Connections contributed important support to the Washington State Children's Administration at a very critical time. When this project initiated in 2012, the Child Health and Screening Track (CHET) program was an established program that provided broad screening to children in their first 30 days in care. There was an awareness that the screening tools didn't include a measure for trauma symptoms. It was unknown to what degree the CHET report findings were applied in the case planning process. Having the opportunity to go through a more formalized and structured needs assessment helped inform what additional supports and directions would be helpful to make the program even more useful and relevant. The two aspects of the project presented in this article are only a small component of the overall Creating Connections project that we hope is having a meaningful impact within our state's child welfare system.

While the potential importance of having an ongoing

mental health screening program was apparent, embedding such a program within an already complex system presented unique challenges. We initially considered a number of different options for the program, including having the child welfare professionals with case-carrying responsibilities administer the screening or adding the responsibilities to the current CHET screening team. However, neither of these options was viable given the context of the existing system. Therefore, it was decided that a centralized unit was the most efficient way to take on the responsibility of conducting the screens. The benefits of this approach included the ability to have close supervision of the program to support fidelity and quality assurance, ability to make timely tweaks and adjustments to aspects of the program, and increased visibility within the central administration. Additionally, centralizing provided an efficient staffing model for coverage if staff members were ill or on vacation. However, like in any new program, there were challenges and unexpected directions.

One such example is that we did not fully anticipate the amount of time that would be required to gather the background information prior to conducting the screen. Collection of such background information is critical in that it provides contact information, verifies status in the foster care system, builds context for the screener concerning the child's needs, and helps the screener have an informed conversation with the caregiver and social worker.

Another example is the necessity of developing training to support CHET, OMH, and field staff in the mental health needs of children and youth in foster care and how to use screening results in case planning. We developed a protocol to inform the case-carrying social worker and caregivers so they would understand screening results and be informed when discussing recommendations. The OMH screeners send area-specific mental health treatment information to the social worker. This includes a booklet of information that informs the caregiver of the program and offers trauma-informed care strategies for a range of developmental stages. Further, OMH screeners complete a screen if requested by the social worker or caregiver. Occasionally additional screenings are provided when a caregiver requests screening for additional children in their home, or when the social worker has a concern about a child or youth.

In summary, projects such as Creating Connections are valuable to child welfare. Washington State Children's Administration continues to be very engaged in the project and is pleased for the opportunity it afforded to embed trauma-informed care into our practices and participate in valuable evaluation analysis.

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References

Enhancing Understanding of the Mental Health Needs of Children and Youth in Foster Care: Validity of Foster Parents as Reporters and Progress Monitoring

Akin, B. A. (2011). Predictors of foster care exits to permanency: A competing risks analysis of reunification, guardianship, and adoption. *Children and Youth Services Review, 33*(6), 999-1011. doi: 10.1016/j.childyouth.2011.01.008

Berliner, L., Fitzgerald, M. M., Dorsey, S., Chaffin, M., Ondersma, S. J., & Wilson, C. (2015). Report of the APSAC Task Force on Evidence-Based Service Planning Guidelines for Child Welfare. *Child Maltreatment, 20*(1), 6-16. doi: 10.1177/1077559514562066

Briggs-Gowan, M., Carter, A., & Schwab-Stone, M. (1996). Discrepancies among mother, child, and teacher reports: Examining the contributions of maternal depression and anxiety. *Journal of Abnormal Child Psychology, 24*(6), 749-765. doi: 10.1007/bf01664738

Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(8), 960-970. doi: 10.1097/01.chi.0000127590.95585.65

Finkelhor, D. (2017). Screening for adverse childhood experiences (ACE): Cautions and suggestions. *Child Abuse & Neglect*. doi: 10.1016/j.chiabu.2017.07.016

Gardner, W., Murphy, M., Childs, G., Kelleher, K., Pagano, M., Jellinek, M., . . . Chiappetta, L. (1999). The PSC–17: A brief pediatric symptom checklist with psychosocial problem subscales. *Ambulatory Child Health, 5*(3), 225.

Hayek, M., Mackie, T. I., Mule, C. M., Bellonci, C., Hyde, J., Bakan, J. S., & Leslie, L. K. (2014). A multi-state study on mental health evaluation for children entering foster care. *Administration and Policy in Mental Health, 41*(4), 552-567. doi: 10.1007/s10488-013-0495-3

Horwitz, S. M., Hurlburt, M. S., Heneghan, A., Zhang, J. J., Rolls-Reutz, J., Fisher, E., . . . Stein, R. E. K. (2012). Mental health problems in young children investigated by U.S. child welfare agencies. *Journal of the American Academy of Child and Adolescent Psychiatry, 51*(6), 572-581. doi: 10.1016/j.jaac.2012.03.006

Iteld, L. A. (2010). *Examining multiple predictors of emotional and behavioral functioning in foster care youth* (Doctoral dissertation). Seattle: University of Washington.

James, S. (2004). Why do foster care placements disrupt? An investigation of reasons for placement change in foster care. *Social Service Review, 78*(4), 601-627. doi: 10.1086/424546

Kerns, S. E. U., Pullmann, M. D., Negrete, A., Uomoto, J. A., Berliner, L., Shogren, D., . . . Putnam, B. (2016). Development and implementation of a child welfare workforce strategy to build a trauma-informed system of support for foster care. *Child Maltreatment, 21*(2), 135-146. doi: 10.1177/1077559516633307

Leathers, S. J. (2006). Placement disruption and negative placement outcomes among adolescents in long-term foster care: The role of behavior problems. *Child Abuse & Neglect, 30*(3), 307-324. doi: http://dx.doi.org/10.1016/j.chiabu.2005.09.003

Leslie, L. K., Hurlburt, M. S., James, S., Landsverk, J., Slymen, D. J., & Zhang, J. (2005). Relationship between entry into child welfare and mental health service use. *Psychiatric Services (Washington, D.C.), 56*(8), 981-987. doi: 10.1176/appi.ps.56.8.981

Masters, J. C., Achenbach, T. M., McConaughy, S. H., & Howell, C. T. (1987). Child/adolescent behavioral and emotional problems: Implications of cross-informant correlations for situational specificity. *Psychological Bulletin, 101*(2), 213-232. doi: 10.1037/0033-2909.101.2.213

McMillen, J. C., Zima, B. T., Scott, L. D., Jr., Auslander, W. F., Munson, M. R., Ollie, M. T., & Spitznagel, E. L. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(1), 88.

Parker, E. M., Jacobson, J., Pullmann, M. D., & Kerns, S. E. U. (2018). Identifying psychosocial problems among children and youth in the child welfare system using the PSC-17: Exploring convergent and discriminant validity with multiple informants. *Child Psychiatry and Human Development, 1-13*. https://doi.org/10.1007/s10578-018-0824-6

Pullmann, M. D., Jacobson, J. H., Parker, E. M., Cevasco, M., Uomoto, A. U., Putnam, B. J., … & Kerns, S. E. U. (2018). Tracing the pathway from mental health screening to services for children and youth in foster care. *Children and Youth Services Review, 89*, 340-354.

Leadership Change Within a System During an Implementation Effort: Considerations After Implementing Trauma-Informed Care in Child Welfare and Behavioral Health Systems

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Introduction

Leadership is a crucial force within the ever-changing landscape of a social service system. Particularly during implementation efforts, leaders contribute proximal and distal influence on how change happens for an organization. Implementation scientists have explored the specific leadership decision-making processes contributing to adoption or dismissal of change efforts (Palinkas, Campbell, & Saldana, 2018; Palinkas et al., 2017) and ways leaders influence organizational climate, innovation, and strategic alignment (Aarons & Sommerfeld, 2012; Aarons, Ehrhart, Farahnak, & Sklar, 2014; Aarons, Sommerfeld, & Willging, 2011). With such a critical role, leadership change often creates challenging ripples throughout an organization during implementation efforts. New directions can include immediate changes in leadership decision making, priorities and perceptions, implementation team alignment, and subsequent changes in the organizational context.

During multi-year implementation projects for child-serving social service systems, such as child welfare and children's behavioral health, leadership change is the norm. However, there is a great deal still to understand about this frequent occurrence and how it serves to facilitate or hinder implementation progress. Policy makers, change effort funders, implementation intermediaries, system leaders, and system staff alike are treading essentially unmapped terrain as leader shift occurs during implementation efforts.

The California Screening, Assessment, and Treatment (CASAT) Initiative was implemented through the Chadwick Center for Children Youth and Families at Rady Children's Hospital-San Diego, in partnership with the California Department of Social Services and funded by the Children's Bureau and Office of the Administration of Children, Youth, and Families, a division of the U.S. Department of Health and Human Services. The 5-year project started in 2012 and centered on the implementation of trauma-informed practices in child welfare and in children's behavioral health systems throughout California. Trauma-informed care (TIC) is a developing concept that includes a collection of evidence-based and evidence-informed practices used to enhance the ways service systems "recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers" (National Child Traumatic Stress Network [NTCSN], 2007, ln 1).

The CASAT Initiative specifically emphasized

implementation of screening systems to identify trauma-related needs for children and youth served by child welfare systems, leading to trauma-informed mental health assessment and subsequent delivery of trauma-focused, trauma-informed, and evidence-based mental health treatments. Workforce development was also emphasized during the CASAT Initiative, including special attention to organizational climate, attitudes toward evidence-based practices (EBPs), cross-system collaboration, and staff training in the concept of TIC. Different elements of the project took place in several of California's 58 county-administered child welfare or children's behavioral health systems. In the process, we encountered multiple leadership changes with varying impacts on our implementation efforts.

As an initial step to further explore, measure, prevent, and intervene when leadership change could disrupt an implementation effort, we propose a model for considering crucial contributing factors for an implementation project when leadership change occurs. This leadership change model includes characteristics of the implementation effort pre- and post-leadership change, as well as elements of the system context, such as system attributes as well as characteristics of the outgoing and incoming leaders. We then provide a case example based on experiences from the CASAT Initiative to apply this model and better understand the role of leadership change, the outputs in the model, and next steps to address the impact of leadership change for implementation intermediaries and social service system leaders.

For the current model, we define *leadership change* as occurring when "an individual (a) is in a position of leadership, responsibility, and power in a given system, (b) is contributing directly or indirectly to a specific implementation effort that is taking place in the system, and this individual (c) changes roles within the system." Based on this definition, leadership change occurs broadly through an organization, from a high level (such as a CEO or deputy director), to a day-to-day manager, or to a peripherally involved leader. It can include changes caused by promotion, demotion, lateral moves within the organization, or exit from the organization. We offer the following model with the goal of beginning to better understand how leadership change influences change efforts. Increased attention to this topic will gradually spur more effective techniques to mitigate negative and maximize positive influences caused by leadership changes during system and organization improvement efforts.

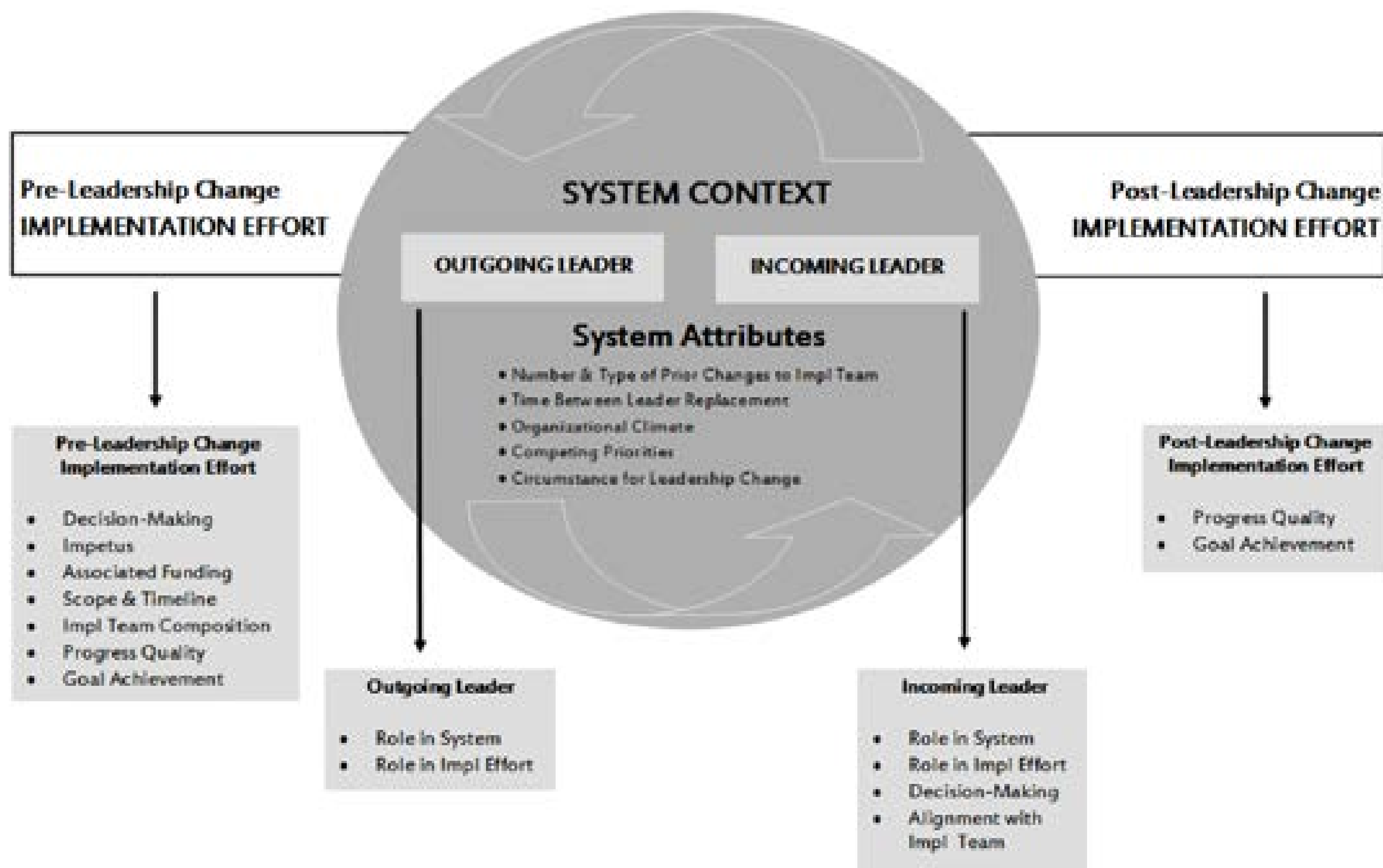
Model for Leadership Change

Most research related to this topic has focused on employee turnover, as opposed to changes at the management level (Parker & Skitmore, 2005), and existing research on leadership change has typically focused on executive-level changes in corporations and their impact on subsequent company performance. A body of literature examines leadership change in sports teams (Carroll, 1984; Gamson & Scotch, 1964; Grusky, 1963) and, more recently, the impact of project manager changes during IT and software development projects. Although there is limited research on leadership change in social services systems, we explore extant research from assorted sectors in the context of our experience with the CASAT Initiative to develop a heuristic model of the impacts of leadership change during implementation efforts. This model is presented in Figure 1 and then described in detail—organized by pre-leadership change characteristics of the implementation effort, the system context factors associated with the change itself (including characteristics of the outgoing and incoming leaders, and attributes of the system in which the leadership change occurs)—followed by the resulting effects of the leadership change on the implementation effort.

Implementation Effort: Pre-Leadership Change

The decision making associated with undertaking an implementation effort makes a powerful impact on how new leaders perceive the effort. Based on Palinkas et al. (2017), decision making crucially includes the perceived costs and benefits associated with the adoption, perceived system capacity for adoption, and perceived acceptability of adopting the practice changes. For example, a change effort preceded by a collaborative and intentional decision-making process, aligned with an overarching strategic

Figure 1. Model for Leadership Change Within a System During an Implementation Effort.



plan and involving colleagues and stakeholders at different levels of the organization, will be perceived very differently from a change effort started by an opportunistic decision by a single leader with overburdened, inattentive, or unconcerned colleagues and stakeholders. If the decision-making process is not articulated or is unintentional, new leaders are unlikely to adopt the previous leader's reasoning. Similarly, if an outgoing leader perceives acceptability of the change effort based solely on feelings, opinions, personal experiences, or biases, one could expect high likelihood of immediate incongruence in perceived acceptability from a new leader.

Prior to a shift in leadership, initial characteristics of the change considerations (such as funding, scope, and timeline) will influence perceptions, attitudes, and commitment of those involved in the change effort and inevitably influence implementation team perceptions and the strategies used to respond to leadership transition. Was the effort initially elective for members of the implementation team or compulsory? Was the change intended to build on previous work completed by the organization, or did it represent the vision of a sole strong leader?

Organizations with longstanding academic-practice partnerships or shared values across levels of management might undertake sturdier change efforts than those championed by a distinctive leader. In each example, the organizations may be poised for success at the onset of the change effort, but loss of the distinctive visionary leader may result in loss of the change-prompting vision. This would create a more disruptive transition than loss of a comparable leader within an organization with widely held shared values. Changes prompted by legislative mandate or court order will have specific consequences for discontinuing (e.g., not meeting legal requirements, potential for funding recoupment).

The scope and timeline of a change often signal the level of coordination and commitment required to accomplish the task. Scope includes the proportion of leadership, staff, consumers, and system programs involved in or influenced by the intended

change. Scope also involves the expected degree of transformation or deviation from the status quo. Often the implementation timelines are developed to align with system needs early in the change effort; however, the flexibility of that timeline becomes critical when leadership change occurs and needs within a system shift.

Team composition also influences how change efforts continue as leadership reorganizes. A project involving only internal staff might be easier to discontinue, while one involving external stakeholders or a contracted intermediary organization may be more stable, as the structure is likely more formalized.

Finally, quality of existing progress and goal achievement of the change effort will play a role in stakeholder commitment and engagement. A project in its early stages may be more easily derailed, whereas one with several years of successful effort is more likely to continue and succeed (Carroll, 1984). The level of goal achievement might be best conceptualized within the Exploration, Preparation, Implementation, and Sustainment (EPIS) model of evidence-based practice implementation (Aarons, Hurlburt, & Horwitz, 2011). While disruption can occur at any stage, one might expect change efforts in the Exploration and Planning phases to be more easily disrupted by leadership change than those in later stages (i.e., Implementation and Sustainment).

System Context

Beyond the context of the implementation effort itself, system and organizational attributes are continuously influencing each member of the implementation team, the setting for the change, and the leaders involved in the effort. Those organizational contexts are likewise influenced by outgoing and incoming leaders.

Outgoing leader. The gap left by the outgoing leader can range from hardly noticeable to dramatically influential, depending on the type of role changes that occur, both for the system and the implementation team. Shift from a system leader, such as a director charged with setting the strategic roadmap for the organization, will be very different from that of a mid-level supervisor. The impact of change on the implementation team will also vary based on the formal and informal roles of the outgoing leader. Was the outgoing leader a main champion or driving force behind the effort or the day-to-day manager of the effort? Was she or he actively involved in the implementation team, or did she or he take a supportive role in the background? On the other hand, a staff person may be promoted up in the system, or make a lateral change, but continue to be part of the implementation team. In some situations, these internal changes may lead to the person discontinuing active involvement, while still being accessible for periodic questions or her ability to effect change as part of the implementation team may increase.

System attributes. The frequency and type of prior changes to the implementation team, the time lapse between outgoing leader replacement with the incoming leader, the organizational climate, competing priorities, and circumstances for leadership change are important considerations. For example, the impact of a retirement or promotion on the implementation team may contribute to a sense of stability while staff termination or resignation could have the opposite effect. These changes may lead to reduced overall team performance due to the loss of historical memory that the departing team member(s) maintained (Carley, 1992; Huy, 1999; Argote, 1993).

The type of organization (public versus private) in which the change is occurring and any associated political or social pressure may impact on the continued progress of the implementation effort. The leadership structure in the organization may also play a role—how many leaders are there and how well integrated are they? For example, a small organization with concentrated leadership may struggle more with turnover at the deputy director level than an organization with multiple deputy directors. Timing of leadership change also plays a role. Was this change one in a string of multiple leadership changes within the overall system? Changes in multiple positions in a short period of time may destabilize the overall system, while a position left vacant for a long period of time may result in other leaders becoming overworked as they try to divvy up responsibilities. These factors interact with the system's existing organizational climate, as well as the overall level of receptiveness inside the organization to the change effort (e.g., are

staff generally supportive or is the change unpopular?).

Incoming leader. Once the transition has occurred and a new leader is in place, the new leader's characteristics will impact the ongoing change effort. First, what is her or his role in the system? Is she or he appointed as a permanent or temporary replacement? Researchers have observed poorer team performance during the period in which the interim high-level leader serves (Ballinger & Marcel, 2010). The new leader's previous role is also important, with inside succession or promotion found to be associated with improvement in team performance; whereas, succession from outside the organization (e.g., hiring a leader who is new to the organization) has been associated with some deterioration in team performance (Grusky, 1963).

The incoming leader's assumed role in the implementation effort is also critical and can be influenced by the leader's personality and leadership characteristics. For example, what is her leadership approach and how receptive are staff members to this approach and the leader herself? Does the new leader have a shared value base with the implementation team or are there incongruences that will cause conflict?

Similar to pre-leadership change, this is a period that includes decision making for the new leader, including conducting a cost-benefit analysis, examining the capacity for continuing the effort, and assessing the acceptability of the change effort for the new leader (Palinkas et al., 2017). One management and system dynamics researcher found that new managers are often less committed than the original project managers and make changes that may impact project performance (Abdel-Hamid, 1992). These key decision points are likely to influence how responsive and engaged the new leader will be in the project and how the new leader will align with the implementation team.

Implementation Effort: Post-Leadership Change

While the outcome of interest in this model is the impact of leadership change on the implementation effort, these are many ways to operationalize the impact. For example, the quality of ongoing progress for the implementation effort may be affected by the transition. Changes in stakeholder participation, engagement, and responsiveness can be enhanced or disrupted as new leaders influence the implementation effort. In fact, existing research suggests manager turnover has a significant impact on project cost and duration (Abdel-Hamid, 1992). Additionally, achievement of the implementation team's goals may also be affected. Both progress quality and goal achievement are likely influenced by loss of historical memory due to transition and the impact of a learning curve or orientation phase when the new leader comes on board (Chapman, 1998; Abdel-Hamid, 1989, 1992).

The implementation effort itself may also be changed as the new leader puts his or her own stamp on the process, especially when someone is brought in from an outside sector or agency. In general, the less familiarity a new leader has with the organization and the field in which it works, the more likely it is that comprehensive organizational change will take place (Villadsen, 2012). This type of leadership change is not unusual in social services systems such as Child Welfare, in which a system leader with management experience but little content knowledge may be brought in to respond to a crisis or address perceived performance issues by "shaking things up."

Application of the Model: A Case Study

Over the course of the CASAT Initiative, one county exemplified varying leadership changes leading to a broad range of adaptations in our collaborative implementation work and subsequent changes to the post-leadership change implementation effort.

Implementation Effort: Pre-Leadership Change

In our early discussions to explore collaboration with this county, we relied on existing ties with a key senior leader who had visionary strategic goals tied to TIC that closely aligned with our organization and with whom we had collaborated previously. The foreseeable resource and capacity demands for being

involved in the CASAT Initiative offered benefits far outweighing costs given her commitment to TIC and our shared experiences together. From this alignment, she volunteered her system in this multi-year project, created capacity by identifying within-system stakeholders who would be engaged in the effort, and engaged senior leader colleagues in other sectors to do the same.

Our early work with this county included a day-to-day manager who served as the key leader directly supporting the implementation effort. This manager shared and supported the strategic goals of the senior leader but was tasked with confronting and overcoming the obstacles we would encounter. Consideration of these inevitable practical barriers may have contributed to marginal weariness, though he still demonstrated an engaged and empowered approach to our shared work. For example, a new position was created to strengthen a TIC training initiative, but during the wait for funding of this position, a valued employee left the organization after becoming overburdened as she tried to cover the new responsibilities and her previous role. This turnover impacted the day-to-day leader and his team immediately as they redistributed responsibilities and hurried to hire for both positions. While both the day-to-day and the senior leaders perceived CASAT Initiative changes as positive, the path to those changes included higher immediate and direct costs for the day-to-day leader. Nonetheless, we were able to collaboratively increase the system training capacity related to TIC and create a trauma screening system.

System Context

After taking steps to implement two major changes in the organization, with the implementation team in place and emphasis shifting from implementation to sustainment and exploration of the next step of our initiative, two leadership changes occurred. In a 3-month window, the senior leader was promoted, and the day-to-day manager retired.

Outgoing leader. The senior leader, a visionary and strategic leader in the system, was promoted to oversee two large systems as well as the system in which we were implementing change. Prior to the change, she provided the foundation for the project by establishing collaborative partnerships and communicating her vision and goals related to the project. After laying the foundation, she was only peripherally involved in the practice changes. The day-to-day leader, an experienced and respected mid-level manager overseeing specific crucial programs for our work, and with whom we constantly communicated and collaborated, informed the implementation team that she had decided to retire from the organization in 2 months.

System attributes. Upon promotion, the senior leader was replaced by one of her direct report staff as the interim and then appointed senior leader. However, after the retirement of the day-to-day manager, a lapse of 8 months took place that included two interim leaders joining the implementation team, then one interim leader, and finally the appointment of a new leader, who was internal to the system but uninvolved in the implementation effort prior to the predecessor's retirement. The implementation team was generally stable prior to the leadership changes, with only one implementation team member and champion of the effort shifting laterally and leaving the team.

Organizational climate during a time of significant leadership change may be an unstable construct to measure because changes in leadership are known to influence organizational climate (Aarons, Sommerfeld, & Willging, 2011). Certainly, the organizational climate in these leaders' system seemed to fluctuate during the initiative. We encountered shifts in culture spreading through the organization gradually, possibly mediated by varying leadership levels within the hierarchy of the organization.

At the onset and close of our time collaborating, we administered the organizational climate subscale of the Survey of Organizational Functioning (Institute of Behavioral Research, 2005) to staff at all levels of the system, which revealed average organizational climate, generally consistent with other social service systems based on national norms established for the tool (Lehman, Greener, & Simpson, 2002). Nevertheless, this system-level survey did reveal shifts in organizational climate (e.g., reduced cohesion, reduced autonomy) over the course of our project.

Additionally, at the time of transition between the outgoing and incoming day-to-day leaders, new state-directed changes unrelated to TIC were required and rolled out to the county, requiring time-sensitive implementation from the system and thus reducing some capacity for our change effort.

Incoming leader. In both cases of leadership change (the senior leader and day-to-day manager), the incoming leaders were hired from internal staff previously uninvolved in the CASAT Initiative. These incoming leaders were assigned to the same positions as their predecessors, although their influence in the systems was different. The new senior leader was well-respected but less visionary in his approach to guiding the system, playing a supportive role to his predecessor's work as he became oriented to the position. He continued peripheral support of the CASAT project and sustainment of the practice changes that had been implemented. However, with the new senior leader supporting an existing strategic plan rather than creating and cultivating his own vision, there seemed to be slightly less engagement or alignment in the partnership to implement CASAT-related practices.

The incoming day-to-day manager was very pragmatic and seemed to prioritize executing standard system operational efforts (adhering to and meeting requirements of the state or policies of the system). After initial discussions with CASAT staff and the implementation team to orient the new leader, she did not attend implementation team meetings and became involved only after prodding from senior leadership. Once participating on the implementation team, her involvement was focused on completing the tasks at hand and the team membership began to rapidly change with only one original system-based team member still involved in the effort after 2 months.

The decision-making processes of these incoming leaders were not transparent to our team as implementation intermediaries, but there seemed to be indications that perceptions of costs and benefits and acceptability had changed for the day-to-day manger. The misalignment with the implementation team was evident but quickly became irrelevant as the team was nearly entirely re-staffed.

Implementation Effort: Post-Leadership Change

The new senior leader seemed aligned with goals of the implementation team but was previously uninvolved in CASAT change efforts. Consequently, the previous CASAT Initiative status of "centrally important in the senior leader's priorities" diminished. The quality of our prior progress had not changed, but the perceptions of this collaborative progress (perceived value, acceptability, cost/benefit ratio) had shifted with the leadership transition. We had fewer interactions with the implementation team and communication was primarily funneled to the day-to-day manager with a focus on defining the discrete remaining steps. Emails from the day-to-day leader included defining phrases, such as "I have been asked to follow up…," or requests to clarify specific commitments the organization had made with us. Prior to the leadership change, the implementation work was collaborative, with ideas and work generated from county and intermediary members of the implementation team. This status change impacted future goal achievement for the project. We followed through with and concluded our collaborative in-progress steps, but with no clear champions remaining in the process and a new emphasis on achieving the remaining steps as quickly as possible.

The day-to-day manager declined a final undefined discrete step related to building capacity for trauma-informed evidence-based practices. We presented this step as optional and transparently informed leadership we had another county system eager to participate in the project to reduce perceptions of obligation to participate in the last step. Although support continued from the initial senior-level leader and generally from her replacement, their attention was pulled to different areas and the landscape in which the CASAT Initiative operated for this county changed almost entirely.

Although this case study presents an example of leadership diminishing the progress quality and goal achievement of our change effort, we also had experiences with opposite outcomes. In one county children's behavioral health system, a day-to-day manager (who was a key champion to our change effort and the implementation team) was promoted to

a senior leadership position. This leadership change enhanced and encouraged the progress quality and goal achievement of our collaborative efforts.

Implications and Next Steps

In the final analysis, one of the most daunting challenges of creating change in social service settings is maintaining progress over time and through leadership transitions. The unpredictable nature of these frequent leadership change events can appear to create inevitable disruptions. Without concerted efforts, the introduction of program improvements become meaningless over time as the agency or department lurches from one initiative to the next without ever building upon the success of what has come before. Our exploration of this phenomenon has led to implications and recommended next steps for implementation intermediaries, system leaders, policy makers, and other stakeholders and organizations contributing to change efforts in large systems.

For individuals involved in technical assistance, implementation intermediaries, or implementation teams driving a change process or EBP implementation, concrete steps can be taken to encourage a smooth transition process. First, the multi-level and multi-stakeholder nature of the implementation team itself can be a strong support for the effort, as it will be clear to the incoming leader that there is a broad backing and buy-in for the change. Initial steps for forming the implementation team can systematize multi-level, multiple stakeholder involvement in a change effort. In this way, the disruption of leadership change in a single system is somewhat partitioned, and multiple systems and stakeholders serve as champions for the effort during leadership transitions.

Second, the implementation team process should be well documented, including meeting notes, relevant communications with agency administrators, and decision documents. For example, at the end of each stage of implementation or periodically, it may be helpful to create a historical summary of the current process. These summaries can emphasize the decision making associated with the change effort, the contributing stakeholders, and how implementation outcomes are tied to overarching system needs or goals. These summaries can be reviewed as new stakeholders engage in the implementation process and can be useful for orienting new leaders to the process. Further, these summaries might provide concrete support and clarity to the current direction of the project.

Third, in addition to strategic team creation and written support for the process, the implementation team may want to be involved in the new leader hiring process to encourage shared value and alignment with the implementation effort. Whether as part of the

Leadership stability in child welfare is critical for the sustainability of evidence-based practices for children and families. Leadership changes, however, can derail even the most diligent implementation. Exploring the effect of leadership stability and transitions on evidence-based practice implementation could lead to critical new insights among researchers, policy makers, and system leaders.

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recruitment and interview process or when providing feedback on the job description and task assignments, the team can help set the tone for the continuation of the project from the start of the transition process.

Last, in some instances system change purveyors may "follow along" with administrators as they move from one agency to another, working to ensure a direct warm handoff of existing projects from the outgoing leader to the new leader. Purveyors and implementation intermediaries may want to target high-level administration groups, such as the Board of Supervisors, to ensure that both sides have a mutual understanding of the benefits of implementing the change effort and how the changes align with the values and goals of the larger agency or government. Developing a long-term deep relationship between purveyors and forward-thinking agency leadership can be mutually beneficial while ensuring continued forward movement during implementation. The actions of system leaders will also be critical for an implementation project.

Both incoming and outgoing leaders bear a responsibility for maintaining progress in quality improvement initiatives even if they inherited the effort from their predecessor, as do their subordinate staff and those who manage them. At times the outgoing leader may feel powerless to influence the person who follows them, especially in the case of changing political winds in public agency leadership. That should not excuse any one from taking proactive steps to shape how the next leadership team embraces important initiatives. This can take several forms, including in-system staff strategically building internal and external stakeholder support, and advocating for continued progress as the new leadership team takes shape. This may mean reaching across the aisle politically to those who have influence with the new leaders or to nonpartisan groups who have sway with the new leader. Such stakeholder constituencies can also be created internally to actively support the continued effort. The extent to which improvements can be woven into the very culture of the organization so that they become "just the way we do business around here," is the degree to which they become more resistant to the whims of a new and unsupportive leader. Finally, the outgoing leader can prepare a formal briefing document that explains the nature of key initiatives, who the key players are, the likely benefits of the effort, and how to share it with those who will follow.

By a similar token, it is important that new leaders pause and assess, particularly when coming into the role after an acrimonious election in a public agency or an unplanned and stressful departure of their processor. As a practical matter, before assuming that any change the predecessor supported is bad, and before the launch of new efforts, new leaders must pause and evaluate carefully all the efforts underway. Ask the staff and stakeholder what is working about the change. The best move may not be to start new initiatives that bear your personal stamp, but to fully embrace change already underway and carry it into day-to-day reality for the benefit of the families the agency serves. Without that type of thoughtful leadership, the risk is great that an organization will never truly progress due to the egos of its leaders.

Conclusion

Our intent in the initial exploration of leadership change is to urge continued and ongoing attention to this critical aspect of implementation system change efforts. The ubiquitous nature of system change impacts all stakeholders and the general capacity for meaningful, sustained improvement for large systems. The proposed model and associated recommendations are informed based on the limited research on the topic and our experiences with a multi-year implementation project across multiple child welfare and children's behavioral health county systems in California. We hope the understanding of these crucial factors and contributors will advance over time, informed by empirical evaluation. The capacity to sustain meaningful change efforts during leadership transitions will improve the efficacy of policy makers, funders, implementation intermediaries, system leaders, system staff, and ultimately the capacity for child welfare and behavioral health systems to strengthen children, youth, and families.

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References

Leadership Change Within a System During an Implementation Effort: Considerations After Implementing Trauma-Informed Care in Child Welfare and Behavioral Health Systems

Aarons, G. A., Ehrhart, M. G., Farahnak, L. R., & Sklar, M. (2014). Aligning leadership across systems and organizations to develop a strategic climate for evidence-based practice implementation. *Annual Review of Public Health, 35*, 255-274.

Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research, 38*, 4-23.

Aarons, G. A., & Sommerfeld, D. H. (2012). Leadership, innovation climate, and attitudes toward evidence-based practice during a statewide implementation. *Journal of the American Academy of Child & Adolescent Psychiatry, 51*, 423-431.

Aarons, G. A., Sommerfeld, D. H., & Willging, C. E. (2011). The soft underbelly of system change: The role of leadership and organizational climate in turnover during statewide behavioral health reform. *Psychological Services, 8*, 269.

Abdel-Hamid, T. K. (1989). A study of staff turnover, acquisition, and assimilation and their impact on software development cost and schedule. *Journal of Management Information Systems, 6*, 21-40.

Abdel-Hamid, T. K. (1992). Investigating the impacts of managerial turnover/succession on software project performance. *Journal of Management Information Systems, 9*, 127- 144

Argote, L. (1993). Group and organizational learning curves: Individual, system, and environmental components. *British Journal of Social Psychology, 32*, 31-51.

Ballinger, G. A., & Marcel, J. J. (2010). The use of an interim CEO during succession episodes and firm performance. *Strategic Management Journal, 31*, 262-283.

Carley, K. (1992). Organizational learning and personnel turnover. *Organization Science, 3*, 20-46.

Carroll, G. R. (1984). Organizational ecology. *Annual Review of Sociology, 10*, 71-93.

Chapman, R. J. (1998). The role of system dynamics in understanding the impact of changes to key project personnel on design production within construction projects. *International Journal of Project Management, 16*, 235-247.

Gamson, W. A., & Scotch, N. A. (1964). Scapegoating in baseball. *American Journal of Sociology, 70,* 69–70.

Grusky, O. (1963). The effects of formal structure on managerial recruitment: A study of baseball organization. *Sociometry*, 345-353.

Huy, Q. N. (1999). Emotional capability, emotional intelligence, and radical change. *Academy of Management Review, 24*, 325-345.

Institute of Behavioral Research. (2005). *TCU survey of organizational functioning (TCU SOF).* Fort Worth: Texas Christian University, Institute of Behavioral Research. Available at ibr.tcu.edu

Lehman, W. E. K., Greener, J. M., & Simpson, D. D. (2002). Assessing organizational readiness for change. *Journal of Substance Abuse Treatment, 22*, 197-209.

National Child Traumatic Stress Network (NCTSN). (2007). *Creating trauma-informed systems*. Retrieved from http://www.nctsn.org/resources/topics/creating-trauma-informed-systems

Palinkas, L., Campbell, M., & Saldana, L. (2018). Agency leaders' assessments of feasibility and desirability of implementation of evidence-based practices in youth-serving organizations using the stages of implementation completion. *Frontiers in Public Health, 6*, 161.

Palinkas, L. A., Um, M. Y., Jeong, C. H., Chor, K. H. B., Olin, S., Horwitz, S. M., & Hoagwood, K. E. (2017). Adoption of innovative and evidence-based practices for children and adolescents in state-supported mental health clinics: A qualitative study. *Health Research Policy and Systems, 15*, 27.

Parker, S. K., & Skitmore, M. (2005). Project management turnover: Causes and effects on project performance. *International Journal of Project Management, 23*, 205-214.

Villadsen, A. R. (2012). New executives from inside or outside? The effect of executive replacement on organizational change. *Public Administration Review, 72*, 731-740.

Policy Change to Support Trauma-Informed Care in Child Welfare

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Introduction to the Project

The Connecticut Department of Children and Families (DCF) is an integrated state agency with mandates to manage services for Connecticut's children across five areas: child welfare, behavioral health, prevention, juvenile justice, and education. DCF employs more than 3,000 staff and completed 44,158 investigations on more than 37,000 children in 2011. In that same year, DCF was awarded a 5-year grant from the Administration for Children and Families (ACF) to support development of a trauma-informed child welfare system in Connecticut. Made possible by the ACF grant, the Connecticut Collaborative on Effective Practices for Trauma (CONCEPT) is a collaboration between DCF, the Child Health and Development Institute of Connecticut (an intermediary organization that functioned as the CONCEPT Coordinating Center), and the Consultation Center at Yale University (project evaluator). The activities of the CONCEPT grant are described in more detail elsewhere (Lang, Campbell, Shanley, Crusto, & Connell, 2016). The remainder of this article describes the development of trauma-informed child welfare policy to support implementation of the goal of creating a trauma-informed child welfare system.

Framing the Major Issue

Increased recognition about the effects of childhood trauma exposure on health, mental health, substance use, criminal justice involvement, and other negative outcomes has pushed child welfare and other child-serving systems to pursue trauma informed-care (TIC). While TIC is broadly intended to use research to improve outcomes for children at risk for and experiencing trauma exposure, the components of TIC have been defined in numerous ways and relatively little is known about its key components and effectiveness (Berliner & Kolko, 2016). Creating trauma-informed policies together with other practice changes is an important component of implementing TIC (Heffernan & Viggiani, 2015). In a review of TIC definitions, trauma-informed policy was identified as one of the 15 common components of TIC and one of those least likely to be implemented (Hanson & Lang, 2016).

Agency policies and procedures represent and communicate to staff the values of the agency, set the standards for practice, and serve as written norms of conduct for agency staff (O'Connor & Netting, 2011). For a change (such as TIC) to be effective, it must be embedded within the structure of the organization, including policy (Aarons, Hurlburt, & Horwitz, 2011; Fixsen, Blasé, Naoom, & Wallace, 2009; Kusmaul, Wilson, & Nochajski, 2015). Changes that are made and reflected in agency policies indicate an agency-wide commitment to the change (Heffernan & Viggiani, 2015).

A readiness and capacity assessment was conducted in

the first year of CONCEPT to assess the child welfare system's trauma-related strengths and needs, and its ability to support implementation of the CONCEPT grant activities. This assessment included an informal review of DCF's policies to determine the extent to which trauma was already acknowledged in policy and to identify strategies for further integrating trauma into policy through the grant. This assessment indicated little recognition about trauma in policy. For example, a keyword search for the word *trauma* across all the child welfare system policies found not a single mention (however, related terms such as *abuse* and *neglect* were found), despite the DCF Commissioner's recent addition of trauma-informed care to the seven guiding principles for agency practice. The assessment also idenitifed many policies that were relevant to TIC, including foster care and adoption, immigration, and intake services, yet it included no description of how to put trauma-informed principles into child welfare practice. These findings indicated a clear opportunity to align policies with DCF's approach to implement TIC through CONCEPT and other activities. DCF leadership showed its commitment to advancing trauma-informed care by ultimately recommending that a formal review of all relevant policies from a trauma-informed perspective be conducted, and a new TIC practice guide would be developed to further inform worker practice about trauma.

Solution: Trauma-Informed Policy and Practice Guide Revisions

As CONCEPT began, DCF was beginning to separate longstanding agency policies into policies and practice guides. Policies were brief descriptions of legislative and administrative mandates, and practice guides were intended to provide more in-depth practice procedures and resources specific to each policy or program area. The DCF Commissioner mandated that all policies and practice guides being revised would be sent to a CONCEPT policy workgroup for review and recommendations to support TIC. The total number of policies governing child welfare practice included 44 overarching policy areas; although most were relevant to trauma-informed care (e.g., Child Protective Investigations and Foster and Adoption Services), the minimally relevant ones (e.g., Fiscal and Engineering Services) were not reviewed.

Formal Review of All Policies

Trauma-informed policy workgroup. A key strategy for developing a trauma-informed system is inclusion of community stakeholders, consumers, and staff members in the planning and implementation of change processes (Substance Abuse and Mental Health Association, 2014). The diverse policy workgroup included DCF staff from a range of job functions and roles, grant staff to ensure integration with other trauma-related work, community stakeholders such as behavioral health providers, and family members (both previously involved with DCF and uninvolved). Involving staff and other stakeholders in policy development ensures that policies are useful to frontline staff in their everyday practice (Lambert, Richards & Merrill, 2016). To make access to the group easier for workgroup members, members were allowed to rotate in and out of the group as their availability permitted. This process gave staff without the ability to commit to long-term participation an opportunity to contribute, broadening the pool of participating staff.

For example, the workgroup recommended adding an extensive array of questions to the protocol used by the Careline Unit (which reviews reports of abuse/neglect for acceptance or screen-out) when answering calls from reporters of abuse/neglect. After the Director of the Careline Unit gave input, however, it became clear that the unit had limited opportunities to learn about trauma from a reporter of abuse/neglect given the often minimal knowledge a reporter may have about the family, including its trauma exposure. Based on this feedback, the recommendations for changes to the Careline policy were reduced, and additional information related to trauma and the initial contact with reporters was added to the accompanying practice guide as more informal considerations for practice.

Policy review tool. A policy review tool was developed based on the Chadwick essential elements of a trauma-informed child welfare system (Chadwick Trauma-Informed Systems Project, 2013), which is defined as

Table 1. Chadwick's Elements of a Trauma-Informed Child Welfare System.

Maximize physical and psychological safety for children and families	In addition to maximizing the child's physical safety, it is also important to attend to the child's sense of safety or th ability to feel safe within one's self and safe from externa harm.
Identify trauma-related needs of children and families	Screening and other methods of questioning a child and family about their trauma history and responses to trauma provides the worker with an understanding of how these issues affect the child and family's current functioning an can help to identify their needs for intervention.
Enhance Child Well-Being and Resilience	Case planning should include interventions that can give the child the tools to manage the lingering effects of trauma exposure and to help them build supportive relationships to help the child grow and mature.
Enhance Family Well-Being and Resilience	Providing caregivers with trauma-informed education anc services, including treatment for caregivers own trauma, enhances their protective capabilities for children.
Enhance the Well-Being and Resilience of Those Working in the System	A trauma-informed system must acknowledge the impact of primary and secondary trauma on the workforce and develop organizational strategies to enhance the resilienc of its members.
Partner With Youth and Families	Youth and family members who have been involved in th child welfare system have a unique perspective and can also serve as partners by providing valuable feedback about how the system can better address trauma within children and families.
Partner With Agencies and Systems That Interact With Children and Families	Child welfare must reach out and coordinate with other systems so they too can view and work with the child and family through a trauma lens.

Source: Chadwick Trauma-Informed Systems Project, 2013.

> …one in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, and families, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery. (p. 5)

The policy review tool was based on Chadwick's definition of a trauma-informed system and the associated elements listed in Table 1. Examples of each element were included in the review tool to assist reviewers with understanding how elements related to child welfare practice. Workgroup members were trained to use the tool by practicing as a group to review one policy with the tool. Additional questions about how to use the tool were answered after members began to review policies with the tool.

Even though the Chadwick elements guided all policy reviews, formal use of the tool was eventually phased out not only because most group members had become familiar with the Chadwick elements but also to expedite the process when there was limited time to complete a review. However, the definition and

elements of a trauma-informed child welfare system continued to guide the additions made to policies and practice guides to make them more trauma-informed.

Trauma-informed care practice guide.

In addition to the review of all relevant policies, the workgroup created a stand-alone "Trauma-Informed Care Practice Guide." This information is intended to supplement the trauma training all staff receive and to assist staff with putting knowledge about trauma into practice in their daily work. For example, the Guide provides an overview of trauma, child traumatic stress reactions, and coping responses; strategies for talking with children, families, and behavioral health providers about trauma; information about evidence-based practices; information about secondary traumatic stress; and a list of web-based resources related to trauma. The Guide is available at https://tinyurl.com/ycfn9hsv.

Results of Policy Review

The workgroup reviewed the 23 policies and associated practice guides between 2012 and 2015. Recommended changes were made and accepted for 11 policies and 17 practice guides of the 23 that were reviewed. When changes were not made or accepted, this was typically due to policies having legislatively mandated information that could not be changed (time frames, required forms), the entire policy/practice guide was eliminated, or there was limited time to complete the policy review. A review of the modified and approved policies and practice guides showed that the word trauma appeared 41 times in the 11 policies and 61 times in the 17 practice guides.

Table 2 provides a sample of the policies and practice guides that were reviewed by the workgroup and gives examples of recommendations that were made and ultimately approved and included in policy. Each policy is also linked to the applicable element of a trauma-informed child welfare system, which helped to guide the recommended modifications. For example, one element of a trauma-informed child welfare system is actively identifying and screening children for trauma exposure and symptoms. Reflecting the implementation of trauma screening in the Multi-Disciplinary Evaluation (MDE) of children in care, the MDE policy was changed to include procedures for completing a trauma screen.

A trauma-informed child welfare system also includes a workforce that considers the impact of trauma on child behaviors in various settings. Various policies, such as Adolescent Services, were amended to include various types of knowledge, from how trauma affects children to the knowledge and skills needed by an Adolescent Services Specialist. Trauma-informed child welfare also acknowledges and addresses the impact trauma has on staff. During the policy review process, DCF developed a policy that established the Worker Support and Wellness Community of Practice and local support teams to address the issue of worker wellness and secondary traumatic stress. This policy and the accompanying practice guide required no amendments by the workgroup.

Accompanying practice guides provided more in-depth coverage of the changes made to policies, including suggestions for introducing the topic of trauma with clients and providing links to more extensive materials on trauma related to the policy topic.

Lessons Learned and Recommendations

Based on key themes that emerged throughout the policy review process, the following recommendations have been made for developing trauma-informed policy in the child welfare system or other child-serving systems.

Diverse group members. The diversity of workgroup staff in role and job function, together with those with expertise in trauma, family members, and the Policy Sponsor, facilitated the group's success. Implementation of trauma-informed care requires involvement of all staff through shared decision making and teamwork (Heffernan & Viggiani, 2015; Kusmaul et al., 2015). Child welfare staff and the Policy Review Unit (including attorneys) also advised about policy elements that could not be changed due to legislative or other mandates. In addition, policy change efforts that include staff at all levels built frontline employee buy-in and provided motivation to implement changed practices as intended (Cao,

Bunger, Hoffman, & Robertson, 2016). Further, participants were thought more likely to share their positive feelings about an initiative with peer staff, thus contributing to the spread of new ideas and practices (Cao et al., 2016).

Challenge of relying on staff volunteers. Soliciting volunteer child welfare staff with an interest in trauma is recommended; however, the policy workgroup was also challenged with relatively high turnover of group members due to changing demands and system-wide fiscal challenges and increases in caseloads. This sometimes created delays in finishing policy reviews as time was taken to explain the review process to new group members, or efforts had to be undertaken to recruit new members when former members rotated out of the group. Because limited commitment was required for a minimal term of service to the group, the number of group members diminished over time, placing the responsibility for reviewing entire policies and practice guides on only a few members. Even though flexibility in membership is important, we recommend that group members and their supervisors commit to a minimal term of service in the group up front. Providing back-up support to cover emergencies on member caseloads while they participate in the workgroup could provide the support needed to commit to a term of service.

Leadership support. Involvement of agency leadership is a key element of any successful organizational change to provide support and communicate the importance of the change initiative to staff (Fixsen et al., 2009; Cao, et al., 2016). In CONCEPT, the DCF Commissioner indicated her support of the policy workgroup by mandating that all policies and practice guides be reviewed by the group prior to forwarding the policy for final approval. This was done through written communication to all policy developers about the change to the policy development process that included a review by the policy workgroup and an identification of the workgroup chair as the person to whom policies would be directed. She also instructed the staff person who was responsible for the final review of all policies to ensure that they had been reviewed by the workgroup and to send them back to the policy developer if they had not. Throughout the review process, the Commissioner and her staff supported the workgroup chair's efforts to track down specific policies that the workgroup selected for review. The Commissioner sustained her commitment to the trauma review process by requiring that the review of all policies for trauma language be embedded in the ongoing policy practice of the agency after the grant ended. The Commissioner also signaled to the staff the value she placed on developing practical policies that reflected the true nature of trauma-informed practice in child welfare by approving and encouraging staff from all levels of the agency to participate in the review process.

Additional leadership was provided by the agency program managers and supervisors. Commitment to participating in the policy development process was modeled by those program managers and supervisors who participated in the process themselves. In addition, leaders who reminded their staff about opportunities to participate in the process emphasized the importance of the process. Finally, program managers and supervisors, who recognized staff who participated in the process in emails or staff meetings, communicated to all staff their belief in the process.

Using a framework to review policy. As the policy workgroup was being created, knowledge among DCF staff about how to design a trauma-informed child welfare system was limited, so the availability of the Chadwick framework, which included the recommended elements of a trauma-informed child welfare system, was invaluable to the policy review process. The Chadwick framework provided common language and definitions for group members to apply to different policies and practice guides, rather than having to develop this framework themselves. The initial development of the policy workgroup was also facilitated by the use of a standardized tool to review policies and provided a method of orienting new members to the group process as they rotated into the group. The identification and use of an existing framework for reviewing and amending policies and procedures served as a valuable resource to facilitate the initiation and sustainment of a newly-developed review process.

Next Steps

The policy review process has been continued through an extension of the CONCEPT grant and will be completed by the end of 2018. The CONCEPT trauma-informed policy review process has been adopted by DCF and will continue beyond the grant for each policy that is amended or developed. Though a formal evaluation of staff use of the trauma-informed policies has not been conducted, anecdotal evidence indicates that DCF supervisors use policies during staff meetings or individual supervision with staff to inform staff about changes made or new policies. They also refer to policies when incidents occur in the field that require clarification for how to proceed. Supervisors and program managers also take time to review components included in practice guides, such as the "Trauma-Informed Care Practice Guide," to provide suggestions on how to improve practice.

Commentary on the Trauma Policy Review Process

Practice in child welfare is driven by federal, state, and local policies. It is no surprise to learn, therefore, that internal agency policies are also instrumental in driving frontline practice. Though changes made to practice in child welfare agencies, usually facilitated through large scale initiatives, are often communicated to staff through agency-wide training and other written updates and leadership communications, staff may not always know how to put new changes into place. Agency policies provide needed direction to supervisors and frontline social workers when they are challenged to know exactly how new initiatives, such as trauma-informed care, are put into practice. Amending internal policies to reflect trauma-informed principles also help to ensure that all aspects of the agency are moving toward trauma-informed care as well as support the changes workers are making to practice.

The trauma policy review workgroup was established in the Connecticut Department of Children and Families (DCF) as part of the CONCEPT grant. It provided an outlet through which DCF could communicate specifically how to put trauma-informed care into each aspect of child welfare practice. The Trauma-Informed Care Practice Guide developed by the group has also supported the trauma training that all child welfare staff receive as part of their orientation training, reminding staff how to identify trauma and refer children to trauma assessments, if needed. The Guide also provides links to additional information that can further inform staff about trauma and its impact on the children and families we serve.

The interest Connecticut's DCF has developed in ensuring that services provided to children and families are trauma-informed is reflected in the inclusion of trauma-informed care as one of its seven cross-cutting themes to guide practice and its interest in pursuing mechanisms for advancing trauma-informed care in practice, such as securing the CONCEPT grant. This interest in advancing trauma-informed care in practice was also evidenced in the development and support of an agency process for reviewing all new agency policies and practice guides for trauma-informed language throughout the CONCEPT grant. The development of such a process highlighted the need for such work as the agency continued its journey toward a trauma-informed agency. As a clear commitment to the ongoing support of trauma-informed care, DCF has established the trauma policy review group as a permanent fixture in the process of reviewing and finalizing amended and new policies developed within the agency.

Table 2. Policy Workgroup Policies Reviewed and Outcome of Reviews.

Policy Title	Policy Description	Sample Trauma-Informed Language Recommended by Policy Workgroup	Chadwick's Essential Elements of a Trauma-Informed Child Welfare System
Policies Approved by DCF Leadership With Trauma Language Recommendations			
Adolescent Services	Services provided by units in DCF Area Offices, which specialize in issues related to adolescents.	Added "**Adolescent Specialists shall be trained in the impact of trauma in early childhood and its impact on the adolescent**" to the list of criteria describing the Adolescent Specialist position.	Identify trauma-related needs of children and families.
Case Planning	The process and actions involved in developing the case plan for youth and families.	Added "**trauma history, impact on functioning and current trauma-related assessment and treatment needs of the child and parents**" to a list of items social workers should address in the case plan.	Identify trauma-related needs of children and families.
Child and Family Permanency Teaming (CF-PT)	The processes involved in the Child and Family Team Meetings when a child is in need of a permanency plan. Child and Family Team Meetings are meetings in which DCF social workers meet with the family members identified by the family as supportive, and potentially other service providers working with the family to develop a permanency plan for a child in care.	Added "**Children experience trauma when they are separated from their families. When children must be removed to be protected, their trauma is lessened when they can remain in their own neighborhoods and maintain existing connections with families, schools, friends, and other informal supports**" to a description of how services should be trauma-informed.	Enhance child well-being and resilience.

Table 2. Policy Workgroup Policies Reviewed and Outcome of Reviews, cont.

Policy Title	Policy Description	Sample Trauma-Informed Language Recommended by Policy Workgroup	Chadwick's Essential Elements of a Trauma-Informed Child Welfare System
Considered Removal: Child and Family Team Meetings	The processes involved in the Child and Family Team Meetings when a child is at risk of removal from the home. Child and Family Team Meetings are meetings in which DCF social workers meet with the family that is the subject of DCF intervention, members identified by the family as supportive, and potentially other service providers working with the family to discuss alternatives for a potential out of home placement.	Added "**The social worker should alert the [family teaming] Facilitator to the child's trauma history exposure and any known child traumatic stress symptoms currently exhibited by the child, including whether or not the child is receiving any trauma-specific assessment or treatment services. If the latter is occurring, DCF should determine what role, if any, the treating therapist might play [in the teaming].**"	Maximize physical and psychological safety for children and families. Partner with agencies and systems that interact with children and families.
Early Childhood Education	DCF eligibility criteria for early childhood education programs for children in care and details of the enrollment process.	Added "**including the child's exposure to traumatic events and his or her stress reactions**" to issues to consider when identifying an early education program for a child in care.	Maximize physical and psychological safety for children and family.
Family Assessment Response (FAR)	A differential response process for families who are in need of services but do not meet the criteria for an abuse or neglect report. The policy and practice guide outline the procedures of this service.	Added "**trauma history and symptoms**" to list of items the social worker should assess for at the initiation of services.	Identify trauma-related needs of children and families.

Table 2. Policy Workgroup Policies Reviewed and Outcome of Reviews, cont.

Policy Title	Policy Description	Sample Trauma-Informed Language Recommended by Policy Workgroup	Chadwick's Essential Elements of a Trauma-Informed Child Welfare System
Health and Wellness Practice Guide: HIV Testing	A sub-category of the "Standards and Practice Regarding the Health Care of Children in DCF's Care," which describes the standards and procedures for HIV testing of youth in care.	Added "**being diagnosed with a life-threatening illness has been characterized as a traumatic stressor**" as an additional reason for addressing coping with the emotional consequences of test results in post-test counseling.	Identify trauma-related needs of children and families.
Health Care of Children Practice Guide- Multidisciplinary Evaluation (MDE)	A description of the evaluation conducted with children within 30 days after placement in care. The areas included in the evaluation are physical, dental, developmental, educational, behavioral, emotional, and child traumatic stress components.	Added "**documentation of any trauma exposure history and any current child traumatic stress symptoms, as well as administration of the Connecticut Trauma Screen for those children ages 7 and above**" to what should be included in the MDE.	Identify trauma-related needs of children and families.
Juvenile Services (Parole)	Services provided to youth whose behavior does not conform to the law or to acceptable community standards.	Added "**ensure that the caregiver(s) are informed about potential trauma triggers or reminders and can identify the strategies and safety plan management of emotional and behavioral issues including trauma triggers and reminders**" to a list of items to consider when approving an initial pass supervised by a family member.	Partner with youth and families. Maximize physical and psychological safety for children and families.

Table 2. Policy Workgroup Policies Reviewed and Outcome of Reviews, cont.

Policy Title	Policy Description	Sample Trauma-Informed Language Recommended by Policy Workgroup	Chadwick's Essential Elements of a Trauma-Informed Child Welfare System
Permanency Placement Services Program (PPSP)	Describes services provided to a child/youth preparing for permanency. It includes placement planning with youth along with home study evaluation of placement.	Added "**communication about traumatic events in the child/youth's developmental history that will promote the caregiver's ability to have a positive relationship and understand the child emotionally**" to a list of items to include in casework services for placement planning.	Partner with agencies and systems that interact with children and families. Maximize physical and psychological safety for children and families.
Prison Rape Elimination Act (PREA) Compliance	The process for investigating all allegations of sexual abuse and sexual harassment generated by youth residing in a facility operated or contracted by DCF, in compliance with the Prison Rape Elimination Act.	Added "**and through the use of trauma screenings and assessment**" to the recommendations for medical and psychological assessments of a child after being victimized.	
Runaway	The notification and follow-up process for youth who are identified as runaways from foster homes and congregate care programs that serve DCF-involved children or youth.	Added • **"What is the child's trauma history?** • **Is it likely that the runaway event may have been triggered by a trauma reminder?"** to issues to consider when securing a child in care who has run away.	Identify trauma-related needs of children and families.

Table 2. Policy Workgroup Policies Reviewed and Outcome of Reviews, cont.

Policy Title	Policy Description	Sample Trauma-Informed Language Recommended by Policy Workgroup	Chadwick's Essential Elements of a Trauma-Informed Child Welfare System
Standards and Practice Regarding the Health Care of Children in DCF's Care	Describes the standards and practices of health care provided to children in DCF care.	Added "**complex medical conditions are also a source of traumatic stress for children and youth. Therefore, the mental health needs of children with complex medical needs must continually be assessed for the presence of traumatic stress and an action planned developed to address the mental health needs of the child/youth**" to a section with information about caring for a child's complex medical needs.	Identify trauma-related needs of children and families.
Therapeutic Foster Care	The policies and practices related to services with DCF-contracted providers of therapeutic foster care. Therapeutic foster care is foster care provided for children with social, emotional, or psychological issues that require a higher level of care than traditional foster care.	Added "**address the trauma of placement of children**" to a list of activities of contractors serving children through the Therapeutic Foster Care Program.	Enhance child well-being and resilience.
Permanency Placement Services Program (PPSP)	The role of DCF in the purchase of permanency placement services contracted by DCF. Permanency placement services are those related to services for children in care who are in need of the realization of a permanency plan.	Added "**communication about traumatic events in the child's developmental history**" to a description of what should be included in the introduction of the child and family in the placement planning services that should be provided by the DCF-contracted provider agency.	Enhance child well-being and resilience.

Table 2. Policy Workgroup Policies Reviewed and Outcome of Reviews, cont.

Policy Title	Policy Description	Sample Trauma-Informed Language Recommended by Policy Workgroup	Chadwick's Essential Elements of a Trauma-Informed Child Welfare System
Working With Transgender Youth and Caregivers	DCF policy and processes for practice with Transgender Youth and Caregivers, based on P.A. 11-55, which added gender identity or expression to the list of protected classes within Connecticut's civil rights statutes.	Added "**Trauma History: If the child has experienced trauma, determine if there is a connection to his or her gender expression or identity. Has the child been shamed or abused specifically due to gender behaviors? At what developmental stage and by whom?**" to areas to explore with family of transgendered youth.	Identify trauma-related needs of children and families.
Worker Support-Secondary Traumatic Stress	Describes services available within DCF to support the wellness of staff and to prevent and/or address secondary traumatic stress.	Added "**preparedness and estimation of exposure to primary and secondary trauma**" to a list of action steps to be taken by supervisors	Enhance the well-being and resilience of those working in the system.
Policies Currently Under Review by DCF Policy Unit			
		assure the safety of employees.	
Foster and Adoption Services	The policies and practices of placing children into foster or adoptive homes, monitoring their progress, supporting foster and adoptive parents, and working with birth parents while children are in foster care.	Added "**understand that multiple placements are traumatic for a child so it is important to work hard to maintain the child's placement and access supportive resources to help address issues that may lead to placement disruption**" to list of criteria to consider when selecting foster or adoptive parents.	Maximize physical and psychological safety for children and families.

Table 2. Policy Workgroup Policies Reviewed and Outcome of Reviews, cont.

Policy Title	Policy Description	Sample Trauma-Informed Language Recommended by Policy Workgroup	Chadwick's Essential Elements of a Trauma-Informed Child Welfare System
Immigration Issues	The services provided to undocumented children who come to the attention of DCF.	Added "**The traumas associated with the journey to the U.S. border are often severe and have life-long implications. Therefore, it is important that workers engage Unaccompanied Alien Children (UAC) from a trauma-informed framework, assess them, and refer them to appropriate behavioral health treatment services to address the symptoms.**"	Maximize physical and psychological safety for children and families. Identify trauma-related needs of children and families.
Interstate Compact on the Placement of Children (ICPC)	A uniform law enacted by all 50 states, the District of Columbia, and the U.S. Virgin Islands to ensure protection and services to children who are placed across state lines for foster care or adoption.	Added "**Help protect the safety of children while minimizing the potential trauma to children caused by interim or multiple placements while ICPC approval to place with a parent or relative is being sought through a more comprehensive home study process**" to potential reasons to expedite the interstate placement of a child in care.	Maximize physical and psychological safety for children and families.

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Table 2. Policy Workgroup Policies Reviewed and Outcome of Reviews, cont.

Policy Title	Policy Description	Sample Trauma-Informed Language Recommended by Policy Workgroup	Chadwick's Essential Elements of a Trauma-Informed Child Welfare System
Standards and Practice Regarding the Health Care of Children in DCF's Care	The practices related to accessing health care for youth in DCF care.	Added "**Complex medical conditions are also a source of traumatic stress for children and youth. Therefore, the mental health needs of children with complex medical needs must continually be assessed for the presence of traumatic stress and an action planned developed to address the mental health needs of the child/ youth**" to issues to consider when working with children in care with complex medical conditions.	Enhance child well-being and resilience.
Voluntary Services	Provides an overview of procedures included in evaluating families for voluntary service eligibility and monitoring family progress under these services.	Added "**Review the child/ youth's history of trauma exposure and their reaction to the trauma**" to a list of items to include in an initial assessment for service eligibility.	Identify trauma-related needs of children and families.

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References

Policy Change to Support Trauma-Informed Care in Child Welfare

Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health, 38*(4), 4-23. doi:10.1007/s10488-010-0327-7

Berliner, L., & Kolko, D. J. (2016). Trauma-informed care: A commentary and critique. *Child Maltreatment, 21*(2), 168-172.

Cao, Y., Bunger, A. C., Hoffman, J., & Robertson, H. A. (2016). Change communication strategies in public child welfare organizations: Engaging the frontline. *Human Service Organizations: Management, Leadership, and Governance, 40*(1), 37-50. doi:10.1080/23303131.2015.1093570

Chadwick Trauma-Informed Systems Project. (2013). *Creating trauma-informed child welfare systems: A Guide for administrators (2nd ed.)*. San Diego, CA: Author.

Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*(5), 521-540.

Hanson, R. F., & Lang, J. M. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child Maltreatment, 21*(2), 95-100.

Heffernan, K., & Viggiani, P. (2015). Going beyond trauma-informed care (TIC) training for child welfare supervisors and frontline workers: The need for system-wide policy changes implementing TIC practices in all child welfare agencies. *The Advanced Generalist: Social Work Research Journal, 1*(3/4), 37-58.

Kusmaul, N., Wilson, B., & Nochajski, T. (2015). The infusion of trauma-informed care in organizations: Experience of agency staff. *Human Service Organizaitons: Management, Leadership & Governance, 39*, 25-37. doi:10.1080/23303131.2014.968749

Lambert, D., Richards, T., & Merrill, T. (2016). Keys to implementation of child welfare systems change initiatives. *Journal of Public Child Welfare, 10*(2), 132-151.

Lang, J. M., Campbell, K., Shanley, P., Crusto, C. A., & Connell, C. M. (2016). Building capacity for trauma-informed care in the child welfare system: Initial results of a statewide implementation. *Child Maltreatment, 21*(2), 113-124.

O'Connor, M. K., & Netting, F. E., (2011) *Analyzing social policy: Multiple perspectives for critically understanding and evaluating policy*. Hoboken, NJ: Wiley.

Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioral health services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publications No (SMA) 14-4816. Rockville, MD: Author.

Creating Trauma-Informed Systems of Care: Reflections on the Special Issue

J. Bart Klika, MSW, PhD

Few would disagree that the abuse and neglect of our nation's children is truly one of the most concerning public health problems of our time. The physical, emotional, psychological, and economic burdens of abuse and neglect are staggering, yet are also preventable. Building coordinated systems of care for family support, inclusive of early intervention services (e.g., home visitation), are key to moving upstream to ensure that abuse and neglect never occur (Klika, Lee, & Lee, 2017). Creating systems and processes for transitioning children and families across the service continuum (and at various levels of intensity) depending upon need is essential in our pursuit of preventing trauma and adversity.

We must also be realistic that, despite our best efforts to prevent all cases of abuse and neglect, some children and families will find themselves at high risk for, or involved in, child welfare, juvenile justice, and mental/behavioral health systems. When families find themselves in our agencies, offices, or communities, it is our collective responsibility to provide high-quality, culturally responsive, and coordinated treatment services based upon the best available evidence, or what the contributors of this special issue term *trauma-informed care*.

This collection of articles provides a window into the complexity of translating concepts advanced by the trauma-informed care movement into actionable practice strategies at the local, state, and policy level. I would like to thank the authors of this special issue for their contributions to the field and for sharing their wisdom, insights, and lessons learned so we all can capitalize on their innovations. They provide many take-away messages, and here are a few of the most important cross-cutting themes identified throughout the articles.

Screening

Children who have experienced trauma, abuse, and significant adversity present with a host of physical, behavioral, and emotional problems (Szilagyi et al., 2015). Identifying traumatized children who are in need of referral for assessment and evidence-based trauma treatment by a trained clinician can be accomplished through screening in child welfare or mental/behavioral health systems. But, as the authors of this special issue highlight, a number of critical components of screening must be taken into account, such as what should we screen for (Hazen, Crandal, & Rolls-Reutz; Kerns et al.), the timing of the screening (Kerns et al.), and the target of the trauma exposure and symptoms screening (Parton, Barnett, & Jankowski; Kerns et al.). There is also a major challenge of gaining worker buy-in or engagement in new initiatives such as screening. Some workers may not understand the purpose or be skeptical of screening or simply may not have the time to complete screening due to the demands of the job (Trautman, Rides At The Door, Zimmerman, & Realbird; Parton et al.). In addition to addressing the critical screening issues identified by the authors, Finkelhor (2017) suggests that agencies must also weigh the cost-benefit of screening children (e.g., time, energy, ongoing training) along with the availability of effective services for those children identified through screening as needing further assessment and treatment services.

Creating Change Within Dynamic Systems

The authors also discuss the challenge of how to create pockets of stability and consistency within dynamic service systems such as child welfare, where rates of worker turnover are consistently high. Vicarious and secondary trauma resulting from listening to horrific accounts of client abuse and trauma can lead even the most seasoned worker to experience empathic strain, compassion fatigue, and eventually burnout. Turnover creates worker shortages that place stress on the child welfare system by leading to increased caseloads for those left behind and through losses of institutional knowledge. As Jankowski, Butcher, and Barnett highlight, external factors such as the opioid crisis can place additional stress on already hemorrhaging child welfare caseloads. With all of the added stressors placed on child welfare workers, it is no wonder why engagement in initiatives such as screening were such a challenge for a number of the authors of this special issue (Trautman et al.; Parton et al.; Campbell, Lang, & Zorba). Under the right leadership, steps can be taken to create stability for workers despite their challenging job. However, as Crandal, Rolls-Reutz, Wilson, and Hazen and Jankowski et al. highlight, supportive and visionary leaders can turn over, leaving systems vulnerable to a loss of productive momentum. Institutionalizing change initiatives by creating teams (Hemenway et al.), implementation intermediaries, or key stakeholder groups (Crandal et al.), or through documenting these initiatives in organizational policies and procedures (Campbell et al.; Crandal et al.) appear to be strategies to create stability for the system and to minimize institutional knowledge loss occurring through turnover at multiple levels of the system.

Need for Concept Clarity

Although advances have been made in the definition and operationalization of trauma-informed care (see Hanson & Lang, 2016), there appears to be great variability in how professionals use and represent the concept in their day-to-day practice and at an organizational level (Berliner & Kolko, 2016). Claiming that an organization or its menu of services is “trauma-informed” is ubiquitous in the field, yet we cannot say with certainty that the concept means the same thing across professionals or service contexts. By gaining professional consensus on a working definition and key components of a trauma-informed system, the field will be able to create and test logic models and theories of change for how components such as screening, workforce development, and availability of evidence-based services are related to improved outcomes for children and families (Bartlett). Further, Tullberg reminds us that more effort is needed to include the voices and perspectives of those who are affected by the system, for example, the foster parents. Integrating the knowledge and expertise of this “forgotten front line” is essential for creating systems that respect the commitment and wisdom of our foster families.

Our collective vision is to create environments where all children can thrive. I hope these articles have created opportunities for reflection, learning, and a renewed commitment to improving services for children and families. In closing, thank you again to the authors and anonymous reviewers who helped push forward the field of trauma-informed care through their contributions to this special issue of the *APSAC Advisor*.

About the Guest Editor

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Policy Change to Support Trauma-Informed Care in Child Welfare

Berliner, L., & Kolko, D. J. (2016). Trauma-informed care: A commentary and critique. *Child Maltreatment, 21*, 168-172.

Finkelhor, D. (2017). Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child Abuse & Neglect.* Advance online publication. doi.org/10.1016/j.chiabu.2017.07.016

Hanson, R. F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child Maltreatment, 21*, 95-100.

Klika, J. B., Lee, S., & Lee, J. Y. (2017). Prevention of child maltreatment. In J. B. Klika & J. Conte (Eds.), *The American Professional Society on the Abuse of Children handbook on child maltreatment, fourth edition*. (pp. 235-251). Thousand Oaks, CA: Sage.

Szilagyi, M., Rosen, D. S., Rubin, D., Zlotnick, S., & the Council on Foster Care, Adoption, and Kinship Care, the Committee on Adolescence, and the Council on Early Childhood. (2015). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics, 136*, e1142-e1166.

APSAC Research-to-Practice Brief – Effectiveness of a Trauma-Informed Care Initiative in a State Child Welfare System: A Randomized Study

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Background

In the past 20 years, trauma-informed care (TIC) initiatives have gained increased interest in the social service arena. Interest in trauma by child welfare agencies is fitting; children entering the child welfare system have often experienced trauma such as abuse, neglect, and witnessing domestic violence. The child welfare system itself can also be traumatic, such as when children are removed from their homes, placed in foster care, and experience placement disruptions. Children involved in the child welfare system have significantly higher rates of trauma than children in the general population.

TIC initiatives have gained interest, but TIC's definition, measurement, impact, and ability to be cost effective are still unclear.

The purpose of this study is to rigorously examine, using a randomized, matched-pairs, crossover design, whether a 5-year, multi-pronged, statewide trauma-informed care initiative in a child welfare agency changed trauma-informed attitudes, skills and behaviors, and perceptions of system performance related to trauma among child welfare staff. The state system studied was the New Hampshire Division for Children, Youth and Families (DCYF), which includes both the child protective and juvenile justice systems.

Intervention

Ten district offices of DCYF were randomly assigned to either Cohort 1 (early intervention group) or Cohort 2 (late intervention group). Data were collected three times: Time 1 was prior to any intervention, Time 2 was post-intervention for Cohort 2, and Time 3 was post-intervention for Cohort 3.

Interventions included (1) monthly training focused on principles of TIC and their application to child welfare and juvenile justice, along with training in using the Mental Health Screening Tool, (2) installation and implementation of a new web-based Mental Health Screening Tool, (3) weekly consultative support to each district office for 3 months after training to provide guidance for staff members implementing the TIC practices in their work, (4) identifying and providing advanced training to three staff members (Trauma Specialists) responsible to maintain application of TIC practices, and (5) subcommittee work to review and implement system-level processes and policies on TIC (i.e., establish formal policies to integrate the new screening, case planning, and progress monitoring) .

Measures

Measures were based on self-report of involved staff. Six TIC domains were measured:

1. trauma screenings (frequency and proficiency),
2. case planning (frequency),
3. referrals for trauma-informed treatment and involving families in meeting behavioral needs of the child (frequency),
4. progress monitoring (i.e., frequency of rescreening, updating case plans, communication with mental health providers for child's progress),
5. collaboration between DCYF staff and mental health providers (i.e., information sharing, attitudes toward a shared vision), and
6. system-level TIC practices (attitudes about the state child welfare system carrying out several TIC practices).

Results

At Time 1, 51.3% of eligible staff responded to the survey; after certain responses had been eliminated for not meeting the criteria of working with children and families or for missing data, 145 were included: 77 in Cohort 1 and 68 in Cohort 2.

Linear mixed modeling was used to examine the effect of the intervention on the six outcome variables. There were significant findings in three areas: initial case planning and communication, trauma screenings, and perceptions of DCYF's TIC system performance.

Across all three domains, there was little change for Cohort 1 across all three time points. For Cohort 2, ratings dropped from Time 1 to Time 2, and then increased significantly at Time 3. Researchers hypothesize that the TIC intervention may have buffered Cohort 1 from the effects of an increasing number of stressors on the child welfare system, from Time 1 to Time 2. For Cohort 2, the intervention improved attitudes and behaviors for trauma screening, case planning, and TIC system performance at Time 3. While Cohort 2 was receiving the intervention, the child welfare system was burdened with even more stressors. Researchers hypothesize that staff in Cohort 2 District Offices were particularly receptive to a TIC approach and the additional support provided via the project given the continued opioid crisis and more children entering the child welfare system.

The mixed findings are consistent with the mixed findings of prior studies. With few significant results, the authors question if such a comprehensive TIC intervention is cost effective. The authors acknowledge that the ongoing systemic challenges in child welfare, such as budget reductions, increased need for services partly due to the opioid crisis, and chronic workforce shortages, are a factor in any TIC initiative being effective in child welfare services. Further research is warranted, perhaps to identify whether certain domains of TIC are more effective than others and can achieve measurable, objective child and family outcomes.

Bottom Line

While these results were mixed, showing effects in three of the six measured domains (case planning, trauma screening, and perceptions of TIC), the authors maintain support for adopting a "trauma lens" in the child welfare and juvenile justice systems. They also acknowledge that the effects will likely be limited if these systems continue to face challenges such as under-funding, increased need for service, and issues with workforce shortages and turnover. Until a larger effort is made to address the core issues facing child welfare, the authors suggest TIC interventions must take into consideration the challenges child welfare inevitably faces.

About the Research-to-Practice Brief Author

Areesah Abdus-Shakur, LMSW*, has been a social worker for 25 years in a variety of community based services, She is currently working with Quality Assuance for Behavioral Health Services within county government. She resides in Pennsylvania.*

Regular Features

News of the Organization

Janet Rosenzweig, MS, PhD, MPA, Executive Director

Our Past, Our Future

The staff members at APSAC are hard at work updating the online platform to better serve our members. We hope you login soon and explore the exciting new resources and opportunities to connect on our new membership platform.

As part of the process of migrating files, I had the opportunity to review some historical documents; when I randomly came across a list of Board members from 1987 to 1994, I saw APSAC's past and future on one page. Current Board members, including ***Kathleen Faller*** and President ***Dave Corwin***, were on that list. Former 1987–1994 Board members—***Charles Hendrix, Patti Toth, David Kolko, Bea Yorker, Sandra Alexander, Ben Saunders, Vince Palusci, Jordan Greenbaum, Julie Kenniston, Lucy Berliner, and Barbara Kelly***—are currently active with APSAC committees or projects. Cohort members—***Charles Wilson, David Finkelhor, Jon Conte, and Paul Stern***—have all agreed to produce modules for our online course for early career professionals, launching next year.

I had a "full-circle moment" when I saw that my first boss and mentor, the late ***Charles Gentry*** from Tennessee, had served as a director from 1988 to 1991, long after I'd left Tennessee and we had lost touch. Gentry was widely known and respected for developing creative solutions in child welfare. His outside-the-box decision in 1978 to hire a sex educator with no background in child protection set the stage for my career focusing on child sexual abuse. Under his tutelage, I directed one of the first comprehensive child sexual abuse programs in the country, funded with NCCAN grants and managed by 1988–1991 APSAC Board member ***Kee McFarlane***.

I can't wait to see the names on lists that surface from other years!

APSAC has been an important pillar in the professionalization of services and policies affecting maltreated children and their families, built on the dedication of these and other committed volunteers. Facing current issues ranging from CAPTA reauthorization to preventing abuse in youth sports, APSAC needs your expertise now more than ever. Immediate Past President ***Tricia Gardner*** will be reaching out to past Board members, and anyone reading this is encouraged to contact me and get involved!

The 25th Anniversary Colloquium Is a Happy Memory; Plan Now for the 26th in Utah!

Thanks to everyone who attended the 25th Anniversary Colloquium! We had so much to celebrate this year. Our two plenary speakers, the ***Rev. Dr. Darrell Armstrong*** and ***Dr. Elizabeth Letourneau***, brought the perfect blend of inspiration and information to attendees. Our new media-ready micro sessions (now available on the APSAC YouTube channel) offered new opportunities to disseminate research and practice information quickly and widely. The ***Doris Duke fellow*** track ensured that we will maintain focus on prevention. Our presenters—from pre-conference institutes, to workshops, to roundtables, to posters—brought both the evidence and the passion needed to improve outcomes for children and families. And, of course, our attendees brought the curiosity, questions, and challenges that help make all of us stronger professionals.

APSAC is excited to announce the call for abstracts for our 26th Colloquium to be held in Salt Lake City,

Utah, in 2019. APSAC's 26th Colloquium will continue our tradition of bringing high-quality learning opportunities to child maltreatment researchers and practitioners across experience levels and professions. Priority will be given to presentations including an emphasis on integrating the principles of trauma-informed interventions for all fields working with child maltreatment.

The Deadline to Submit an Abstract Is November 15.
More Information
Submit Your Abstract

The APSAC Amicus Committee

The New Jersey Supreme Court recently decided a case in which APSAC filed an amicus brief earlier this year. It was a partial victory for our position on the admissibility of testimony on child sexual abuse accommodation syndrome (CSAAS). In this case, *State vs. JLG*, the court found that an expert may testify to one element of CSAAS – *delayed disclosure*. The other components—secrecy, helplessness, inability to defend themselves against adults, retraction, and denial—were disallowed for various reasons, including lack of consensus among experts and in the professional literature.

The APSAC Amicus Committee stands ready to support you! The APSAC Amicus committee comprises APSAC members who are skilled and dedicated attorneys. If a case involving a critical issue in child maltreatment is being heard in your state, consider asking the APSAC committee to file an amicus brief. Contact: Frank Vandervort, JD, Chair.

The Psychological Maltreatment Alliance

APSAC, in collaboration with New York Foundling and Columbia University, has established the Psychological Maltreatment Alliance. Its main goal is to inform, guide, and empower child caregiving and child services at all levels and sectors of society toward the elimination of psychological maltreatment, and in so doing, to advance the development, health, and safety of children.

Psychological maltreatment is defined as "a repeated pattern or extreme incident(s) of caretaker behavior" that thwart the child's basic psychological needs (e.g., safety, socialization, emotional and social support, cognitive stimulation, and respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another's needs, or expendable.

Psychological maltreatment is the most pervasive and widespread form of child abuse. Research indicates that, with few exceptions, it is the most damaging form of abuse and the foremost contributor to negative psychological and physical health outcomes in childhood and adulthood. Substantial evidence supports the claim that more people have experienced psychological maltreatment than other forms of childhood violence, abuse, or neglect.

The Psychological Maltreatment Alliance will achieve its goals through professional training, research, policy formation, and advocacy and the development of a webinar with an archived, searchable online source of historical, present, and emerging knowledge. The Alliance has received a grant for $50,000 to convene a national and international Summit to End Psychological Maltreatment, bringing together the leading experts in the field. For more information, please contact APSAC Board member Dr. Mel Schneiderman via info@apsac.org.

From the National Summit to End Corporal Punishment

Under the leadership of an Executive Committee, the ***New York Foundling***, and the ***U.S. Alliance to End Hitting of Children***, in partnership with APSAC, 40 leading experts gathered for a National Summit to End Corporal Punishment 10 months ago. The goals and priorities developed at that summit have led to the development of a strategic plan to reduce the most prevalent risk factor for child abuse: social norms around corporal punishment. In less than a year, hardworking committees have contracted for a professional media campaign to change attitudes and behaviors regarding the use of corporal punishment, developed platforms to assist in the proliferation of No Hit Zones, collected and reviewed resources for parents, and offered

numerous seminars and workshops.

In the fall of 2018, APSAC NY and the Foundling are launching a campaign to end corporal punishment in New York State, and they will share their plans and materials with other interested states.

The Executive Committee recently launched an online platform to generate support for the movement by inviting supporters to become “ambassadors” and by making a one-time contribution.

If you would like assistance in starting a No-Hit Zone, find more information here.

Join APSAC’s efforts to eliminate corporal punishment in the United States!

Please Take Note!

Ready to Start a State Chapter?

State chapters are eligible for financial support from APSAC and help provide a unified voice on behalf of all aspects of child maltreatment in your state. For information, please contact info@apsac.org

Visit Our Database of Educational Programs

Click here to find a program. To add your program to our database, complete this survey!

Remember APSAC for End-of-Year Giving

APSAC relies on the generosity of donors to continue to provide services, such as free Guidelines for Professional Practice and inexpensive memberships for students, young professionals, and front-line professionals. We hope you respond when we ask for your support this fall. We also invite you to consider a collaborative campaign using our fundraising platform. Please contact info@apsac.org for more information.

We Can Help With Conferences and Training!

APSAC makes a great partner for a statewide organization planning a conference. Contact Jim Campbell if you’d like us to bring our national resources to your state or community. APSAC is now certified to offer CEUs in certain disciplines, further adding value to your event!

The American Professional Society on the Abuse of Children™

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Washington Update

Ruth J. Friedman, PhD

Overview

The House of Representatives and the U.S. Senate are both in recess through the November mid-term elections. Congressional activity in November and December is likely to be influenced by the outcome of the elections. A new Congress will be sworn in on January 3, 2019. The agenda for the new Congress is uncertain because the composition of the Congress may change.

Congress Passes F.Y. 2019 Appropriations for D.H.H.S.

On September 28th, the President signed the FY19 funding bill for the Department of Health and Human Service (among others). Congress has not yet passed a spending bill for the Department of Justice. A summary of the "Labor-H" package is available here, and the conference report is available here. Child abuse programs received funding levels identical to FY2018. Twenty million dollars were appropriated for Regional Partnership Grants, and $20 million for kinship navigator programs. In addition, Congress indicated interest in the Secretary of HHS to take more action to help states improve reporting of suspected or known child abuse or neglect. Specifically, Congress included the following non-binding report language:

> Child abuse reporting—in order to improve compliance with the State assurance in regards to section 106(b)(2)(B)(i) of the Child Abuse Prevention and Treatment Act, the conferees strongly support efforts by HHS to develop evidence-informed best practices in State training and procedures to improve reporting of suspected or known incidents of child abuse or neglect to the appropriate law enforcement or child welfare agency (as applicable under State law) and, if applicable, to the individual's supervisor or employer, including reporting by individuals employed by or volunteering in youth-serving organizations. The conferees request an update in the fiscal year 2020 Congressional Justification on this topic and a briefing on ACF's child abuse programs within 90 days after the date of enactment of this Act. (164 Cong. Rec. H153, 2018)

Congress Passes Opioid Legislation

On October 3rd, Congress passed H.R. 6, the SUPPORT for Patients and Communities Act, a broad legislative package aimed at addressing the opioid crisis. The bill includes a number of provisions relevant to child abuse and trauma, including, notably,

- A new funding stream to support state implementation the plan of safe care provision in CAPTA (the final agreement was for this to become a separate grant program under section 105 of CAPTA).
- Several provisions related to trauma and trauma-informed care, including the following: authorizing the CDC to support state efforts to collect data on ACEs; creating an interagency task force to make best practices to identify, prevent, and mitigate the effects of trauma on children and families; increasing the authorization level for the National Child Traumatic Stress Initiative; creating a new grant program to increase student access to evidence-based trauma support services; and requiring the HHS secretary to disseminate information and resources to early childhood providers working with youth children on ways to recognize and respond to early childhood trauma.
- Provisions to support family-focused substance abuse treatment, including the follow-

ing: requiring HHS to develop an issue guidance to states identifying funding opportunities to support family-focused residential substance abuse treatment programs; a new grant program to replicate a "recovery coach" program for parents with children in foster care due to parental substance abuse; and a new grant program to help states develop, enhance, or evaluate family-focused treatment programs to increase the number of evidence-based programs that will later qualify for funding under Family First.

NIH Announces New Grants for Research Centers on Child Abuse

The National Institutes of Health is funding three centers that will conduct research on all forms of child abuse and neglect. The Capstone Centers for Child Maltreatment Research promise to identify best practices for prevention and screening, as well as treatment of children affected by abuse. You can find more information here.

Chairman Smith and Ranking Member Davis Send Letter to Child Welfare Administrators

On September 20, U.S. House of Representatives Human Resources Subcommittee Chairman Smith (R-NE) and Ranking Member Davis (D-IL) sent a letter to child welfare administrators and stakeholders to aid implementation of an important effort to help our communities nationwide combat the opioid crisis. It includes non-binding guidance on FFPSA, based on Jerry Milner's testimony before the Committee.

Associate Commissioner of Children's Bureau Testifies on Family First Prevention Services Act

On July 24th, Jerry Milner, Associate Commissioner of The Children's Bureau in the Administration for Children and Families at the U.S. Department of Health and Human Services testified before the U.S. House of Representatives Committee on Ways and Means. His testimony focused on the implementation on the Family First Prevention Services Act.

Administration Proposes Significant Change to "Public Charge" Rule

The Administration announced a new immigration rule that would restrict green cards and visas for those who use public benefits legally. The rule would change the long-standing way in which immigrants seeking residence were evaluated and excluded if determined to be a "public charge" – i.e., more than half of individual's income derived from TANF, SSI, long-term care benefits Medicaid. Additional public benefits like Medicaid and SNAP would be considered, including for citizen-children. There are numerous implications for children and families.

CRS Website Goes Live

The Congressional Research Service (CRS), which is a non-partisan research arm of Congress, launched a new public-facing website to make its reports available to the general public. Currently the website includes only a certain subset of CRS content, but the Library of Congress says they are planning to add more. The new site is available at crsreports.congress.gov. CRS has long provided summaries and analyses to Congress on various laws and proposals. This is the first time these reports have been made available to the public.

References:

164 Cong. Rec. H153 (daily ed. Sep. 13, 2018).

About the Author

***Ruth Friedman, PhD**, is Executive Director of the National Child Abuse Coalition. She is an independent child and family policy consultant and national expert on early education, child welfare, and juvenile justice. She spent 12 years working for Democratic staff of the U.S. House Committee on Education and the Workforce, helping spearhead early learning, child safety, and anti-poverty initiatives. Dr. Friedman has a doctorate in clinical psychology and a master's degree in public policy. Prior to working for Congress, she was a researcher and therapist, focusing on resiliency in children and families living in high-poverty neighborhoods.*

Conference Calendar

November

November 10—14, 2018
APHA Annual Meeting & Expo
San Diego, CA
202-777-2475
www.apha.org/events-and-meetings/annual

December

December 2—5, 2018
ISPCAN Caribbean Regional Conference
Child Protection Realities Within A Changing Caribbean and World
Montego Bay, Jamaica
ipscan@ipscan.org
https://www.ipscan.org

January

January 26—27, 2019
Ray E. Helfer Society Annual Meeting
Pre-Conference Institutes: Abusive Head Trauma and Medical Evaluation of Child Physical Abuse
www.helfersociety.org
In Conjunction with Rady Chadwick Conference
http://www.sandiegoconference.org

January 27, 2019
APSAC's Pre-Conference
Advanced Training Institutes
San Diego, CA
877-402-7722
apsac@apsac.org
www.apsac.org
In Conjunction with the Rady Chadwick Conference
http://www.apsac.org

January 26, 2019—January 31, 2019
34th Annual San Diego International Conference on Child and Family Maltreatment
San Diego, CA
858-966-4972
http://www.sandiegoconference.org

March

March 18—21, 2019
35th International Symposium on Child Abuse
Huntsville, AL
256-533-KIDS(5437)
www.nationalcac.org

April

April 9—13, 2019
Child Welfare League of America
Meeting the Challenge of the Family First Prevention Services Act
Washington, D.C.
www.cwla.org

April 7—April 10, 2019
Ray E. Helfer Society Annual Meeting
Orlando, FL
www.helfersociety.org

May

May 31—June 4, 2019
National CASA Conference
Atlanta, GA
www.casaforchildren.org

May 29—June 1, 2019
56th AFCC Annual Conference
The Future of Family Justice: International Innovations
Toronto, Ontario, Canada
afcc@afccnet.org

June

June 5—7, 2019
The Field Center for Children's Policy, Practice and Research
One Child, Many Hands: Multidisciplinary Conference on Child Welfare
https://fieldcenteratpenn.org/one-child-many-hands/

June 18—22, 2019
26th APSAC Colloquium
Promoting Trauma-Informed Practice in All Disciplines
Salt Lake City, UT
877-402-7722
apsac@apsac.org
www.apsac.org

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