NCTSN The National Child Traumatic Stress Network

Using Trauma-Informed Child Welfare Practice to Improve Placement Stability Breakthrough Series Collaborative

Promising Practices and Lessons Learned

June 2013

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June 2013

The Need for This Work

Children placed in foster care not only experience the traumatic experience(s) of abuse or neglect that led to their placement, but often face additional chronic stressors including separation from parents, siblings, friends, and community; possible maltreatment in foster care settings; and uncertainty about future plans and their reunification with their parents (Pecora, 2007). Despite the extraordinary number of children in foster care who have experienced traumatic events and are exhibiting traumatic stress symptoms, and the growing body of science about efficacious treatments for child traumatic stress, few child welfare agencies across the nation integrate trauma knowledge into their practices, policy, training, performance standards, or assessment and have evidence-based trauma-specific interventions available in their community or their service continuum, including mental health contract portfolios.

The longer traumatic stress reactions to these events remain unaddressed, the more likely it is that children will experience behavioral, psychological, and other problems (Cook et al., 2005). These untreated traumatic stress reactions may lead to placement disruptions (Rubin, O'Reilly, Luan, & Localio, 2007; Pecora et al. 2005; Hartnett, Leathers, Falconnier, & Testa, 1999) that only intensify the problem reactions and behaviors. If or when these placements are disrupted, feelings of blame and rejection along with the breaking of attachments (siblings, schools, foster parents, or kinship care) can compound the child's traumatic experience and result in externalizing behaviors. Thus, a system designed to create safety and permanency may inadvertently amplify instability.

The National Child Traumatic Stress Network's (NCTSN) Child Welfare Committee has been looking at the issue of trauma-informed child welfare practice (TICWP) for several years. As part of its work, it has created the *Essential Elements of Trauma-Informed Child Welfare Practice* as part of the *Child Welfare Trauma Training Toolkit* (Child Welfare Collaborative Group, NCTSN, & the California Social Work Education Center, 2008). These elements include maximizing the child's sense of physical and psychological safety, using comprehensive screening and assessment practices, and coordinating services with other agencies. Given the impact of foster care placement stability on permanency (Wulczyn, Kogan, & Harden, 2003), and the impact of children's trauma experiences on the stability of foster care placements (Kolko, Hurlburt, Zhang, Barth, Leslie, & Burns, 2009), the NCTSN Child Welfare Committee, with guidance from an expert panel, brought together child welfare and child trauma experts and practitioners to develop, test, and disseminate trauma-informed practices that improve foster care placement stability using the Breakthrough Series Collaborative (BSC) quality improvement model.

Project Background and Overview

In recent years, the NCTSN has adapted the quality improvement methodology of the BSC, as created by the Institute for Healthcare Improvement (2003), for use in the child trauma field. In September 2010, the NCTSN, with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), launched this BSC, which focused on developing and implementing trauma-informed child welfare practices (decisions, actions, policies, procedures, staffing, and supports for children and caregivers) that increase the probability that children who need out-of-home placement remain in a single, appropriate, and stable home whenever possible.

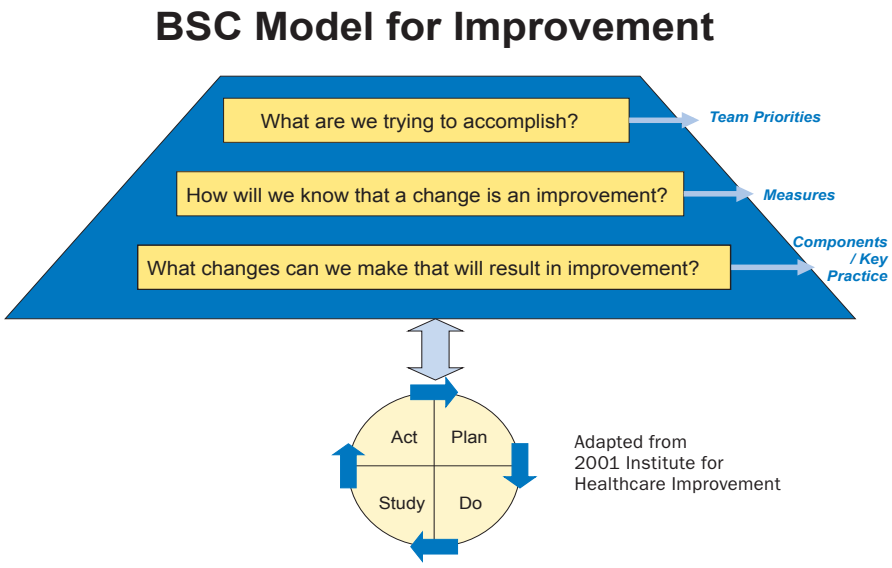
This BSC included nine teams from around the country, each of which was lead by the public child welfare agency. Each team represented a unique partnership between the public child welfare agency (at either the county or state level) and a mental health agency or organization that provides evidence-based interventions for child trauma to children in foster care.

- Arapahoe County (CO) Department of Human Services, with Aurora Mental Health Center
- Florida Department of Children and Families – Circuit 5, with Kids Central, Inc.
- Los Angeles County (CA) Department of Child and Family Services, with Children's Institute, Inc.
- North Carolina Division of Social Services, with Center for Child and Family Health
- New Hampshire Division for Children, Youth, and Families, with Dartmouth Trauma Interventions Research Center
- Massachusetts Department of Children and Families, with L.U.K. Crisis Center, Inc.
- Oklahoma Department of Human Services with Family, with Children's Services, Inc.
- San Diego County (CA) Child Welfare Services, with Chadwick Center for Children and Families, Rady Children's Hospital
- Texas Department of Family and Protective Services, with DePelchin Children's Center

Each core team included eight to ten members: a high-level child welfare and mental health administrator; a day-to-day manager; child welfare frontline workers and supervisors; a trauma therapist; a birth parent; a foster parent; and, for many teams, a youth who had been placed in foster care. Extended teams, which ranged from ten to twenty additional people, included cross-system partners from across the community who were strategically engaged to assist in the change process.

The nine core teams attended three "Learning Sessions" (two-day in-person interactive meetings) between October 2010 and June 2011, where they met with the other participating teams from across the country, as well as with the national faculty, to share resources developed, practices implemented, and lessons learned, as well as to identify strategies for

overall system change. Due to additional funding received in September 2011, the project was extended through September 2012. The additional funding supported the attendance of four members from each team at a Roundtable Summit in June 2012 that included five national experts representing the National Resource Center on Organizational Improvement, the American Academy of Pediatrics, the Child, Youth and Family Division of the National Association of Mental Health Program Directors, foster/adoptive parents, Casey Family Programs, and the National Council of Juvenile and Family Court Judges. In addition to sharing their own work with their colleagues from other teams, this final Roundtable placed an intentional emphasis on spreading and sustaining improvements, including beyond the nine participating teams.



Participating teams initially tested changes at the practice level using the Model for Improvement, a standard quality improvement process that uses Plan-Do-Study-Act (PDSA) cycles to test improvements rapidly on a very small scale. All of the changes were directly connected to the five themes that served as the foundation for this BSC: 1) knowledge building and developing practices; 2) trauma-informed mental health assessment; 3) case planning and management; 4) externally delivered trauma-informed services; and 5) child welfare systems, cross-system partnerships, and system collaboration. These five themes are described more completely in the BSC's Collaborative Change Framework, which detailed the scope, mission, and key objectives for implementing trauma-informed child welfare practice to improve placement stability. The design and testing of these changes in a targeted site by each team were supported and guided by the BSC staff, faculty, and published material. As teams tested changes, they were expected to identify the critical components of successful efforts toward systemic change and track standard improvement measures on a monthly basis. Key strategies and specific examples of small tests of practice change that have shown promise in improving placement stability in each of the five key theme areas are described in the following section.

Key Strategies and Promising Practices

A key expectation in any Breakthrough Series Collaborative is that participating teams will test and implement improvements in order to achieve the overall Collaborative mission. The mission for this BSC was specific to the implementation of trauma-informed practices that increase the likelihood that children who need out-of-home placement remain in a single, appropriate, and stable placement whenever possible. In order to translate this mission into action, a specific

section in the BSC's Collaborative Change Framework delineated five critical themes that needed to be addressed:

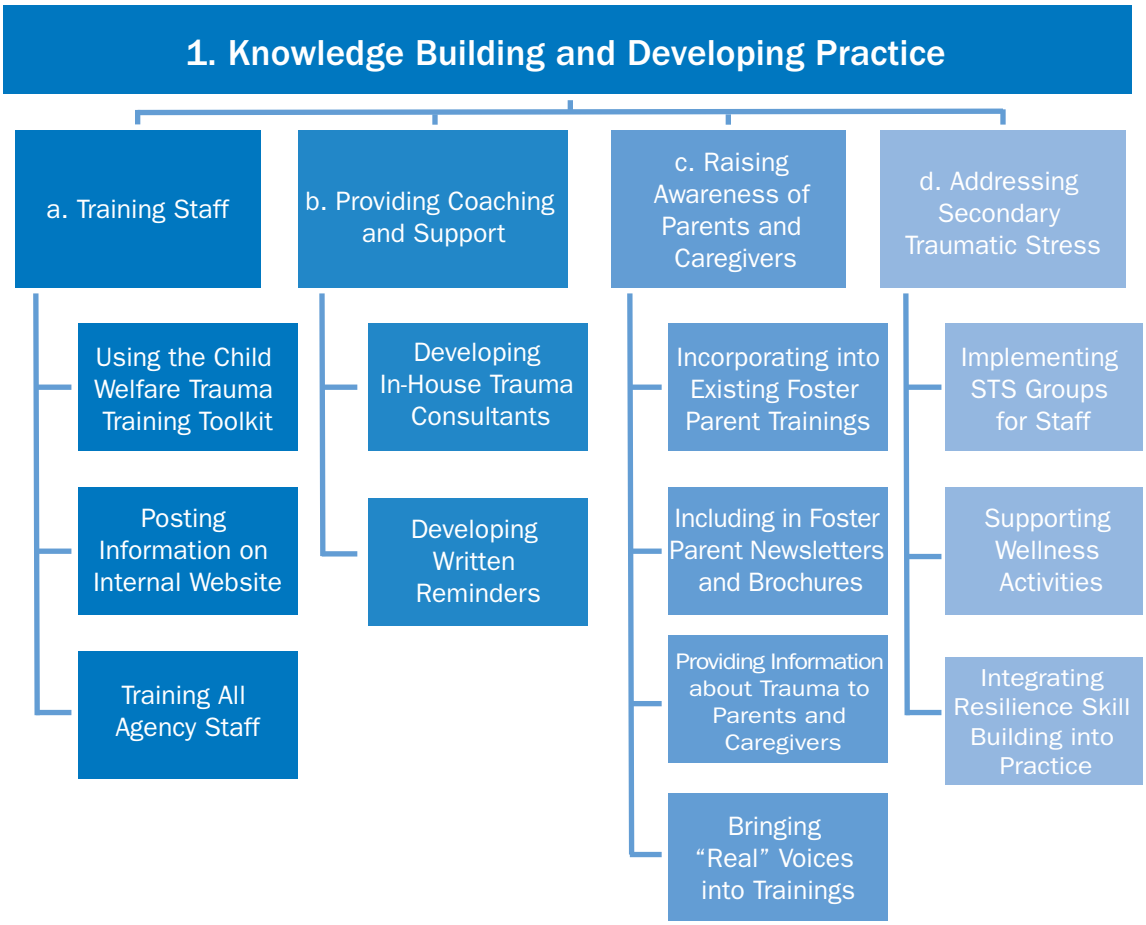
1. Knowledge Building and Developing Practices
2. Trauma-Informed Mental Health Assessment
3. Case Planning and Management
4. Externally Delivered Trauma-Informed Services
5. Child Welfare Systems, Cross-System Partnerships, and System Collaboration

Although the distinction between these five themes is somewhat artificial because they are so clearly interconnected, it is critical to divide a complex system into 'manageable' and distinct pieces in which changes can be tested in a BSC. As the teams in the BSC tested practices in these areas, many emerged as having promise in achieving the overall mission of the project. Promise was identified on many levels – through feedback from the individual participants who tested specific changes; feedback provided during focus groups; discussions during affinity group meetings; interviews with teams; and evaluations of the Learning Sessions. As noted above, although quantitative data were collected monthly by each team, these were not used as primary determinants to identify promising practices based on the variations in target sites, sizes, and differences between teams.

Each theme is described in more detail below, along with the key strategies and practice highlights from participating teams. These practice highlights are also listed by strategy area in the Practice Cards, which are meant to be brief stand-alone 'how-to-guides' to provide information to assist with the implementation of similar trauma-informed practices. Because trauma-informed child welfare practice could easily be considered 'just good child welfare practice,' there are notes for each strategy on what specifically makes it trauma-informed. Moreover, it is important to note that this BSC was intended to focus not on trauma-informed child welfare practice broadly speaking, but specifically connected to placement stability. Many teams went beyond this scope, as many practices that were intended to positively impact placement stability were found to positively impact general child welfare practice as well.

Theme 1. Knowledge Building and Developing Practice

Before trauma-informed practice can be implemented, it first must be understood. All participating teams developed and implemented various strategies for a) training staff at multiple levels in numerous ways; b) providing coaching and support to staff to reinforce the use of their trauma 'lens;' c) raising awareness and providing training for foster parents on trauma; and d) providing supports to staff to address the secondary trauma that can result from working with children and families adversely affected by traumatic events. All four elements were found to be important in creating the awareness, knowledge, and skills needed to work with families and children in trauma-informed ways.



Strategy 1a: Training Staff in a Variety of Ways

What Makes This Strategy "Trauma-Informed"

Staff who interact with families and children on a daily basis must understand what trauma is; how it impacts children and their development, behaviors, and reactions; how to work with children to minimize additional trauma; and how they can address this trauma to increase children's stability in placement.

> "[Training] has created a more trauma-focused atmosphere/ environment in my office and in our community. I [now] look past a child's behavior and more at his/her trauma history."
>
> —Child Welfare Worker

Practice Highlights

- **Using the CW Trauma Training Toolkit:** Teams used information on trauma from the NCTSN *Child Welfare Trauma Training Toolkit*, ranging from specific modules to the complete curriculum, to train new workers, for continuing trainings, and at periodic agency summits, conferences, and other meetings. These trainings were intended to raise awareness of – and continue to reinforce – what trauma is and how it impacts children and families.
- **Posting Information on Internal Website:** Teams collected and shared key articles, research, and literature on the impact of trauma, behaviors, symptoms, and the need for trauma-focused practice on internal intranet sites. Using a variety of methods, teams were able to refresh, reinforce, and add to staff's knowledge of trauma.
- **Training All Agency Staff:** Some teams moved beyond training social workers and decided to focus on a family's entire experience – beginning with the family's first contact with the agency. This resulted in these teams training their front office clerical staff, receptionists, and administrative staff in trauma-informed practice. As a result, the front-office staff in these agencies reported having a new understanding and respect for the anger they sometimes perceived when parents entered the office and they felt better prepared to respond compassionately.

Strategy 1b: Providing Coaching and Support

What Makes This Strategy "Trauma-Informed"

Applying new learning to everyday practice requires supports and job aids so that new practice becomes routine practice. Behavior change is rarely a simple process and most people have experienced a disconnect between intended practice and actual practice in their life. Thus, training on trauma is necessary, but not sufficient, to creating a trauma-informed workforce. The training received by staff must not only be reinforced, but there must be opportunities to receive additional coaching and support as workers interact with families and children who have experienced trauma. Additionally, providing reminders to child welfare workers helps ensure that the work they do with children and families is trauma-informed and trauma-focused. They reinforce trauma training, strengthening both knowledge and skills.

Practice Highlights

- **Developing In-House Trauma Consultants:** One team developed a cadre of social workers as in-house trauma consultants through an intensive one-day training. These workers were considered onsite "expert consultants on trauma" to whom other workers could then go for information, support, and general consultation about trauma. They also led office "learning circles" to provide opportunities for staff to continue discussing issues related to trauma on an ongoing basis. Staff in this office felt that this practice was extremely supportive, as it took the burden of 'having to feel like an expert on trauma after one training' off of them.

- **Developing Written Reminders:** One team adapted a hints and tips reminder sheet from the Center for Improvement of Child and Family Services, 2009. It is printed on bright pieces of paper and is intended to help remind social workers to use a trauma lens whenever removing, placing, or working with children, youth, and families. These Trauma-Informed Practice Sheets (TIPS) are included with the agency's regular assessment packet to help child welfare workers keep trauma as a focal area when working with children and their families.

Strategy 1c: Raising Awareness of Parents and Caregivers

What Makes This Strategy "Trauma-Informed"

Those who care for children on a daily basis when they are in placement must have awareness and skills related to traumatic stress and how it is displayed across the developmental spectrum. This knowledge not only allows them to be more sensitive to potential trauma triggers, but it also helps them see some behaviors as traumatic reactions rather than simply "bad behavior." As this is recognized by foster parents, it can reduce the likelihood that the placement will disrupt.

> "I now look at my work through a trauma lens. I talk with foster parents about the trauma [the] children in their care have experienced and the behaviors that they may see in the hopes of helping placement stability. We do not [want to] add another traumatic experience to the child."
> —Child Welfare Worker

Practice Highlights

- **Incorporating into Existing Foster Parent Trainings:** Many teams tested and implemented practices in which training, education, and skill-building about trauma was incorporated into existing foster parent trainings. The NCTSN curriculum *Caring for Children who Have Experienced Trauma: A Workshop for Resource Parents* was the most common source of information used in developing these modules and trainings. These modules were incorporated into new and existing foster parent trainings.

- **Including in Foster Parent Newsletters and Brochures:** Information about trauma across the developmental spectrum was also included in foster parent newsletters and brochures to ensure that existing foster parents received continuous information about recognizing and responding to trauma for the children in their care.

- **Providing Information about Trauma to Parents and Caregivers:** One team developed an information card for parents and caregivers that described behavioral indicators of children who may have experienced a traumatic event.

- **Bringing "Real" Voices into Trainings:** Foster parents, birthparents, and youth were invited by some agencies to talk with prospective foster parents during their initial foster parent training about the trauma of placement and the ability to minimize this trauma through positive birthparent–foster parent relationships. (See more on this in 3.a below.) This was not only lauded by the foster parents in the training as one of the most valuable parts of the training, but it was also therapeutic and supportive to the trio who served as presenter-trainers.

Strategy 1d: Addressing Secondary Traumatic Stress (STS)

What Makes This Strategy "Trauma-Informed"

There was broad agreement among the BSC teams and faculty that improving placement stability of children in foster care placement could not be fully met without ensuring that the staff and caretakers working with children were themselves adequately supported. In addition, over the course of the BSC, several teams noted that the increase in trauma awareness among their staff, and the subsequent increased exposure to children's trauma stories through screening and other activities, had likewise increased the need to provide staff with strategies for understanding and coping with their own secondary traumatic exposure.

Practice Highlights

- **Implementing STS Groups for Staff:** Several teams increased knowledge of secondary traumatic stress by implementing regularly scheduled groups directed at supervisors and frontline staff. These teams served as forums for discussing the challenges of child welfare work; developing positive coping strategies; and promoting mutual support and collaboration among staff members. Teams also used the groups to share many readings and resources about STS. Some of these groups are facilitated by staff within the department and other teams have looked to external facilitators to further promote the sense of psychological safety and confidentiality.

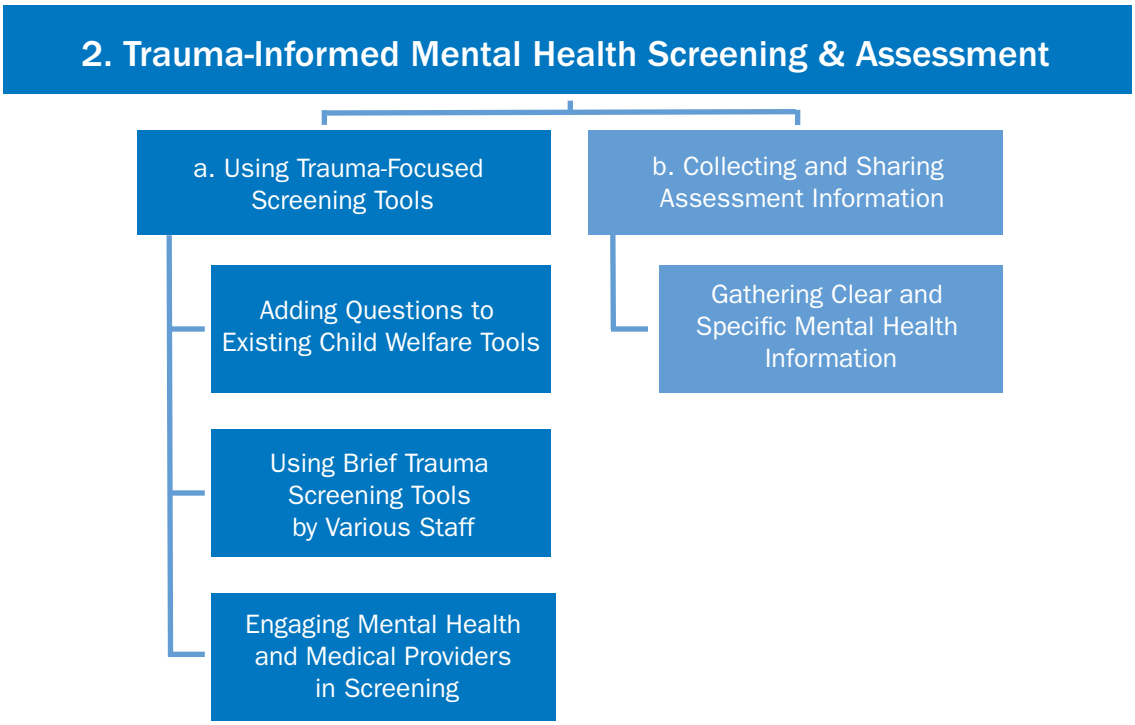
- **Supporting Wellness Activities:** Many of the teams have undertaken creative strategies for increasing self-care activities among their staff, ranging from the availability of lunchtime yoga classes in the office to exercise groups to healthy eating campaigns. These efforts share an emphasis on the needs of staff, and send the message that self-care is both an individual activity and an organizational responsibility.

- **Integrating Resilience Skill-Building into Practice:** Several teams were looking to the Resilience Alliance, an intervention developed by the ACS-NYU Children's Trauma Institute (an NCTSN Category II site), and were either planning on delivering the intervention in its entirety to their staff, supervisors and managers, or integrating selected strategies and tools from the intervention into existing forums like staff meetings, individual and group supervision, etc.

Theme 2. Trauma-Informed Mental Health Screening and Assessment

A key component of trauma-informed practice is conducting appropriate and effective trauma screening and assessment of children in foster care. While assessment is a continuous process, the initial assessment must gather comprehensive information from a variety of sources; be inclusive of birth parent, foster parent, and youth perspectives; and ultimately be used as a guide for case planning and treatment.

As child welfare staff increased their understanding of trauma, how it affects children and families, and how it can be identified, many teams recognized the opportunity to screen children entering placement for trauma. For many agencies, this had previously been seen as the domain for mental health partners, rather than child welfare staff. But child welfare staff realized that they could do a fairly simple screening, either by using any of a variety of existing assessment tool ranging from tested tools, such as the Child and Adolescent Needs and Strengths (CANS; Lyons, Griffin, Fazio, & Lyons, 1999) to asking a few simple questions about trauma exposure and reactions. The results of these screenings would then help them refer those children who needed more attention to mental health providers.



Strategy 2a: Using Trauma-Focused Screening Tools

What Makes This Strategy "Trauma-Informed"

Brief screenings allow for the rapid and early identification of trauma experiences and traumatic stress reactions. Because child welfare workers are already closely engaged with families and gathering information on many aspects of the child and family, adding (or simply revising) key questions that focus on trauma is a fairly easy, no-cost practice improvement. Implementing

screening practices that are done by child welfare workers and other mental health and medical partners also helps continue to raise awareness about trauma and keep it in the forefront of their work with children and families.

Practice Highlights

- **Adding Questions to Existing Screening Tools:** Several teams identified a few key questions about trauma and these questions were incorporated into the interview tool the child welfare social worker uses during initial face-to-face meetings with families. After using these questions, staff told stories about learning "new" information about families with whom they had been working for some time.

- **Using Brief Trauma Screening Tool by Various Staff:** Several teams adopted, adapted, or developed brief screening tools to use that were concise, simple, and could be used by staff at various levels and in various positions. These tools were implemented at a variety of points in time, including at the time of initial contact; at the time of removal/placement; and at the time of a family team meeting. The screening results were most often used to evaluate whether a referral was needed for a more complete trauma assessment.

- **Engaging Mental Health and Medical Providers in Screening:** A local trauma center incorporated a trauma screen into their own center referral form; pediatricians incorporated screenings into their assessments; and mental health intake coordinators trained in trauma screening. This helped reinforce the focus on trauma-informed practice beyond the social work staff, while also gathering critical information about a child's history and trauma exposure.

Strategy 2b: Collecting and Sharing Assessment Information

What Makes This Strategy "Trauma-Informed"

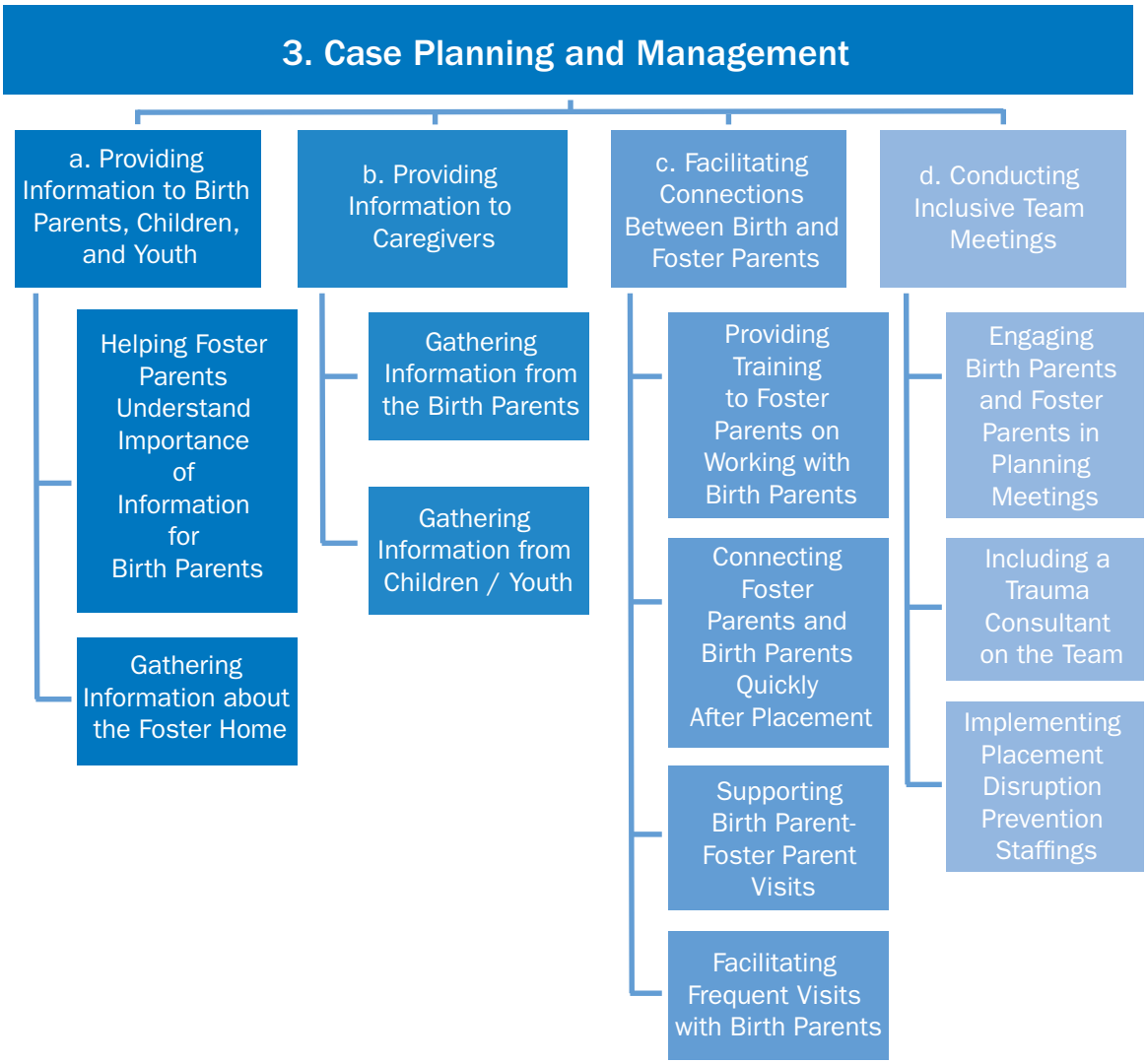
Screening for trauma is only of value if the results of the screening are shared and used for a next level of assessment. Similarly, once trauma information is collected, whether through screening or more comprehensive assessment, it must be shared across partners to ensure that everyone is operating with the same critical information and can work with and respond to the child and family appropriately.

Practice Highlights

- **Gathering Clear and Specific Mental Health Information:** One team worked with a key mental health provider to develop a *Foster Care Mental Health Assessment Summary* as well as a *Foster Care Mental Health Treatment Summary*. Both of these documents were intended to gather clear and specific information relevant to the mental health and trauma assessment of the children they saw who were in foster care. The information was captured on these forms and then shared with the child welfare social workers as well as the courts.

Theme 3. Case Planning and Management

A critical component of trauma-informed practice is the relationship between social workers, families, and children. Once trauma has been assessed, all contacts with the birthparents, foster parents, and children must be sensitive and responsive to their trauma experiences. This theme undoubtedly received the most attention from BSC teams. Much of what is described below could simply be considered "good child welfare practice," but in fact those practices highlighted below demonstrate intentional *trauma-informed* child welfare practice.



Strategy 3a: Providing Information to Birth Parents, Children, and Youth

What Makes This Strategy "Trauma-Informed"

Being removed from parents and placed in foster care is a traumatic experience in itself for birth parents and the children being removed. Providing them with as much information as possible about the placement and what will happen next is an opportunity to minimize this trauma as well as provide support.

> "It has made me more informed about how trauma affects the child [and] bio parents when the child comes into foster care."
>
> —Foster Care Supervisor

Practice Highlights

- **Helping Foster Parents Understand Importance of Information for Birth Parents:** This tip sheet was created by the foster parent on one of the teams. It was designed to be a guide to help foster parents engage with birth parents at the time of their first contact. It included intentional information explaining why it was so important for foster parents to share information about themselves, their families, and their homes with birth parents to help alleviate their stress and associated trauma, as well as to support the development of a positive relationship between them.
- **Gathering Information about the Foster Home:** This form was developed by a team in both English and Spanish. It is being given to foster parents whenever a child is placed in their home. The form collects basic information about the home and the family so that it can be given to that child's birth parents. The goal is for this form to help create an open dialogue between parents and caregivers and increase cooperation between the two parties so that families can be reunified faster.

Strategy 3b: Providing Information to Caregivers

What Makes This Strategy "Trauma-Informed"

Providing the foster parent with more information about the child upfront ensures that the foster parent knows what things are comforting and distressing to the child, thus providing as much familiarity to the child as possible and potentially reducing the negative impact of separation from his or her parents. Variations of these practices were tested by nearly all teams.

Practice Highlights

- **Gathering Information from Birth Parents to Share with Foster Parents:** Based on the recommendation of a birth parent participant on one of the teams, nearly all teams tested changes related to gathering information from birth parents about their children and providing this information to foster parents at the time of the initial placement. Birth parents, foster parents, and youth felt this would be a significant practice to help minimize the trauma of the initial placement. This has been done by providing opportunities for birth parents to share information about their children with foster parents using tools such as the "All About My Child" form, "Let Me Tell You About My Child" form, or letters written by birth parents and provided to foster parents. In an attempt to reduce redundancy, one team incorporated this information into the Child Info Fact Sheet that social workers are already responsible for completing.
- **Gathering Information from Child/Youth to Share with Foster Parents:** Nearly all teams also created, adapted, and/or implemented forms and processes to collect information about children and youth, such as the "All About Me" form and "Five Things I Want You to Know About Me" form, directly from them. These forms and processes were intended to

give the children and youth an opportunity to open a conversation with foster parents. Staff were trained to use these tools with all children and youth who are capable to articulating their likes, dislikes, and other information about themselves. One team created an "All About Me" form designed specifically for infants, to be completed by parents or caregivers.

Strategy 3c: Facilitating Connections Between Birth and Foster Parents

What Makes This Strategy "Trauma-Informed"

Maintaining the connection between children and parents can help ease the transition of coming into foster care, make the experience less disruptive or traumatic for children, and minimize behavior problems (McWey, Acock, & Porter, 2010). Having the child see that there is communication between his or her parents and foster parents can also help reduce his or her anxiety and feelings of guilt around living with another caregiver.

Practice Highlights

- **Providing Training to Foster Parents on Working with Birth Parents:** As teams developed new programs and protocols for how foster and birth parents could work together in partnership, many found it necessary to provide training to foster parents on the rationale for and importance of it. To do this, one team brought together a foster parent and birth parent who had successfully partnered to achieve reunification, and had them attend new foster parent training to talk about their experiences and success. Based on the reactions of participants, the team hopes this will become a regular part of their new foster parent training going forward.

- **Connecting Foster Parents and Birth Parents Quickly After Placement:** Many practices tested by teams focused on finding ways to connect foster parents and birth parents as quickly as possible after placement. Several teams asked foster parents to call birth parents within 24 hours of the placement to talk about the child's transition. This practice has often allowed the birth parent to talk with his or her child on that first night of placement, providing reassurance and engagement of the parent, and offering comfort and connections for the child.

- **Supporting Birth Parent-Foster Parent Visits:** Teams also worked to encourage visits among birth parents, their children, and the foster parents on an immediate and regular basis, beginning as soon as possible after the initial placement is made.

- **Facilitating Frequent Visits with Birth Parents:** Facilitating frequent visits in a family-friendly setting is thought to lessen the effect of possible detachment between a child and his/her parent(s) following a removal. One team kept this practice within its Family Finders model, and employed Family Engagement Specialists (FES) to effectively engage parents and family in recognizing their strengths and areas of unmet needs, especially in the context of the parents' interactions and visits with their children. They also helped pull in additional natural supports to create a support team for the family, such that parents could feel prepared for visits with their children and spend time with their children in ways that felt as natural and normal as possible.

Strategy 3d: Conducting Inclusive Team Meetings

What Makes This Strategy "Trauma-Informed"

Facilitated meetings, held specifically to address individual children, not only allow for foster parents and birth parents to come together on behalf of the child's needs, but also provide forums for the open sharing of information about the child. These regular meetings are facilitated by the child welfare worker to focus specifically on issues related to trauma, assessment, and treatment, as indicated. Moreover, other partners, including mental health providers, may be invited to these meetings to help support the child and placement.

Additionally, by recognizing that many placements disrupt because of caregivers' response to children's behaviors, meetings that are held specifically to prevent disruptions provide an opportunity to discuss and address the underlying factors for the behavior. Plans can be put into place to prevent the disruption, including appropriate treatment for the child and respite and support for the foster parent. Rather than focusing on a child's behavior, these meetings allow for a focus on the child's trauma and ways to identify and help manage the child's reactions.

Practice Highlights

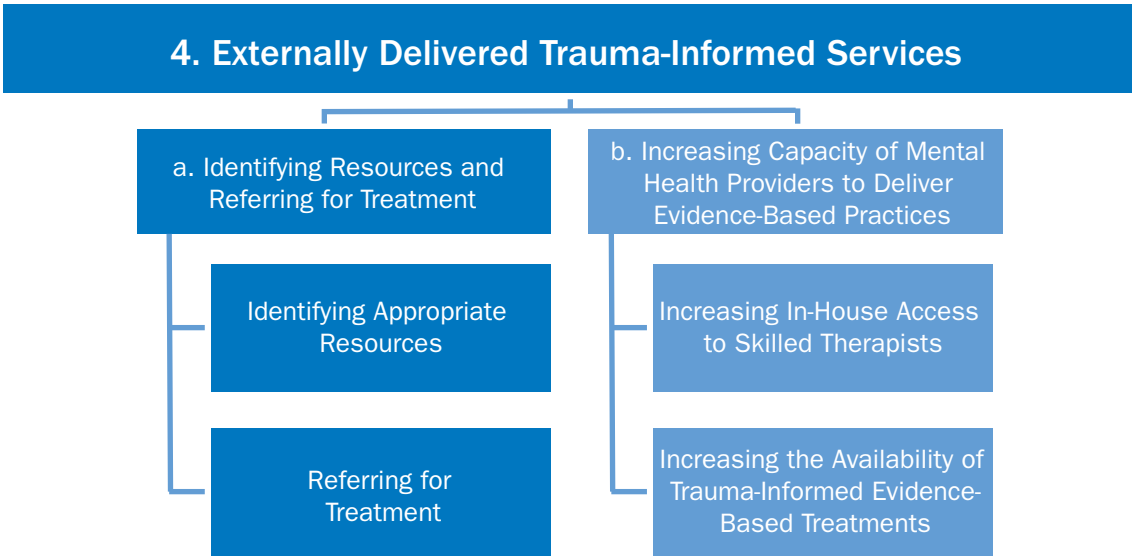
- **Engaging Birth Parents and Foster Parents in Planning Meetings:** Many teams supported the connections between birth and foster parents by actively focusing on specific meetings, such as family team meetings, special meetings held shortly after the placement was made, or meetings specifically focused on maintaining placement stability. At a three-week post-placement meeting created by one team, birth parents, foster parents, and workers were brought together within three weeks of placement to talk specifically about the child's trauma history, the impact on behavior and placement, trauma triggers, and opportunities for co-parenting.

- **Including a Trauma Consultant on the Team:** As a way to provide early intervention to children who were displaying troubling behavioral symptoms in placement, which may lead to placement disruptions and academic struggles, one team invited a mental health counselor to join their placement team. The counselor interviewed the child, foster parents, and case manager and then provided support to the foster parents as needed, including a home visit within 24 hours and/or phone support. This counselor could also make a referral to a treatment provider if appropriate. The counselor remained involved to ensure linkages and reduce the likelihood of any further crises that could lead to disruption.

- **Implementing Placement Disruption Prevention Meetings:** These meetings, which included staff at a variety of levels as well as external partners, were held by one team with great success. These meetings were done whenever a placement was at risk of disruption, as determined by either the worker or the foster parent. The meetings focused on what needed to happen to stabilize the placement with a specific focus on the child's trauma and managing associated behaviors. Although convening and conducting these meetings was somewhat time intensive, all permanency units from this jurisdiction's target area adopted them based on the outcomes they were achieving.

Theme 4. Externally Delivered Trauma-Informed Services

Once children are more effectively screened for trauma and identified as needing comprehensive assessment and treatment, those must be available from skilled mental health providers. The primary strategy that emerged in this theme was a focus on increasing capacity for trauma-focused mental health treatment.



Strategy 4a: Identifying Resources and Referring for Treatment

What Makes This Strategy Trauma-Informed?

Although BSC teams were made up primarily of child welfare agency staff, each team did have members from local mental health providers. Moreover, all team members clearly understood the need for trauma-informed services, once trauma was identified as an issue for a child in placement. Trauma-informed child welfare practice cannot end with the interactions between child welfare social workers and families; truly trauma-informed child welfare practice to improve placement stability must also include the identification of appropriate resources and referrals for necessary trauma-informed treatment.

> "[I have] a greater awareness of how trauma impacts people's lives [and] the importance of deeper collaboration between child welfare and mental health systems."
> —Mental Health Partner

Practice Highlights

- **Identifying Appropriate Resources:** Members on one team determined that a critical challenge they faced in accessing trauma-informed resources and services was simply the fact that very few child welfare social workers actually knew what trauma-informed resources and services were available in the community. Working with the mental health agency partners on their team, they compiled a Resource Guide of trauma-informed therapists for child welfare social workers to use as a reference tool for referrals.

- **Referring for Treatment:** As child welfare agency staff began conducting trauma screenings of children in foster care, their numbers of children needing trauma treatment grew. One team set aside dedicated time during their 'transfer' meetings, as children changed workers, to refer children who needed it directly to an appropriate evidence-based treatment.

Strategy 4b: Increasing Capacity of Mental Health Providers to Deliver Evidence-Based Practices

What Makes This Strategy Trauma-Informed?

Providing trauma-informed evidence-based treatments is essential to ensuring that children and families' trauma-focused needs are met. According to research, effectively addressing a child's trauma history through the provision of evidence-based trauma treatment has a significant and lasting impact on the outcomes that children in placement can achieve (Rubin et al., 2007).

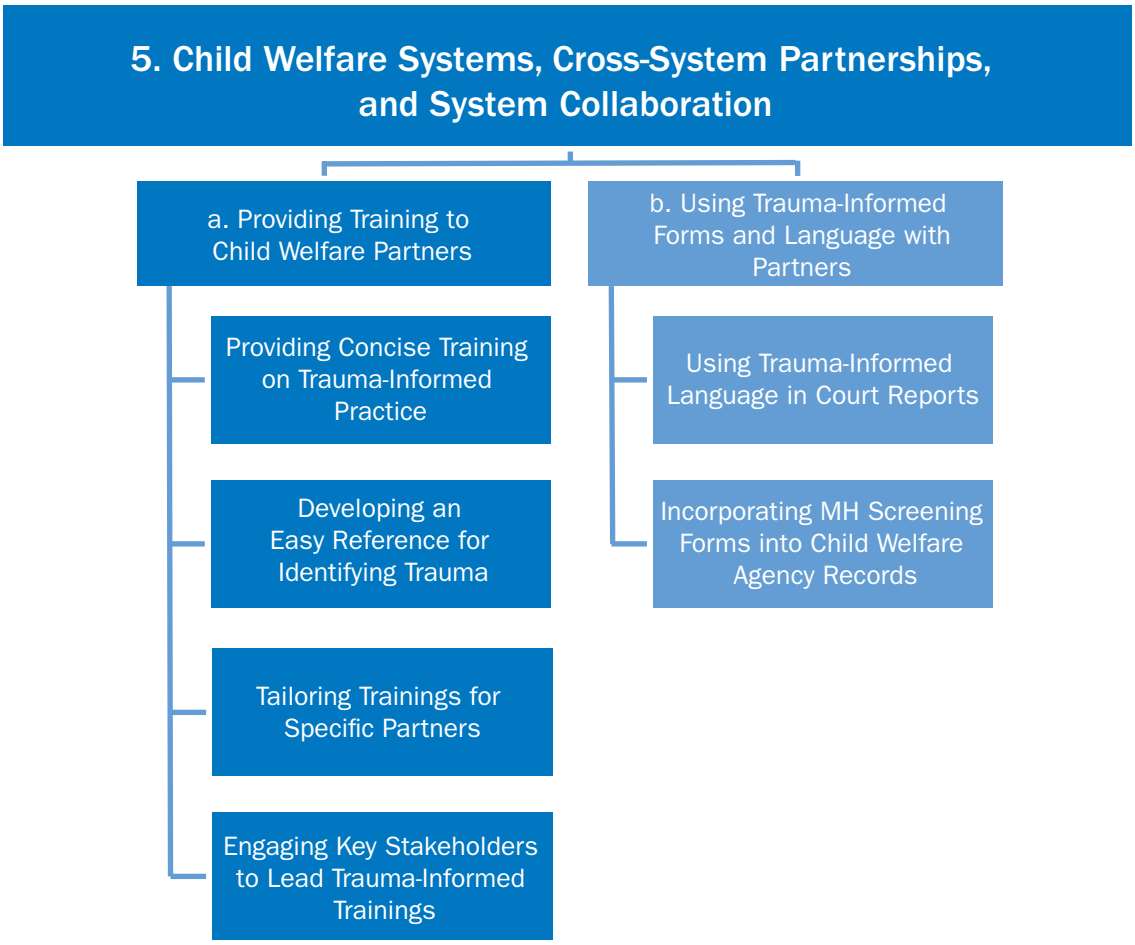
Practice Highlights

- **Increasing In-House Access to Skilled Therapists:** Because mental health administrators and clinicians were part of each team's core group, they watched first-hand as the demand for evidence-based trauma treatments was growing. One child welfare agency already had an in-house mental health therapist on staff to support assessments, treatment planning, and provide trauma-informed consultation. Based on their work in this BSC, this team decided to reallocate internal funds to hire a second therapist as the needs in the agency grew.

- **Increasing the Availability of Trauma-Informed Evidence-Based Treatments:** Several teams worked with partners to increase the availability of trainings on evidence-based treatments (EBTs). While this does not answer immediate demands (or needs) for treatment, it is a longer-term response that is critical.

Theme 5. Child Welfare Systems, Cross-System Partnerships, and System Collaboration

This final theme was not an area in which small tests of change were conducted, but it has proved to be critical in spreading these promising strategies beyond the target sites, as well as ensuring that the work done in this project will be sustainable. Moreover, it also proved to be closely connected to Theme 4 as other partners can help provide support for responding to the trauma-informed needs that were being identified.



Strategy 5a: Providing Training to Child Welfare Partners

Teams provided training at a variety of in-county/in-state conferences; provided training- for-trainer sessions on the NCTSN *Child Welfare Trauma Training Toolkit*; and incorporated trauma-informed care into a Children's Mental Health Awareness Day through written materials and verbal sharing.

What Makes This Strategy "Trauma-Informed"

The child welfare system is comprised of a much broader group than the child welfare agency alone. Thus, implementing a truly trauma-informed system requires that all partners and stakeholders who come into contact with children and families understand trauma, its impact on children and families, and the impacts of their own interactions and relationships with children and families.

> "The process of cross-system work has strengthened relationships not only with other core team members but with others in the agency."
> —Mental Health Partner

Practice Highlights

- **Providing Concise Training on Trauma-Informed Practice:** Because time is often limited, teams developed abbreviated trainings on trauma to deliver to cross-system partners. One team used a two-hour trauma-informed curriculum based on the NCTSN *Child Welfare Trauma Training Toolkit* that could be used for a variety of other agencies and partners. This allowed them to reach many more partners in a much shorter period of time than the standard training they were offering staff.
- **Developing an Easy Reference for Identifying Trauma:** Booklets and tips sheets from Project ABC (About Building Connections) were focused on addressing early childhood trauma and mental health. They provided tips to recognizing trauma symptoms in young children with child welfare partners in an easy to read format. Child welfare staff hoped these would raise their partners' awareness of trauma, traumatic reactions, and associated behaviors.
- **Tailoring Trainings for Specific Partners:** Tailored trauma trainings were created and delivered to mental health case managers; school staff; and partners in local child placing agencies to introduce them to trauma-informed work.
- **Engaging Key Stakeholders to Lead Trauma-Informed Trainings:** One team worked with a judge who was very interested in understanding trauma-informed care. After he began using a trauma-informed tool to make his final determination, he decided to train all juvenile probation officers to use it as well.

Strategy 5b: Using Trauma-Informed Forms and Language with Partners

What Makes This Strategy "Trauma-Informed"

Communication is at the heart of cross-systems work. Partners must speak the same language with common understanding. Trauma-informed language must be consistent and continuous if the overall child welfare system is expected to embrace and operate in a trauma-informed way.

Practice Highlights

- **Using Trauma-Informed Language in Court Reports:** As child welfare staff begins using trauma-informed language in court reports and documentation, it is critical that court personnel, judges, and others understand them. This goes beyond the training described in Strategy 5a. Teams began to use trauma-informed language in court reports to reinforce the focus on trauma.

- **Incorporating Mental Health Screening Form into Child Welfare Agency Record:** One team incorporated the mental health agency's screening form into the child welfare agency record. This not only increased collaboration and consistency across the agencies, but reduced redundancies and allowed them to share a single report with the courts when needed.

Challenges and Lessons Learned

Teams in the BSC had many successes and were able to identify many promising practices, as described throughout this report. In their efforts to test and implement practices that improve placement stability for children in foster care, teams also encountered and identified a variety of challenges. Those teams that either did not experience these challenges, or were able to address them in some way, seemed to demonstrate positive impacts. But when these challenges went unaddressed, they seemed to pose difficulties for the team.

The most significant challenges, barriers, and lessons learned from the BSC teams are described below. They have been divided into those challenges that were related to organizational / system-level functions, and those that were more connected to child welfare practice.

Organizational / System-Level Functions

- **Strong and Consistent High-Level Leadership:** Implementing trauma-informed practice inherently relies on a shift in organizational culture, as it is more than simply a set of 'new' practices or revised policies. Using a trauma lens means that all staff – at all levels – begin to see and work with children and families in different ways. In order to facilitate such an organizational culture shift, strong and consistent leadership is necessary. Moreover, while the core team members were intentionally on-the-ground folks who had the ability to test actual changes in practice in real time, spreading and sustaining the promising improvements was reliant on high-level leadership as well. While there are many aspects of the BSC that depend on direct service staff and consumers designing and testing improvements, there are also many critical aspects that are fully dependent on a consistent leader who provides ongoing support and can maintain continuity, momentum, and priority for this work.

- **Sustained Attention from Leaders and Shifting / Competing Agency Priorities:** While this BSC was intended to last for one year, it was extended to two years. Over this time period, some agencies experienced changes in overall priorities, as well a changes in leadership. This was especially true for those agencies that had several major initiatives occurring simultaneously, such as the implementation of practice models, organizational restructuring efforts, and agency redesigns. The ability to maintain focus on this work became extremely dependent on high-level leadership for these agencies in particular, and when the leaders were unable to sustain their attention to this work, the team often experienced difficulty continuing to test, implement, spread, and sustain practice improvements.

"It has helped me regaining voice and to help spread the voice of youth to my team."
—Youth Team Member

- **Culture of a Learning Organization:** Beyond the consistent and strong support of agency leadership, the testing, implementation, and sustainability of trauma-informed practice is reliant on an agency culture that encourages and inspires innovation. No idea should be off limits as long as it is safe for children and families. Staff who are motivated, excited, and creative should be nurtured as 'champions' in this work. While high-level leaders are essential for spreading promising practices and sustaining the work, it is the staff on the ground who are essential to the development and testing of the initial ideas.

- **Collaboration Across Different Agencies:** Having the "right" people at the table is only the first piece of cross-system collaboration, and even this can be quite difficult to accomplish. But in recognizing that the child welfare *system* goes far beyond the child welfare *agency*, many agencies must be willing to step forward and roll up their sleeves. The BSC teams did remarkable work in bringing the "right" mental health partners to their tables, but once there they often faced the challenges of different institutional languages, regulations, policies, and mandates. While these challenges were not insurmountable, they were also not issues that could be addressed by simply testing a small change. The established cultures, norms, and identities of all partners (including the child welfare agencies themselves) needed to shift over time as they became true collaborative partners in the broader child welfare *system*.

- **Engaging Consumers as True System Partners:** Not only were birth parents, foster parents, and youth required to be members of each agency's core team in the BSC, but these perspectives were also represented on the BSC faculty. Despite many years of working to engage these 'consumer' groups as authentic partners in system improvement efforts, teams were still faced with challenges on how to do this effectively. Youth and parents who had participated on consumer advisory boards or in other system-level roles found their voices on their teams more easily, but the teams themselves often struggled with how to engage – and use – the unique and critical perspectives these team members brought to bear. Despite the challenge, all teams would likely agree that the ideas, inspiration, and impact, provided by these team members were invaluable and necessary as this work continues to unfold.

- **Time Limitations for Staff:** Regardless of the commonly used mantra in many initiatives: "this isn't more work; it's simply a different way of doing the same work," active participation in the BSC definitely required more up front work. Additionally, many of the practices that were considered most promising also required more upfront work. Many social workers who tested these practices shared that they typically resulted not only in better outcomes for children and families, but, in fact, in less work on the back-end. (Key examples included using improved trauma screenings; spending time on placement disruption prevention meetings; and developing relationships between birth and foster parents.) Yet even seemingly simple improvements, such as adding a few questions to a screening tool, was likely to get push back from other staff unless they understood

its importance; how to do it correctly; the likelihood for improved outcomes; and the possibility for less work dealing with placement disruptions, angry phone calls, or days in court. Thus, spreading practices became highly dependent on helping staff understand the benefit for themselves, as well as for the children and families they supported.

Child Welfare Practice

- **Insufficient Availability of Trauma-Informed Treatment:** As child welfare staff and partners (including foster parents) better understood how to identify trauma and why it was so critical to address, the demand for trauma-informed services began to grow. However, the supply of these services did not grow at the same rate, leaving many staff and parents frustrated with being placed on a wait list for what they had identified as a pressing need in order to stabilize a placement and ultimately achieve permanency. While some teams worked to ensure more clinicians and therapists were skilled at providing trauma-informed evidence-based treatments, mental health agency budgets and organizational constraints (e.g., billing, reimbursements, training needs, etc.) sometimes made this quite difficult to do.

- **Lack of Trauma-Informed Services for Birth Parents:** Similar to the general availability of evidence-based trauma-informed treatments for children in placement, nearly all teams identified a dramatic gap in their ability to access trauma-informed services for these children's birth parents. Participants across the BSC identified trauma issues for parents as one of the most significant unmet needs that they experienced. Further compounding the availability of these services was the fact that many child welfare agencies were unable to provide these services to parents as they were intended to be a 'child-serving agency' not an 'adult-serving agency.' The organizational partners they needed for this were not even at the same table. This issue relies on resolution of the cross-system collaboration challenge described above, as the current child welfare system, rather than being seamless and integrated, has created silos that leave gaps into which these issues repeatedly fall.

Overall Recommendations for Testing and Implementing Trauma-Informed Promising Practices to Improve Placement Stability

Based on the work done by teams over the course of this BSC, a number of recommendations are suggested to further test and implement these promising practices:

- **Screen for Trauma:** Focus on creating a system where child welfare workers conduct trauma screenings. This includes training on how to conduct the screenings and how to manage secondary trauma that may emerge in workers while they are conducting the screenings.

- **Address Trauma for All Partners:** Think about and address trauma experienced by different system stakeholders (children, parents, caseworkers, foster parents). Remember that secondary traumatic stress is real, and supporting staff and partners in addressing their own needs helps them better support children and families.

- **Partner with Families and Youth:** Actively partner with families and youth throughout the process. They provide a critical perspective and have creative ideas to assist in informing and improving the system. These participants need to be selected, prepared, and supported in thoughtful and intentional ways to ensure their participation is meaningful.
- **Integrate with Other Agency Priorities:** Identify and map trauma-informed practices with child welfare system's priorities (e.g., implementation of practice models, signs of safety, permanency efforts, etc.). Trauma will almost inevitably impact/intersect with them in some way.
- **Avoid Layering New Practices Over Existing Practices:** Replace existing practices rather than add new practices. The current child welfare workload is already overwhelming.
- **Share Resources:** Share trauma-informed resources across systems. This includes tools, trainings, and other products.
- **Support Change at All Levels:** Change should be made from both the top-down and bottom-up perspectives. If the hierarchy is flattened, there is more room for innovation, buy-in, and ultimately system change.
- **Remember that Trauma-Informed Practice Is More Than Trauma Treatment:** Think beyond linking children with mental health treatment. Address other stakeholders/services within child welfare system (foster parents, mentors, parenting classes, visitation, etc.) and help them develop and use a trauma lens in all interactions with children and families.
- **Collaborate, Partner, and Integrate Across Systems:** Focus cross-system work on shared values and desired outcomes rather than on differences and contrasting requirements. The most effective trauma-informed system will be one that reflects an integrated partnership, rather than one that continues to try to support families in silos.

"The BSC has begun a process of change and growth in our agency and our state beginning trauma informed practice in multiple areas of our child welfare practice - REAL growth, VALUABLE partnerships and hopefulness!"

—BSC Participant

- **Think Broadly About Cross-System Partners:** Cross-system partners in this work go far beyond the child welfare agency and a lead mental health agency. Including parents, youth, foster parents, judges, pediatricians, educators, early education, and others provides critical perspectives and also mobilizes many supporters. As seen at the final Learning Session / Roundtable, the insights of these various perspectives give this work the ability to spread – and ultimately to be sustained.

"I am inspired to see how a BSC can change practice and change systems. I am even more charged to make this work spread in our state."

—BSC Participant

Opportunities for the Future

Although the BSC held its final Learning Session / National Roundtable in June 2012, the work of implementing trauma-informed practice to improve placement stability for children in foster care is continuing in earnest. Many of the teams that participated in the BSC have received federal grants that will help them spread and expand the work that they began. These grants include Administration for Children and Families (ACF) grants on trauma-informed child welfare practice and expanding evidence-based treatments; and the Chadwick Trauma-Informed Systems Project, an NCTSN Category II Center funded by the Substance Abuse and Mental Health Services Administration.

There is also a growing list of resources available online to support the work of implementing trauma-informed practice. Some of these resources were used by the teams themselves during the BSC and others have been developed since the BSC concluded. Highlights of these resources include:

- NCTSN Child Welfare Trauma Training Toolkit
- NCTSN Caring for Children Who Have Experienced Trauma: Resource Parent Workshop
- Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators (2nd Ed.)
- Fact Sheets on Birth Parents with Trauma Histories
- Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway
- Resilience Alliance: Promoting Resilience and Reducing Secondary Trauma Among Welfare Staff
- California Evidence-Based Clearinghouse for Child Welfare
- Trauma-Informed Child Welfare Practice Toolkit

As the work of the BSC teams continues, it is likely that the body of knowledge and promising practices that can increase placement stability for children in foster care by implementing trauma-informed child welfare practice will continue to grow.

1. KNOWLEDGE BUILDING AND DEVELOPING PRACTICE

1a Training Staff on Trauma

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 1a	***Training Staff on Trauma***
Overview & Rationale for the Strategy	Staff who interact with families and children on a daily basis must understand what trauma is; how it impacts children and their development, behaviors, and reactions; how to work with children to minimize additional trauma; and how they can address this trauma to increase children's stability in placement.
Practices to Test	• **Using the CW Trauma Training Toolkit:** Information on trauma from the NCTSN *Child Welfare Trauma Training Toolkit*, ranging from specific modules to the complete curriculum, to train new workers, for continuing trainings, and at periodic agency summits, conferences, and other meetings. • **Posting Information on Internal Website:** Collect and share key articles, research, and literature on the impact of trauma, behaviors, symptoms, and the need for trauma-focused practice on internal shared internet sites. • **Training <u>All</u> Agency Staff**: Move beyond training social workers and train front office clerical staff, receptionists, and administrative staff in trauma-informed practice
Demonstration of Promise	Training and raised awareness were consistently mentioned by many participants in focus groups and surveys as critical in changing the ways that staff saw, understood, and ultimately worked with children and families. *"I now look at my work through a trauma lens. I talk with foster parents about the trauma children in their care have experienced and the behaviors that they may see in the hopes of helping placement stability."* – BSC Participant Another team reported this because of their improvements: "*Placements have stabilized on her caseload and placement disruptions have decreased for the other workers in her unit due to spread. We believe this is linked to the workers developing a more comprehensive approach to trauma and beginning to understand how trauma is a thread throughout the process.*"
Originally Tried in	Florida; Oklahoma; San Diego

1. KNOWLEDGE BUILDING AND DEVELOPING PRACTICE

1b Providing Coaching and Support

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 1b	***Providing Coaching and Support***
Overview & Rationale for the Strategy	Training received by staff must not only be reinforced, but there must be opportunities to receive additional coaching and support as workers interact with families and children who have experienced trauma. Additionally, providing reminders to child welfare workers helps ensure that the work they do with children and families is trauma-informed and trauma-focused.
Practices to Test	• **Developing In-House Trauma Consultants**: One team developed a cadre of social workers as in-house trauma consultants through an intensive one-day training. These workers were considered onsite "expert consultants on trauma" to whom other workers could then go for information, support, and general consultation about trauma. They will also lead office "learning circles" to provide opportunities for staff to continue discussing issues related to trauma on an ongoing basis. • **Developing Written Reminders**: One team adapted a hints and tips reminder sheet from the Center for Improvement of Child and Family Services, 2009. It is printed on bright pieces of paper and is intended to help remind social workers to use a trauma lens whenever removing, placing, or working with children, youth, and families. These Trauma-Informed Practice Sheets (TIPS) are included with the agency's regular assessment packet to help child welfare workers keep trauma as a focal area when working with children and their families.
Demonstration of Promise	Constant reminders about trauma are important for staff, as noted by a birth parent who was a BSC participant: "*We immediately recognized that there was a big difference of opinion as to what the agency thought they were doing and what the consumers thought that they [the workers] were doing. For example…the consumers didn't believe that they were doing their best to talk to the birth parents or foster parents about the children.*"
Originally Tried in	Los Angeles; Massachusetts

1. KNOWLEDGE BUILDING AND DEVELOPING PRACTICE

1c Raising Awareness of Parents and Caregivers

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 1c	***Raising Awareness of Parents and Caregivers***
Overview & Rationale for the Strategy	Those who care for children on a daily basis when they are in placement must have the awareness and skills they need related to traumatic stress and how it is displayed across the developmental spectrum. This knowledge not only allows them to be more sensitive to potential trauma triggers, but it also helps them see some behaviors as traumatic reactions rather than simply "bad behavior." As this is recognized by foster parents, it can reduce the likelihood that the placement will disrupt.
Practices to Test	• **Incorporating into Existing Foster Parent Trainings:** Many teams tested and implemented practices in which training, education, and skill-building about trauma was incorporated into existing foster parent trainings. The NCTSN curriculum *Caring for Children who Have Experienced Trauma: A Workshop for Resource Parents* was the most common source of information used in developing these modules and trainings. • **Including in Foster Parent Newsletters and Brochures:** Information about trauma across the developmental spectrum was included in foster parent newsletters and brochures to ensure that existing foster parents received continuous information about recognizing and responding to trauma. • **Providing Information about Trauma to Parents and Caregivers**: One team developed an information card for parents and caregivers that described behavioral indicators of children who may have experienced a traumatic event. • **Bringing "Real" Voices into Trainings:** Foster parents, birthparents, and youth were invited by some agencies to talk with prospective foster parents during their initial foster parent training about the trauma of placement and the ability to minimize this trauma through positive birthparent–foster parent relationships. (See more on this in Practice Card 3.a.)
Demonstration of Promise	One participant focus group member noted, "*[B]ecause I've got a lot of prospective foster parents and present foster parents starting to hear the language (of trauma) and then because of groups that we're doing with [our public child welfare agency], it's kind of helping them take care of themselves…they make better judgments and look at how their kid is impacted.*"
Originally Tried in	Los Angeles; Massachusetts; New Hampshire; Oklahoma; San Diego

1. KNOWLEDGE BUILDING AND DEVELOPING PRACTICE

1d Addressing Secondary Traumatic Stress

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 1d	***Addressing Secondary Traumatic Stress***
Overview & Rationale for the Strategy	Improving placement stability of children in foster care placement cannot be fully met without ensuring that the staff and caretakers working with children were themselves adequately supported. The increase in trauma awareness among staff, and the subsequent increased exposure to children's trauma stories through screening and other activities, increases the need to provide staff with strategies for understanding and coping with their own secondary traumatic exposure.
Practices to Test	• **Implementing STS Groups for Staff:** Several teams increased knowledge of secondary traumatic stress by implementing regularly scheduled groups directed at supervisors and frontline staff. These teams served as forums for discussing the challenges of child welfare work; developing positive coping strategies; and promoting mutual support and collaboration among staff members. Teams also used the groups to share readings and resources about STS. Some of these groups are facilitated by staff within the department and other teams have looked to external facilitators to further promote the sense of psychological safety and confidentiality. • **Supporting Wellness Activities:** Many teams undertook creative strategies for increasing self-care activities among their staff, ranging from the availability of lunchtime yoga classes in the office to exercise groups to healthy eating campaigns. These efforts shared an emphasis on the needs of staff, and sent the message that self-care is both an individual activity and an organizational responsibility. • **Integrating Resilience Skill-Building into Practice:** Several teams were looking to the Resilience Alliance, an intervention developed by the ACS-NYU Children's Trauma Institute (an NCTSN Category II site), and were either planning on delivering the intervention in its entirety to their staff, supervisors and managers, or integrating selected strategies and tools from the intervention into existing forums like staff meetings, individual and group supervision, etc.
Demonstration of Promise	The issue of secondary traumatic stress, while included in three of the thirty objective areas detailed in the Collaborative Change Framework, was not intended to be a major area of focus in the BSC. Yet, eight of the nine teams identified it as a high priority, tested ideas and changes related to it, and ultimately named it as an area they planned to continue focusing on beyond the end of the BSC.
Originally Tried in	Florida; Los Angeles; Massachusetts; Oklahoma

2. TRAUMA-INFORMED MENTAL HEALTH SCREENING & ASSESSMENT

2a Using Trauma-Focused Screening Tools

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 2a	***Using Trauma-Focused Screening Tools***
Overview & Rationale for the Strategy	Brief screenings allow for the rapid and early identification of trauma experiences and traumatic stress reactions. Because child welfare workers are already closely engaged with families and gathering information on many aspects of the child and family, adding (or simply revising) key questions that focus on trauma is a fairly easy, no-cost practice improvement. Implementing screening practices that are done by child welfare workers and other mental health and medical partners also helps continue to raise awareness about trauma and keep it in the forefront of their work with children and families.
Practices to Test	• **Adding Questions to Existing Screening Tools**: Several teams identified a few key questions about trauma and these questions were incorporated into the interview tool the child welfare social worker uses during initial face-to-face meetings with families. • **Using Brief Trauma Screening Tools by Various Staff**: Several teams adopted, adapted, or developed brief screening tools to use that were concise, simple, and could be used by staff at various levels. These tools were implemented at a variety of points in time, including at the time of initial contact; at the time of removal/placement; and at the time of a family team meeting. The screening results were most often used to evaluate whether a referral was needed for a more complete trauma assessment. • **Engaging Mental Health and Medical Providers in Screening**: Local trauma center incorporated a trauma screen into their own center referral form; pediatricians incorporated screenings into their assessments; mental health intake coordinators trained in trauma screening.
Demonstration of Promise	Teams that created systems enabling them to screen a higher percentage of their children found that they also identified a considerably higher percentage of their population as needing treatment. While one would expect to see increases in total numbers, a parallel increase in the *percentage* identified as needing treatment was a surprising result and makes this a strategy to continue to monitor.
Originally Tried in	Los Angeles; Massachusetts; North Carolina; San Diego

2. TRAUMA-INFORMED MENTAL HEALTH SCREENING & ASSESSMENT

2b Collecting and Sharing Assessment Information

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 2b	***Collecting and Sharing Assessment Information***
Overview & Rationale for the Strategy	Screening for trauma is only of value if the results of the screening are shared and used for a next level of assessment. Similarly, once trauma information is collected, whether through screening or more comprehensive assessment, it must be shared across partners to ensure that everyone is operating with the same critical information and can work with and respond to the child and family appropriately.
Practice to Test	• **Gathering Clear and Specific Mental Health Information**: One team worked with a key mental health provider to develop a *Foster Care Mental Health Assessment Summary* as well as a *Foster Care Mental Health Treatment Summary*. Both of these documents were intended to gather clear and specific information relevant to the mental health and trauma assessment of the children they saw who were in foster care. The information was captured on these forms and then shared with the child welfare social workers as well as the courts.
Demonstration of Promise	A clinician told a story of receiving a referral from a child welfare worker based on a screening: "*This past week I picked up a referral from our front desk, and it said…zero to five trauma, and it's actually not a caseworker that I knew was a part of the project, and…that was … for me, just a nice pivotal moment.*"
Originally Tried in	New Hampshire

3. CASE PLANNING AND MANAGEMENT

3a Providing Information to Birth Parents, Children, and Youth

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 3a	***Providing Information to Birth Parents, Children, and Youth***
Overview & Rationale for the Strategy	The time of removal is a traumatic experience in itself for birth parents and the children being removed. Providing them with as much information as possible about the placement and what will happen next is an opportunity to minimize this trauma as well as provide support.
Practice to Test	• **Helping Foster Parents Understand Importance of Information for Birth Parents**: This tip sheet was created by the foster parent on one of the teams. It was designed to be a guide to help foster parents engage with birth parents at the time of their first contact. It included intentional information explaining why it was so important for foster parents to share information about themselves, their families, and their homes with birth parents to help alleviate their stress and associated trauma, as well as to support the development of a positive relationship between them. • **Gathering Information about the Foster Home:** A form was developed by a team in both English and Spanish that was given to foster parents whenever a child was placed in their home. The form collects basic information about the home and the family so that it can be given to that child's birth parents. The goal is for this form to help create an open dialogue between parents and caregivers; increase cooperation between the two parties so that families can be reunified faster; and help the birth parents see the foster parents as supports who will provide care for their children.
Demonstration of Promise	A foster parent on one of the BSC teams described one of the most important parts of the BSC as, *"Ensuring and providing assurance to parents that their voice is important. They have rights, [and we should be] supporting them in the process, giving them the guidance that they need."*
Originally Tried in	Los Angeles; New Hampshire

3. CASE PLANNING AND MANAGEMENT

3b Providing Information to Caregivers

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 3b	***Providing Information to Caregivers***
Overview & Rationale for the Strategy	Providing the foster parent with more information about the child up front ensures that the foster parent knows what things are comforting and distressing to the child, thus providing as much familiarity to the child as possible and potentially reducing the negative impact of separation from his or her parents.
Practices to Test	• **Gathering Information from Birth Parents to Share with Foster Parents:** Based on the recommendation of a birth parent participant on one of the teams, nearly all teams tested changes related to gathering information from birth parents about their children and providing this information to foster parents at the time of the initial placement. This has been done by providing opportunities for birth parents to share information about their children with foster parent using tools such as the "All About My Child" form, "Let Me Tell You About My Child" form, or letters written by birth parents and provided to foster parents. In an attempt to reduce redundancy, one team incorporated this information into the Child Info Fact Sheet that social workers are already responsible for completing. • **Gathering Information from Child/Youth to Share with Foster Parents:** Nearly all teams also created, adapted, and/or implemented forms and processes to collect information about children and youth, such as the "All About Me" form and "Five Things I Want You to Know About Me" form, directly from the youth themselves. These forms and processes were intended to give the children and youth an opportunity to open a conversation with foster parents. Staff were trained to use these tools with all children and youth who are capable to articulating their likes, dislikes, and other information about themselves. One team created an "All About Me" form designed specifically for infants.
Demonstration of Promise	Birth parents, foster parents, and youth involved in this BSC shared in focus groups that this strategy is a significant practice to help minimize the trauma of the initial placement. One foster parent who was a BSC participant described a placement in her own home: *"I had a sibling group of three; one of the boys was autistic, non-verbal, mentally delayed…. Once he was placed [with me] he was like a wild animal. [There were] no services for him, but he punched things, tore up things. Mom wrote the letter [to me about him and his needs and it was] very helpful, particularly related to this child."*
Originally Tried in	Colorado; Florida; Los Angeles; New Hampshire; San Diego

3. CASE PLANNING AND MANAGEMENT

3c Facilitating Connections Between Birth and Foster Parents

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 3c	***Facilitating Connections Between Birth and Foster Parents***
Overview & Rationale for the Strategy	Maintaining connections between children and parents can help ease the transition of coming into foster care and make the experience less disruptive or traumatic for children and minimize behavior problems (McWey, Acock, & Porter, 2010). Having the child see that there is communication between his or her parents and foster parents can also help reduce feelings of anxiety and guilt around living with another caregiver.
Practices to Test	• **Providing Training to Foster Parents on Working with Birth Parents:** Many teams found it necessary to provide training to foster parents on the rationale for and importance of working with birth parents. To do this, one team brought together a foster parent and birth parent who had successfully partnered to achieve reunification, and had them talk about their experiences and success at a new foster parent training. • **Connecting Foster Parents and Birth Parents Quickly After Placement:** Many teams focused on finding ways to connect foster parents and birth parents as quickly as possible after placement. Several teams asked foster parents to call birth parents within 24 hours of the placement to talk about the child's transition. This practice often allowed the birth parent to talk with his or her child on that first night of placement, providing reassurance and engagement of the parent, and offering comfort and connections for the child. • **Supporting Birth Parent-Foster Parent Visits:** Teams worked to encourage visits among birth parents, their children, and the foster parents on an immediate and regular basis, beginning as soon as possible after the initial placement is made. • **Facilitating Frequent Visits with Birth Parents:** Facilitating frequent visits in a family-friendly setting is thought to lessen the effect of possible detachment between a child and his/her parent(s) following a removal. One team kept this practice within its Family Finders model, and used Family Engagement Specialists (FES) to engage parents and family in recognizing their strengths and areas of unmet needs. They also pulled in additional natural supports to create a support team for the family.
Demonstration of Promise	A focus group quote from a clinician in the BSC sums up the impact this practice strategy can have: "*I think the thing that kind of stood out…was when the birthparent spoke and read the letter that she wrote to her child. I mean everybody walked out with a big—wow… that was so impactful, I think, to everybody.*"
Originally Tried in	Colorado; Florida; Massachusetts

3. CASE PLANNING AND MANAGEMENT

3d Conducting Inclusive Team Meetings

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 3d	***Conducting Inclusive Team Meetings***
Overview & Rationale for the Strategy	Facilitated meetings allow foster parents and birth parents to come together on behalf of the child's needs, as well as provide forums for information sharing about the child. Other partners, including mental health providers, may be invited to help support the child and placement. And by recognizing that many placements disrupt because of children's behaviors, meetings held specifically to prevent disruptions provide an opportunity to discuss and address the underlying factors for the behavior. Plans can be put into place to prevent the disruption, including appropriate treatment for the child, and respite and support for the foster parent. Rather than focusing on a child's behavior, these meetings allow for a focus on the child's trauma.
Practices to Test	• **Engaging Birth Parents and Foster Parents in Planning Meetings:** Many teams supported connections between birth and foster parents by actively focusing on specific meetings, such as family team meetings, special meetings held shortly after the placement was made, or meetings specifically focused on maintaining placement stability. At a three-week post-placement meeting created by one team, birth parents, foster parents, and workers came together within three weeks of placement to talk specifically about the child's trauma history, the impact on behavior and placement, trauma triggers, and opportunities for co-parenting. • **Including a Trauma Consultant on the Team:** To provide early intervention to children who were displaying troubling behavioral symptoms in placement, one team invited a mental health counselor to join their placement team. The counselor interviewed the child, foster parents, and case manager and then provided support to the foster parents as needed, including a home visit within 24 hours and/or phone support. This counselor could also make a referral to a treatment provider if appropriate. The counselor remained involved to ensure linkages and prevent any further crises that could lead to disruption. • **Implementing Placement Disruption Prevention Meetings:** These meetings, which included staff at a variety of levels as well as external partners, were held by one team with great success. The meetings were done whenever a placement was at risk of disruption, as determined by either the worker or the foster parent. The meetings focused on what was needed to stabilize the placement with a specific focus on the child's trauma and managing associated behaviors.
Demonstration of Promise	By July 2011, the team that tested and implemented the Placement Disruption Meetings reported that not only did they have only one child in their BSC target population move since December, but also placement disruptions for the rest of the local jurisdiction had decreased significantly as well.
Originally Tried in	Florida; Massachusetts; Oklahoma

4. EXTERNALLY DELIVERED TRAUMA-INFORMED SERVICES

4a Identifying Resources and Referring for Services

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 4a	***Identifying Resources and Referring for Services***
Overview & Rationale for the Strategy	Although BSC teams were made up primarily of child welfare agency staff, each team did have members from local mental health providers. Moreover, all team members clearly understood the need for trauma-informed services, once trauma was identified as an issue for a child in placement. Trauma-informed child welfare practice cannot end with the interactions between child welfare social workers and families; it must also include the identification of appropriate resources and referrals for necessary trauma-informed treatment.
Practices to Test	• **Identifying Appropriate Resources:** Members on one team determined that a critical challenge they faced in accessing trauma-informed resources and services was the fact that very few child welfare social workers actually knew what trauma-informed resources and services were available in their communities. Working with the mental health agency partners on their team, they compiled a Resource Guide of trauma-informed therapists for child welfare social workers to use as a reference tool for referrals. • **Referring for Treatment**: As child welfare agency staff began conducting trauma screenings of children in foster care, the numbers of children needing trauma assessments and treatment grew. One team set aside dedicated time during their 'transfer' staffing to refer children who needed it directly to an appropriate evidence-based trauma treatments.
Demonstration of Promise	Staff members who were not part of the BSC had many questions about how to determine if trauma treatment is needed, what types were available, and where to find them. Having a guide of resources and making treatment decisions in teams provided this ongoing on-the-ground education and support.
Originally Tried in	Florida; Massachusetts

4. EXTERNALLY DELIVERED TRAUMA-INFORMED SERVICES

4b Increasing Capacity of Mental Health Providers to Deliver Evidence-Based Treatments

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 4b	***Increasing Capacity of Mental Health Providers to Deliver Evidence-Based Treatments***
Overview & Rationale for the Strategy	Providing trauma-informed evidence-based treatments is essential to ensuring that children and families' trauma-focused needs are met. According to the research, effectively addressing a child's trauma history through the provision of evidence-based trauma treatment has a significant and lasting impact on the outcomes that children in placement can achieve (Rubin et al., 2007).
Practices to Test	• **Increasing In-House Access to Skilled Therapists:** Because mental health administrators and clinicians were part of each team's core group, they watched first-hand as the demand for evidence-based trauma treatments was growing. One child welfare agency already had an in-house mental health therapist on staff to support assessments, treatment planning, and provide trauma-informed consultation. Because of this project, this team was able to reallocate funds to hire a second therapist as the needs in the agency grew. • **Increasing the Availability of Trauma-Informed Evidence-Based Treatments:** Several teams worked with partners to increase the availability of trainings on evidence-based treatments (EBTs). While this does not answer immediate demands for treatment, it is a longer-term response that is critical.
Demonstration of Promise	Based on these trainings and access to skilled in-house therapists, child welfare social workers now better understand the types of evidence-based trauma treatment and are able to make more appropriate referrals.
Originally Tried in	Florida; San Diego

5. Child Welfare Systems, Cross-System Partnerships, and System Collaboration

5a Providing Training to Child Welfare Partners

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 5a	***Providing Training to Child Welfare Partners***
Overview & Rationale for the Strategy	The child welfare system is comprised of a much broader group than the child welfare agency alone. Ensuring that all partners and stakeholders are trauma-informed is essential in implementing a truly trauma-informed system.
Practices to Test	• **Providing Concise Training on Trauma-Informed Practice:** Because time is often limited, teams developed abbreviated trainings on trauma to deliver to cross-system partners. One team used a two-hour trauma-informed curriculum based on the Child Welfare Toolkit that could be used for a variety of other agencies and partners. This allowed them to reach many more partners in a much shorter period of time than the standard training they were offering staff. • **Developing an Easy Reference for Identifying Trauma**: Booklets and tips sheets from Project ABC (About Building Connections) were focused on addressing early childhood trauma and mental health. They provided tips to recognizing trauma symptoms in young children in an easy to read format that was shared. • **Tailoring Trainings for Specific Partners:** Tailored trauma trainings were created and delivered to mental health case managers; school staff; and partners in local child placing agencies to introduce them to trauma-informed work • **Engaging Key Stakeholders to Lead Trauma-Informed Trainings:** One team worked with a judge who was very interested in understanding trauma-informed care. After he began using a trauma-informed tool to make his final determination, he decided to train all juvenile probation officers to use it as well.
Demonstration of Promise	One clinician told a story of an unexpected outcome: *"Sometimes, your system seems so hard to make any changes…..So, it's been very helpful to see the system start to change, and I knew for sure that it was really changing….I was talking with the (child welfare) supervisor, and she says 'I think they're getting it…this worker had gone out to the home and…helping out the foster mother and she (the supervisor) was saying no, you don't have to do that, that's not the best use of your time, and she (social worker) said I am preventing…I am keeping a placement disruption from happening."*
Originally Tried in	Los Angeles; Massachusetts; New Hampshire; North Carolina

5. Child Welfare Systems, Cross-System Partnerships, and System Collaboration

5b Using Trauma-Informed Forms and Language with Partners

This card describes practices tested by teams in the Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. They are considered to be promising approaches to implementing trauma-informed child welfare practice to improve placement stability for children in foster care based on the experiences of teams. These strategies can be easily replicated and adapted in most communities.

Strategy 5b	***Using Trauma-Informed Forms and Language with Partners***
Overview & Rationale for the Strategy	Communication is at the heart of cross-systems work. Partners must speak the same language with common understanding. Trauma-informed language must be consistent and continuous if the overall child welfare system is expected to embrace and operate in a trauma-informed way.
Practices to Test	• **Using Trauma-Informed Language in Court Reports:** As child welfare staff begins speaking and communicating in trauma-informed ways, it is critical that these communications are understood by those receiving them. This goes beyond the training described in Strategy 5a. Teams began to use trauma-informed language in court reports to reinforce the focus on trauma. • **Incorporating MH Screening Form into CW Agency Record:** One team incorporated the mental health agency's screening form into the child welfare agency record. This not only increased collaboration and consistency across the agencies, but reduced redundancies and allowed them to share a single report with the courts when needed.
Demonstration of Promise	One team reported this change: "*There have been discussions in the schools and the courts about a child's trauma history and many community providers have been trained in trauma-informed practices.*" And lastly, "*Memorandums of Understanding have been established between the courts, mental health, and juvenile justice agencies that provide a clear pathway for intervention.*"
Originally Tried in	New Hampshire; Oklahoma