Virginia C. Strand · Ginny Sprang *Editors*

Trauma Responsive Child Welfare Systems

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Foreword

Much has been done to raise awareness in the child welfare field about the role of trauma in thwarting successful development of children and adults. Child welfare agencies and their partners are aware of the effects of trauma and, in some cases, are far better at recognizing when it is disrupting child functioning than they once were. However, the work is far from complete.

Recognizing trauma's immense and far-reaching impact has been the first step. As the title of this volume suggests, our work in educating system partners about the role and impact of trauma has amplified the need for the same systems to be prepared *to respond* to trauma. Increased awareness may have reduced the misuse of interventions and medications targeting attention and behaviors rather than their underlying causes, but in many parts of the United States, child welfare systems lack coordinated plans to respond appropriately to problems that stem from trauma exposure. And, while the proliferation of evidence-based treatment approaches has helped to guide practitioners toward more appropriate trauma-sensitive interventions for individual children and their families, we are still without guidance for the workforce at large; we are without an overarching organizational approach that links trauma-informed work to the child welfare goals of safety, permanency, and well-being.

This volume examines the role of the child welfare system in acknowledging and responding to trauma from numerous perspectives. It explores how trauma awareness might be enhanced and used to guide work in child protection, preventive, substitute care, and permanency services and how assessment strategies, treatment approaches, and practices might be realigned to promote trauma-informed responses all along the continuum of care. Using the conceptual frame of stabilization, integration, and consolidation, the chapters that follow draw parallels between the clinical work of healing and the practice and policy work of delivering agency- and system-wide responses to a vulnerable population.

Applying this framework at the macro level has many advantages. It can:

- Prepare a workforce to address challenging behavioral and relational issues and assist substitute and biological parents in delivering similarly appropriate and effective responses

- Encourage healing and self-regulation in the workforce
- Promote empathy and connections between workers and the children and families they serve in order to facilitate permanencies
- Build and strengthen the foundation of a common language within and between child-serving systems
- Engage the communities surrounding child welfare agencies in being similarly informed, educated, and prepared to respond to trauma-related issues when they arise

By underscoring the role of agency culture and the effect of trauma on the workforce delivering child welfare services, this work extends and deepens the conversation about trauma in ways that can enhance the quality of services aimed at achieving safety, permanency, and well-being. Addressing both the client and staff sequelae of trauma in one volume, Strand and Sprang draw parallels that highlight common experience and define a framework for recovery *and* organizational health. It is a framework worthy of attention and testing.

Indeed, *Trauma Responsive Child Welfare Systems* provides essential guidance for agencies that seek to ameliorate the effects of trauma and promote healing. While efforts to build trauma-responsive systems may be nascent, there are examples of initiatives and jurisdictions that have leveraged federal support to blend and braid funding streams, develop a common language, and build coordinated strategic approaches to recognizing *and* responding to trauma across human service systems including mental health, early childhood, juvenile justice, and child welfare. The material presented here will be invaluable to these initiatives, as a resource that provides multiple perspectives, details successful implementations, and illustrates the potential for maximizing positive child welfare outcomes. We believe these collective efforts may ultimately reduce the need for child welfare system involvement and promote well-being for all children and families.

Chapin Hall at the University of Chicago

Bryan Samuels
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Part I
Setting the Stage

Chapter 1
Introduction: Developing Trauma Sensitive Child Welfare Systems

Virginia C. Strand

Achieving trauma-informed child welfare systems and services is a major challenge facing child welfare at the beginning of the twenty-first century. Bryan Samuels, former Commission of Administration on Children, Youth and Families, states that "The research is clear that the experience of abuse or neglect leaves a particular traumatic fingerprint on the development of children that cannot be ignored if the child welfare system is to meaningfully improve the life trajectories of maltreated children, not merely keep them safe from harm" (Samuels, 2011).

Much has been studied, advocated, and written about the trauma history and needs of children coming into the child welfare system (Kisiel, Ferenbach, Small, & Lyons, 2009; Kolko et al., 2010; Greeson et al., 2011; McMillen et al., 2005). Harris, Lieberman, and Marans (2007) noted that most children with trauma histories in child serving systems like child welfare do not receive mental health treatment. There is a genuine concern among both practitioners and researchers about how to better serve traumatized children and families (Ai, Foster, Pecora, Delaney, & Rodriguez, 2013; Black-Pond & Henry, 2007; Hendricks, Conradi, & Wilson, 2011; Ko et al., 2008).

Recently, The Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) identified six key principles to guide a trauma-informed approach: (1) safety; (2) trustworthiness and transparency; (3) peer support and mutual self-help; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) attention to cultural, historical, and gender issues. In addition, the National Child Traumatic Stress Network has created a policy statement for the development of trauma-informed child welfare systems as follows: "Increasing knowledge and building skills among caseworkers and other child welfare person-

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nel are critical to identifying and providing early intervention for children traumatized by maltreatment." (http://www.nctsn.org/sites/default/files/assets/pdfs/Service_Systems_Brief_v1_v1.pdf). These principles and policy statement do not, however, provide sufficient direction for child welfare agencies in regard to *how to* apply these.

Trauma theory offers a conceptual framework to guide a process for more effective infusion of knowledge about trauma, its impact, and empirically supported interventions in child welfare agency practice with children and families. This framework also provides a foundation for understanding the impact on staff working with traumatized children and families in child welfare. In this chapter, the literature on trauma, its impact, and the nature of effective trauma treatments is used to highlight the types of revisions needed in child protection, preventive, foster care, and adoption services.

The Relevance of Trauma Theory and Knowledge

The Impact of Trauma

Trauma is defined as an adverse life experiences that overwhelm an individual's capacity to cope and to adapt positively to whatever threat they face. "Traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory. Moreover, traumatic events may sever these normally integrated functions from one another." (Herman, 1992) We now know that these experiences can cause debilitating behavioral and health difficulties in adulthood (Felitti et al., 1998) as well as adverse outcomes for older youth (McMillen et al., 2005) and adults emerging from the foster care system (Pecora, 2010). The complex impact of trauma on children and families is well articulated (Cook et al., 2005, Courtois, 2004). When children have been exposed to chronic and/or severe trauma, functioning is often compromised across a number of domains (Lieberman & Knorr, 2007).

Of primary concern is the effect on the development of secure attachment (Blaustein & Kinniburgh, 2010), but affective, cognitive, behavioral as well as somatic functioning is typically impacted along with the child's attachment (Cook et al., 2005; Lieberman & Knorr, 2007). The child's perception of self and others may become distorted and the world in general viewed as unsafe. As children and adolescents seek to cope with these adverse experiences and changed worldview, they may employ avoidance strategies, demonstrate hyperarousal to trauma reminders, and have difficulty modulating feelings or regulating behavior. Interpersonal relationships may be perceived as a source of danger, leading to isolation or hostile interactions with others (Cook et al., 2005; Lieberman & Knorr, 2007; Saxe et al., 2007).

A history of abuse and neglect brings children to the attention of the child welfare system. We now know that a majority of children and often their primary caretakers

(Chemtob, Grifing, Tullberg, Roberts, & Ellis, 2011) have experienced trauma. Kolko et al. (2010) found that while the prevalence of posttrauma stress symptoms was on average 12% in a national sample of children referred to child welfare, the rate was almost double for children entering care (19.2% for out of home and 10.7% for those maintained at home). Critical to the experience of trauma is the child's sense of betrayal when the abuse or maltreatment has occurred at the hands of a parent or caretaker. When an intervention placing children in out-of-home care in order to keep them safe inadvertently place the child at further risk for secondary adversities (Appleyard, Egeland, van Dulmen, & Sroufe, 2005) the social contract dictating that a child should have been safe in any substitute care arrangement provided by the state has been breached. Children are then often faced with many new challenges, losses, and stressors. The cumulative impact of these stressors, if unaddressed, often leads to additional emotional difficulties and behavioral disruptions. The challenge for child welfare is to offer children and their families trauma-sensitive services while preparing and sustaining staff impacted daily by direct and vicarious exposure to traumatic events.

The experience of overwhelming danger that occurs at the time of a traumatic event affects the body's neurobiology, which mobilizes to ward off danger, often through fright, flight, or fight responses (Perry, 2008; Saxe et al., 2007). With severe and persistent trauma, even when the child is safe and regulated, the body responds to associations – an event, person, smell, sound, or activity – with past dangers as if they are occurring in the present. For the child and those around him – parents, caregivers, teachers, and peers – these inadvertent, automatic responses to past events can appear unprovoked. It is these reactions to trauma triggers that caregivers and staff need to be attuned. According to the US Substance Abuse and Mental Health Services Administration (SAMHSA) "trauma informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization" (SAMHSA, 2010). The need to put into place trauma-informed services is foremost for child welfare agencies.

If emotional well-being is defined in regard to the internal life of the child, social well-being is focused on the external environment. A trauma-informed definition of social well-being for a child or adolescent rests on the establishment of a secure attachment with at least one primary caregiver. Social well-being is reflected in peer relationships, and there is evidence that children with at least one close friend and who can maintain friendships over time function better. Children who are supported in school achievement through the communication of positive expectations have been found to do better (Lipschitz-El, 2005). From a trauma perspective, children living in safe, protective, and nurturing families, where family values and socialization practices encourage a child's sense of efficacy, promote responsibility and facilitate support from extended family networks as well as the community at large, are more likely to flourish (Werner & Smith, 2001).

Successful Trauma Interventions

We know a great deal about what works effectively with traumatized children, adolescents, and adults that can be used to inform the development of a trauma-informed workforce. There are a number of evidence-based trauma treatments which have been found to be effective with maltreated and violence-exposed children. (Chaffin & Friedrich, 2004; Cohen, Mannarino, & Deblinger, 2006). While there is varying emphasis across empirically supported trauma treatments, common elements found in most include attention to safety, regulating emotions, achieving behavioral control, addressing cognitive distortions, building or sustaining attachment relationships, processing and integrating the traumatic experiences, and attending to posttrauma growth. Posttrauma growth can be understood as an increase in mastery, competency, and self-esteem (Blaustein & Kinniburgh, 2010; Saxe et al., 2007; Strand, Hansen & Courtney, 2013).

Phase-oriented trauma treatment is widely accepted as a defining characteristic of trauma-informed interventions (Brown, Scheflin, & Hammond, 1998, Courtois, 2004) and has been utilized as a framework in treatments for children in the child welfare system (Collins, Strieder, DePanfilis, Tabor, Clarkson, Linde, & Greenberg, 2011). The names given to phases of treatment may vary but the phase-oriented dynamic is present. Most interventions acknowledge either explicitly or implicitly a stage-oriented approach for effective intervention which includes:

1. Stabilization: the establishment of physical safety and emotional stabilization, characterized by an emphasis on the present; a focus on trauma-informed assessment and the development of adaptive coping strategies to better modulate affect dysregulation, stress responses, behavioral dysregulation, and cognitive distortions. The focus is on the here and now.
2. Integration: Processing traumatic memories and experience with the goal of reducing their impact on current functioning; characterized by a focus on acknowledging the reality of traumatic events, harmful relationships, and making meaning of past events. Implicit in the stage is the achievement of a secure attachment relationship. The focus is primarily on the past.
3. Consolidation: Return to a normal developmental trajectory, characterized by the consolidation of personal and interpersonal growth and mobilization of energy to focus on developmental tasks for the future. The focus is on the future.

Trauma-focused cognitive behavioral therapy (Cohen et al., 2006), is an example that aligns with this phase-oriented approach. It is a trauma intervention receiving the highest scientific rating on the California Evidence-Based Clearing House for Child Welfare, http://www.cebc4cw.org/search/results/?scientific_rating[]=1&q_search=Search&realm=scientific_rating) and is rated by SAMHSA National Registry of Evidence-based Programs and Practices as a program with effective outcomes (http://nrepp.samhsa.gov/AdvancedSearch.aspx).

TF-CBT is an example of an evidence-based trauma treatment which illustrates the phase-oriented nature of intervention. The TF-CBT treatment components that

fit into the "stabilization" phase are psychoeducation, parenting skills, relaxation, affect expression and modulation, and cognitive coping and processing. Their "integration" phase trauma processing component is defined as a "trauma narrative", followed by cognitive coping and processing II, in vivo mastery conjoint child–parent sessions components. Their "enhancing future safety" component can be thought of as a consolidation element.

The child welfare outcomes of safety, permanency, and well-being align with this conceptual framework for phase-oriented treatment. Safety is achieved through stabilization, permanency through integration and well-being through consolidation of the traumatic experiences. In terms of the impact of trauma on the child, integration of the trauma experience can only happen once the child is safe and stabilized. Attention to well-being, however, is an iterative process and can begin during the stabilization phase, as children are helped with stress reduction and emotional regulation. A complicating factor for child welfare is that both birth and foster parents (kinship and nonkinship) may have their own unresolved trauma experiences, as well as additional psychosocial problems and stressors (substance abuse, homelessness, serious mental illness) which they will need help addressing in order to provide a psychologically safe environment for the child. Without the integration of the traumatic experience, attempts at reunification may fail, or foster placement, even adoption, be disrupted. Permanency can be achieved through the integration of traumatic experiences, and the role of primary caregivers – birth parents, foster parents, or adoptive parents – is crucial in this process. Consolidation is the foundation for child well-being, as it positions the child and primary caregiver to continue the developmental trajectory with emotional energy freed to direct to on-going maturational tasks.

Resolution of the impact of exposure to trauma will help a child move toward emotional and social well-being. Emotional well-being, using a trauma lens, is defined as the successful integration of traumatic experiences, resulting in emotional and psychological energy being available for the child or adolescent to attend to the developmental tasks at hand, free form preoccupation with danger and safety. The diminishment of internal arousal to trauma reminders, coupled with mastery of coping strategies to deal with some unavoidable physiological and emotional arousal, positions the child or adolescent to bring appropriate affect, attention, and action to the educational, peer, and family challenges facing him or her. It is the attention to these coping strategies which begin in the stabilization phase. Additionally, critical to the sustainability of emotional well-being will be the development of a secure attachment, whether with a biological parent or other primary caregiver.

The next two chapters expand on this framework, first at it relates to the provision of agency services, and secondly, as it relates to workforce development. Chapter 4, with its emphasis on cultural competence, is included in the introduction due to its salience for both direct practice and organizational change. Chapter 4 discusses cultural responsiveness and reviews how historical trauma has shaped the experience of children, families and workers, and what this means for successful engagement and service delivery by child welfare agencies. Historical trauma has been defined as the "cumulative and collective emotional and psycholgocial injury over the life span and across generations, resulting from a cataclysmic hisotry of

genocide" (Struthers & Lowe, 2003, p258). Understanding historical trauma is important for understanding disproportionality and disparity in child welfare and is critical to successful engagement. Subsequent chapters flesh out developments in the creation of trauma-informed child welfare services (child protection, preventive, foster care, and adoption) and in attention to a trauma-informed agency culture.

Organization of the Book

In Part II, the two chapters in the first section deal with the role of child protective services in stabilization and safety. Chapter 5 focuses specifically on trauma-informed family engagement with resistant clients. It will expand on the notion of collaborative practice with parents and caregivers. There is evidence that lack of engagement skills is associated with lack of cultural sensitivity. Some (Dettlaff & Rycraft, 2010) have found that cultural bias in staff was a barrier to equitable provision of services. Dumbril (2006), in his study of parents' experience of CPS workers, found that those parents who experience workers using their power with them, rather than over them, were much more likely to work with CPS, as opposed to fighting or "playing" along. This chapter will identify specific engagement strategies and approaches for child protective services work.

Chapter 6 describes and discusses a specific evidence-informed trauma treatment, trauma system therapy (Saxe, Ellis, & Kaplow, 2009) and describe how it has been implemented in both state and large metropolitan child welfare agencies. With an emphasis on work in the social environment as well as with the individual child and family, the role for CPS is clearly articulated.

A second section in Part II focuses on permanency and the role of preventive services. As children and families move from the crisis of child protective services report to either preventive services, whose goal is to prevent placement, or to foster care, the immediate need for physical safety subsides. This is the time for intervention to ameliorate the impact of traumatic experiences that were identified in the CPS phase of intervention. The section starts in Chap. 7 with an examination of successful implementation of standardized assessment tools in many state-wide child welfare agencies, highlighting the facilitating factors as well as barriers to the implementation of comprehensive trauma assessments.

Chapter 8 continues the discussion of trauma-informed assessment, identifying ways in which the public agency can partner with community agencies for trauma assessments. Again, the goal is to fully assess the trauma impact and to plan for evidence-based trauma treatment where relevant.

Chapter 9 describes the successful implementation of an evidence-based trauma treatment, child–parent psychotherapy (Lieberman & Van Horn, 2009) in a state-funded preventive services program. Designed for children under six and their parents/primary caregivers, this implementation uses both a home- and office-based intervention. Successes, including the use of fidelity instruments with both clinicians and supervisors are discussed; on-going challenges are also identified.

The final three chapters in Part II focus on permanency and the role of foster care, as well as the need to work with preadoptive parents from a trauma perspective. As children move into foster care, there is an important opportunity for intervention to help resolve the impact of the trauma that brought the child(ren) into care, for both children and birth parents. Starting with an emphasis on the importance of establishing psychological safety as well as physical security in the foster home, Chap. 10 will focus on innovative methods that are available to help foster or resource parents become trauma-informed and better able to assist children in their care with emotional and behavioral regulation. Chapter 11, by contrast, will focus on the therapeutic work that can be undertaken with birth parents to assist them in resolving their own histories of trauma that often contribute to disruptions in parenting, and Chap. 12 focuses on a trauma-informed intervention model for supporting pre-adoptive parents.

In Part III, the focus shifts to creating trauma-informed agency culture. The first chapter in this part, Chap. 13, introduces commonly accepted principles for implementation of new practices. Steps associated with each stage are discussed, and examples of implementation are provided. The next three chapters outline a framework of macro strategies aimed at creating stabilization and safety in the organizational culture. Chapter 14 outlines a guiding framework for trauma-informed care in public child welfare, with a focus on organizational policies, practices, workforce development strategies, and evaluation methods that have been successfully used to create a trauma-responsive culture and promote the goals of safety, permanency, and well-being in an effective manner. Building upon this framework of care, Chaps. 15 and 16 will focus on specific tools that public child welfare personnel at all levels can use to assess and monitor progress toward the goal of creating a trauma-informed system of care and promoting and maintaining a secondary traumatic stress informed workplace. In addition to providing an evaluation strategy for child welfare personnel, these tools serve as a checklist of activities that can be used to design a trauma-informed organizational development plan.

Two chapters (17 and 18) focus on micro strategies for the development of safe and stable organizational culture. They include strategies for trauma-informed staff recruitment and selection, as well as a description of a widely disseminated caseworker training tool.

Successful and sustained implementation of the trauma-informed principles and strategies outlined in this text are only realized when this guiding framework is successfully integrated into the agency's workforce development and support practices. In fact, a healthy, committed child welfare worker is one that is capable of delivering trauma-informed care in a sustained way and who works in an environment that is physically and psychologically safe, empowering, trustworthy, and collaborative. In this section, physical safety and psychological security are presumed, and activities are focused on "healing", creating optimism and competency through the integration of current and past traumatizing work experiences.

Two approaches for achieving these goals of strengthening the workforce's attachment are highlighted. Chapter 19 discusses an innovative approach to trauma-informed supervision and support that provides child welfare workers with the

knowledge and skills to regulate and process responses to working with trauma exposed clients on an on-going basis without sacrificing engagement. Chapter 20 describes professional development approaches to equip the worker with the skills needed to navigate the delivery of trauma-informed services. Finally, Chap. 21 outlines the challenges ahead for national transition to trauma-informed agencies and services.

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Chapter 2
Applying Trauma Theory to Agency Practice

Virginia C. Strand

Trauma-informed practice is possible in child protective, preventive, foster care, and adoption services. Applying the phase-oriented approach identified with successful treatment of traumatized children and adults, the first emphasis in work with children coming to the attention of the child welfare system should be on stabilization. This fits well with the organizational emphasis on safety reflected in the mandate for child protective services. While safety may be the focus in this first phase, it does not mean ignoring permanency and especially well-being. Addressing the mental health needs of children as they enter the system is key, as Chap. 6 will elaborate.

Clearly, preservice training for all child welfare staff should include information about the impact of trauma on children, birth and foster parents as well as the impact of working with traumatized populations on child welfare workers. An excellent resource for staff training is the *child welfare trauma training toolkit* (National Child Traumatic Stress Network [NCTSN], 2013) described in some detail in Chap. 18.

Child-Protective Services

The concept of safety includes not only physical safety but also the child's sense of internal or psychological safety. Actions often need to be taken in the external environment with parents or other caregivers so the adults act in ways that help a child establish that sense, and this has implications for referral. Three concepts are used to differentiate strategies designed to stabilize children's external environment from

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those to stabilize a child's internal, emotional environment: safety actions, safety promoting interventions, and safety planning interventions (Strand, Hansen, & Courtney, 2013).

Safety actions in the external environment include those designed to assure physical safety and reduce concerns about immediate physical risk to the child. This may mean removal, or in extreme cases, arrest of a perpetrator. More commonly it requires referral of a nonoffending parent to a domestic violence shelter, advocacy services, or preventive services for support related to reduction of inadequate care.

Less well understood is the need for psychological safety, which is addressed through safety-promoting and safety-planning interventions. *Safety-promoting interventions* include strategies to achieve internal emotional, behavioral, or cognitive stability when a child is at risk of immediate harm or self-injurious behavior. These include actions to reduce dangerously escalating behavior on the part of a parent or child or to intervene with a parent to protect the child. Interventions are directed at helping the child and family achieve internal emotional security and behavioral stability.

Safety planning interventions can be used when the child is safe and there are no concerns about immediate physical risk. They focus on plans for achieving internal control, with an emphasis on activities that help maintain the child, caregiver, and family's physical and emotional safety. They include identification of triggers and predictable stressors that have led to crises in the past and strategies to prepare in advance to stay in control. They may also include education about paying attention to one's sense of danger, body ownership (for example, "good touch–bad touch" explanations), risks involved with keeping secrets, and identification of key people the child can go to with safety concerns and ways to ask for help when feeling unsafe, along with the identification of other high-risk situations for abuse.

Child protective services are best positioned to help with safety actions and often with safety planning; foster care workers and foster parents can assist with safety planning; both foster care and preventive workers are ideally situated to implement safety promoting strategies.

Engaging parents is often the key to successful intervention by child protective services. Because the overwhelming majority of indicated cases seen by child protective services are not referred to family court, the ability to engage parents in understanding and accepting the need for help increases the likelihood that they will follow through with referrals.

Evidence suggests that child protective workers could be more effective by using a partnering rather than an authoritative approach with families (Dumbril, 2006). Family engagement better positions child protective workers to provide psychoeducation about the impact of trauma on children. The fact that traumatic events often result in impulsive behaviors and emotional states that are to a large degree involuntary is an important message to communicate and, if understood, may make parents more willing to accept referrals. Using reflective listening, which can be taught in preservice training, demonstrating empathy, and being knowledgeable about trauma-specific resources are also key components for effective practice.

Preventive Services

The preventive services worker is typically involved with a family once the child has been determined to be physically safe. The risk of placement may still be present, and there are often ongoing concerns about the child becoming unsafe in the current living situation. Assessment of the impact of the trauma exposure becomes critical here and is the key for safety-promoting and safety-planning interventions targeting both parents and children. An important skill for preventive services workers to develop is the capacity to intervene with a child and family or a dyad, since efficiency often requires that the child is not seen alone.

The possibility of traumatic exposure in the history of the birth parent is important to explore, as the child is typically living with the birth parent while receiving preventive services. If the parents have a history of abuse and neglect themselves, this will increase the likelihood of their responding impulsively and at times inappropriately in the care of their children. As with the child who has experienced trauma, the adult, too, may be dealing with emotional and behavioral dysregulation that is affecting their parenting. It may be important to identify this as an issue for the parents and work to help them accept a referral to a trauma-specific service to augment the help from preventive services.

Intervention with a child or adolescent often requires attention to behavioral, emotional, cognitive, and physical dysregulation. If the preventive services worker has the appropriate training, he or she can help the child identify, regulate, and express feelings. Assistance with behavioral regulation often requires that children or adolescents be helped to identify trauma reminders in their environment that may trigger actions that get them into trouble with peers, parents, and teachers.

If the preventive services worker is not trained to undertake this work, a referral to a trauma-specific service may be needed. However, the preventive worker may still need to coordinate services so that the important people in the child's school and family network are involved. This may involve psychoeducation with school personnel about trauma and the potential of trauma triggers at school to interfere with attendance, learning, and appropriate behavior. Trauma work with the parent to support the child's growth is also important, whether it is carried out by the preventive worker or another provider. Placement can be improved by the extent to which the preventive services worker can undertake and reinforce safety promoting interventions with the child and family.

Another key component for parents whose children are at risk for placement is parent training. Preventive services workers need to be aware of the range of evidence-based parent training that is currently available. Evidence suggests that didactic parenting classes are only minimally effective, if at all, in changing parenting practice (Casanueva, Martin, Runyan, Barth, & Bradley, 2008). On the other hand, research has identified a range of parent education programs with promising outcomes in changing abusive and neglectful parenting. Four of these have consistently been demonstrated to be effective in a variety of studies: the Incredible Year (Webster-Stratton & Hammond, 1997), Multisystemic Therapy (Henggeler et al.,

2003), Parent Training (Forgatch & Martinez, 1999), and Parent-Child Interaction Training (Eyberg & Robinson, 1982). While not specifically trauma focused, they have demonstrated effectiveness with parents coming to the attention of the child welfare system (Barth, 2009).

Foster Care Services

As with the preventive services worker, the role of the foster care worker is to provide safety promoting and safety planning services but with the foster parents. An excellent resource for foster care workers is the workshop *Caring for Children Who Have Experienced Trauma* (National Child Traumatic Stress Network [NCTSN], 2010). Ideally, it should become part of the mandatory training for foster parents, but when that is not the case, the curriculum provides excellent content and language that the foster care worker can use in educating foster parents about the impact of trauma and working with them to identify strategies they can use in their home.

While from the system's point of view placing children in foster care removes them from a physically unsafe environment, the child may not experience it this way. Given the heightened concern with danger and safety experienced by traumatized children, there are specific steps that foster parents can take to familiarize children in their care with their new environment, which will help them feel secure. This includes making them familiar not only with the physical environment but also with the structure and rules of the family. Foster parents also need to be prepared for common disruptions in eating and sleeping. Not only do children have trouble falling asleep, but sleep may also be disturbed by nightmares or night terrors (it's important for foster parents to know the difference), and children may have trouble waking up in the morning.

In terms of safety promoting interventions, it is as important for foster parents as for children to be aware of and able to use basic coping techniques to decrease arousal and dysregulation. These include strategies to calm down—listening to music, deep breathing, taking a time out, playing sports, talking, writing, or doing art—whatever works for a particular child. Foster parents will have an easier time and there is less likelihood of disruption if they can help the child regulate emotions and behavior.

Trauma-specific services are often crucial to a child's recovery. A number of evidence-based trauma treatments have been found to be effective with children in foster care. Weiner, Schneider, and Lyons (2009) found that three such treatments—child–parent psychotherapy, trauma-focused cognitive–behavioral therapy, and structured psychotherapy for adolescents responding to chronic stress—were equally effective in reducing symptoms and improving functioning in children in foster care. These treatments were implemented with a racially diverse sample of youth and found to result in no differences in outcome when making culturally sensitive adaptations to the model. Between them, the three models are able to reach a

wide age range; they are designed, respectively, for children under five, school-age children and their families, and adolescents who may not have a primary caregiver actively involved in treatment.

Adoption Services

Services for adoption preparation as well as supportive services to families after adoption appear to be an important factor in maintaining permanency (Coakley & Berrick, 2008). Relatively little attention has been paid to making these services trauma informed. The risk of adoption disruption for children with a preadoptive history of child sexual abuse is high, due to a number of factors. These include the behavioral and emotional problems resulting from sexual abuse, the tendency to have had more moves in care, and the difficulty these children have in attaching to the adoptive mother (Nalavany, Ryan, Howard, & Smith, 2008). This underscores the need for trauma-informed preadoption services. Research supports the need for workers to have the time to complete child and family assessments (Coakley & Berrick, 2008). In addition, the assessment should be expanded to include readiness to adopt a traumatized child; whether it is a kinship or stranger adoption, prospective adoptive parents should be trained in parenting traumatized children and adolescents.

One of the keys to successful adoption or kinship guardianship for traumatized children and adolescents is to help the child successfully resolve the impact of trauma—specifically, to decrease emotional and behavioral dysregulation and strengthen cognitive coping, particularly in the areas of attention and concentration, two areas in which the child will need to function well in order to complete school. The availability of a permanent home implies the opportunity for the development of a positive, secure attachment figure. As part of the preparation for the move to permanent status, it is important that the preadoptive parents are familiar with the impact of trauma, have the necessary skills to reinforce coping behaviors, and have worked on the development of their relationship with the child as a safe, secure emotional base. These developments will reduce the possibility of permanency disruption.

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Chapter 3
Applying Trauma Theory to Organizational Culture

Virginia C. Strand

Introduction

A framework for thinking about how child welfare agencies could be reformed is proposed, suggesting that the phase-oriented sequencing of treatment components reflected in effective trauma treatments offer a framework to consider ways in which child welfare agencies can become less trauma reactive and more effective in service provision. As described earlier, scholars and practitioners have written widely about the impact of trauma and many empirically supported treatments have been developed. Likewise, an increasing knowledge base has been developed about the nature of child welfare practice, the need for workforce development, and the contribution of child welfare agency culture and climate to workforce stabilization and effective service delivery. Yet, few discussions integrating these two lines of inquiry can be found in the literature. This chapter will attempt to summarize existing support for the proposed framework and identify the research gaps.

Impact of Trauma on Staff

Knowledge about the impact of trauma on children can be used to understand the impact on child welfare agency culture where staff are consistently interfacing with clients whose history of abuse and neglect bring them to the attention of child welfare. The effect of working with traumatized children and adolescents, as well as family perpetrators who may also be trauma survivors, can negatively impact staff,

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sometimes in ways that they may not recognize (Pryce, Schackelford, & Pryce, 2007). This is referred to in the literature as vicarious trauma, secondary traumatic stress, or compassion fatigue.

Vicarious trauma is generally defined as a change in cognitive *schemas*—beliefs, assumptions, and expectations related to psychological needs—that organize the experience of self and the world (McCann & Pearlman, 1990). It is thought to result from hearing about (indirect exposure) traumatic events. Traumatic stress is often thought to result from exposure to actual traumatic events, as is the case for police and firefighters and child protective workers (Figley, 1995; Stamm, 1995). Both vicarious trauma and secondary traumatic stress can result in behavioral change in workers, specifically the emergence of symptoms similar to those seen in PTSD, which can include intrusive cognitions related to the client's traumatic disclosures, avoidant responses, physiological arousal, distressing emotions, and functional impairment (Bride, 2007). Compassion fatigue, arising from both direct and indirect exposure, is associated with sadness and depression, sleeplessness, and general anxiety (Cerney, 1995).

Conrad and Keller-Guenther (2006) found that over 50% of child protective workers in one state system reported a high risk of compassion fatigue, even though an equally high percent report high compassion satisfaction. Littlechild (2005) reports on research documenting that violence and threats of violence were widespread sources of stress for child welfare workers. Horwitz (2006) found a positive association between direct and indirect traumatic events experienced by workers and the presents of negative work place effects. Caringi (2007), in an exploration of individual or organizational factors that contribute to secondary traumatic stress, also found that two individual factors were relevant: the unintentional choice of child protective services work, i.e., staff "happened" into the job, and consequently, staff had no relevant education or training for social services work.

Behaviors reflective of secondary traumatic stress can include:

- Avoidance of work responsibility or specific tasks as a fundamental coping mechanism.
- Impulsive behaviors reflected in decisions-making that is not well thought out or modulated.
- Verbal aggression or verbal retaliation with co-workers and sometimes clients.
- Absence from work due to fatigue, somatic complaints.
- Preoccupation with psychological danger and physical safety in the work environment.
- Secondary adversities: Just as the cascade of changes produced by trauma and loss can tax the coping resources of the child, family, and broader community, the increased use of sick days, erratic behavior on the job, distractibility, and irritability can result in increased tension with a supervisor and/or co-workers.
- These adversities and life changes can be sources of distress in their own right and can create challenges to adjustment and recovery.
- The development of risk-avoidant supervisory and management approaches;

- Breakdown in the social contract: the recognition by staff that not only may the CPS response capacity often fail the client, but the agency fails to protect staff from negative societal images/responses.

Just as the traumatized child becomes preoccupied with danger and safety, so can child welfare staff. The stressful and often dangerous working conditions for child welfare staff have been amply documented (Horejsi, Garthwait, & Rolando, 1994; Newhill, 1996; Scalera, 1995) and it is not surprising that preoccupation with physical safety becomes a concern. Just as a child may employ avoidance strategies to deal with adverse situations, so can staff. The tendency toward risk-avoidant supervisory and management strategies that focus on accountability are well documented in the literature (Landsman, 2001; Depanfilis & Zlotnick, 2008).

A history of maltreatment within the family can affect the child's attachment relationship, and likewise, the history of continuous interaction with traumatized children and their families without the support of a facilitative work environment, can affect the worker's attachment to the agency—reflected in diminished organizational commitment and low morale. When perceptions of job characteristics (i.e., importance, autonomy, and challenges of the job for workers) and justice (decisions about worker jobs are made fairly and support; organization shows concern for well-being of worker) are low, organizational commitment is low. The manner in which the impact of an agency culture that is punitive, reactive, and accountability focused contributes to low staff morale and concern with psychological safety is now well documented (Tham, 2007). When there is little emphasis on rewards for a job well done, workers express the intention to leave (Sham) and/or indicate that commitment to the agency is low (Claiborne et al., 2011; Strand, Spath, & Bosco-Ruggiero, 2010).

The traumatized child's difficulty with emotional regulation is reflected in the worker who has difficulty managing their emotions, especially anger, and becomes verbally aggressive and/or defensive in interactions with clients and staff. The hyperarousal of the child, often manifest in sleeping disturbances, hypervigilance and dissociation is mirrored in the worker who develops somatic complaints, misses work, and/or often complains of fatigue.

For the child with behavioral dysregulation, it is not uncommon for antisocial or self-destructive behaviors to become manifest. Likewise behavioral dysregulation in the worker can be reflected in avoidance of responsibilities and procrastination as a means of coping.

The impact of historical trauma on peoples in the Americas is an important dynamic for child welfare. Historical trauma has been defined as the "cumulative and collective emotional and psychological injury over the life span and across generations, resulting from a cataclysmic history of genocide" (Struthers & Lowe, 2003, p. 258). Understanding historical trauma is critical to understanding disproportionality and disparity in child welfare. Disproportionality refers to the overrepresentation of children from particular groups (African American, Latinos/Hispanic, and Native American) in the child welfare system. Disparity refers to the unequal treatment children of color receive once they are in the child welfare system.

A common manifestation of historical trauma is distrust of the mainstream culture, of which the child welfare system is part. This distrust is inherent in guardedness in approaching child welfare, resistance to accept services and poor communication between the population and staff in child welfare, particularly where staff represent the dominant culture.

Child welfare staff have been identified as participating in disproportionate treatment of children in the child welfare system. In a study of factors contributing to disproportionate treatment of African American children by the child welfare system, Dettlaff and Rycraft (2010) identified five barriers to reducing the tendency toward disproportionality in child welfare system. Two of these are directly related to the impact of historical trauma: (1) cultural bias and (2) the climate of fear characteristic of child welfare agencies. Cultural bias is reflected in misconceptions and stereotypes attributed to a population, which may in turn be directly related to lack of knowledge and awareness of how the historic relationship to the dominant culture has been transmitted in an attitude of fear and mistrust. This bias was observed in caseworkers' applying their own values and knowledge about appropriate parenting rather than carefully assessing risk and protective factors for an individual child.

A fearful agency climate is characterized by heightened awareness of the risk of individual liability for a caseworker if a child is left or not removed from a dangerous situation, which in turn often reflects a negative perception of the agency portrayed in local media. Lack of familiarity with parenting and family norms can lead to precipitous removal of children due to the influence of an agency climate where removal is perceived as protecting staff from potential liability. A trauma-informed child welfare system will have strategies in place to adequately prepare staff to interface with children and families affected by historical trauma, and develop culturally sensitive approaches to service planning and service delivery.

Using Trauma Theory for Organizational Change

How can trauma theory contribute to developing a perspective for organizational change? Aligning a phase-oriented trauma intervention theory with the goals of achieving safety, permanency and well-being for child welfare organizations provides a framework. Phase One in trauma interventions is all about achieving safety and stabilization and can be accomplished for organizations through establishing physical and psychological safety for staff. Phase Two, integration, can be understood in an organizational context as the development of agency capacity to support staff in processing on-going exposure to direct and vicarious trauma in their in work. Here is where training in regard to secondary traumatic stress may become an important intervention. It is suggested that achieving the goal of integration will go a long way to improving organizational commitment and retention, i.e., permanency of the work force.

Phase Three, consolidation, can be achieved through developing and sustaining future-oriented learning organizations that support, nurture, and sustain staff in their work of helping children and families move toward well-being. In doing so, agencies

will benefit from the work involved in integration, which will free the psychological energy of the organization to engage in the on-going work of developing competent staff and services, thereby achieving organizational well-being. In practice, these phases are by necessity not so discrete. The supportive child welfare organization has trauma informed supports in place for staff from their entry to the workforce, and physical safety and psychological security remain a priority as the agency develops and elaborates its trauma responsive practices. The phase oriented theoretical framework is offered in order to provide guidance in thinking about the organizaitonal challenges.

Integrating Trauma Theory and Knowledge with Organizational Commitment Findings in Child Welfare

Agency or organizational factors have been identified as the driving force influencing job satisfaction, organizational commitment, and retention, contributing to the growing evidence that organizational culture is the significant variable influencing staff morale and retention. Agency factors are reserved for those variables which address organizational culture and climate, supervision, promotion opportunities, and the clarity of policies. For purposes of this chapter, organizational climate is defined as the collective perception that employees have of their work environment (Schneider, 1990), and organizational culture is defined as the ways things are done in an organization (Shim, 2010). Both are components of organizational context. Factors most consistently found to be related to organizational commitment and retention are organizational or agency characteristics, especially supervision, and a supportive work environment. (DePanfilis & Zlotnik, 2008).

Mor Barak, Levin, Nissly, and Lane (2006), in their study of antecedents to intention to leave found that unjust, exclusionary, and nonsupportive organizational climate negatively influences individual wellbeing, job satisfaction, and organizational commitment, resulting in intention to leave the job. The lack of inclusion in decision making has been found to be a key predictor of intention to leave (Travis & Mor Barak, 2010). The perception of lack of recognition and acknowledgement expressed by staff in organizational commitment ratings (Strand et al., 2010; Tham, 2007) highlight the need for child welfare agencies to provide recognition and rewards for staff.

Findings from a number of studies suggest that supervision that is client-centered, i.e., focuses on helping staff problem solve in regard to client issues—as opposed to agency-centered—is perceived as more supportive (Strand & Badger, 2007) and may contribute more to organizational commitment (Landsman, 2008). It has been suggested that organizations encourage supervisors to solicit input from employees and provide validation (Chia, Landau, & Ong, 2000). Findings from a recent study document that workers who are encouraged to speak up are less likely to become disengaged from the organization (Travis & Mor Barak, 2010). A systematic review of the literature in child welfare practice, however, concludes that the evidence base for supervisory effectiveness is relatively weak (Carpenter, Webb, & Bostock, 2013) and points to the on-going necessity to more fully understand the role of supervision in organizations.

Some have identified training (Curry, McCarragher, & Dellman-Jenkins, 2005), flexible work schedules (Ellett, Ellis, Westbrook, & Dews, 2007), social support, and leadership (Yoo, Brooks, & Patti, 2007) as well as pay, benefits and security as agency factors associated with organizational commitment (Zlotnik, DePanfilis, Daining, & Lane, 2005). Staff perceptions of inadequate pay, security and benefits have also been found to be consistently related to intention to leave (Cahalane & Sites, 2008; DePanfilis & Zlotnik, 2008). Conversely, perception of adequate pay and benefits is associated with intention to stay (Strand et al., 2010).

Research related to worker perception of organizational fairness is particularly relevant to the topic of trauma-informed child welfare organizations. In a meta analysis of 183 studies, Colquitt, Conlon, Wesson, Porter, and Ng (2001) found that both distributive (salary and benefits) and procedural (decisions about hiring and promotions) justice were highly correlated with organizational commitment. In a study of child welfare staff, Cahalane and Sites (2008) found that individuals who left employment perceived significantly lower levels of fairness within their agencies (fairness was defined as "the perception that recognition, promotions, and other types of rewards based upon merit rather than favoritism or bias, p.103"). In a recent study Quiros and Berger (2015) determined that an agency that is truly trauma-informed must align itself with the social work mission of social justice, considering structural and environmental conditions when assessing trauma; that is, trauma is experienced on both interpersonal and sociopolitical levels.

Studies of organizational climate and culture have associated a positive and facilitative work environment not only with job satisfaction and organizational commitment (Landsman, 2001; Shim, 2010; Smith, 2003; Strand et al., 2010) but also with positive outcomes for effective service delivery (Agbenyiga, 2011; Glisson & Green, 2011). Building a positive organizational climate has been viewed as critical to the creation of effective services (Glisson, Dukes, & Green, 2006; Huy, 2002; Mor Barak et al., 2006).

It is becoming evident that job satisfaction and job support will not in and of themselves necessarily reduce the impact of traumatic events. Horwitz (2006) in a recent study hypothesized (1) that negative workplace events were associated with workplace trauma effects, and (2) that perceived job support and perceived job satisfaction would moderate negative workplace effects. Findings confirmed the first hypothesis but not the second.

The case is made here that in order for organizational or institutional norms to be effective in creating a positive and supportive organizational climate in child welfare they need to be trauma-specific, i.e., respond to the particular impact of overwhelming experiences—which we know result in numbing, avoidance, recurrent experiencing, and hypervigilant reactions on the part of staff. In organizational culture, just as in families, these reactions become institutionalized in dysfunctional patterns of relating, communicating, and responding.

Historically, the response to the impact of trauma (when recognized) has been to focus on individual coping with an emphasis on training to deal with secondary traumatic stress. While this may be part of a comprehensive strategy, it is not sufficient to change organizational culture.

Blueprint for Organizational Change

The following approaches organizational change strategies in a phase-oriented conceptualization, emphasizing that stabilization and safety must precede efforts at integration and permanency (retention), which in turn will lay the foundation for consolidation and organizational well-being. In practice, efforts in the three areas may and should often overlap. A previous initiative to conceptualize the components of effective child welfare organizations is presented though a trauma lens. In 2006, a joint initiative of the Children's Defense Fund and Children's Rights, Inc. resulted in the development of a policy brief articulating a road map for positive outcomes for children and families coming to the attention of the child welfare system. It rested on the recruitment and retention of a knowledgeable workforce, the comprehensive integration of services for children, youth, and families and the effective stewardship of public funds. Fourteen essential components of an effective child welfare system were identified, and five of these are stressed in this discussion: (1) Strong and consistent leadership, (2) supportive organizational culture, (3) meaningful supervision and mentoring, (4) quality education and professional preparation, and (5) competency-based training and professional development (Allen & Farber, 2006).

The following discussion integrates findings from this report as well as the literature on organizational culture to move the dialogue toward trauma-specific recommendations for organizational change. While all three phases identified earlier —stabilization (safety), integration (achieving permanency), and consolidation (achieving well-being)—are addressed, the emphasis is on strategies designed to create a *stable* platform for the work of child welfare agencies to go forward. Just as it is impossible to assist a traumatized child or adolescent with integrating trauma experiences into a renewed identity without first establishing a sense of safety, it is difficult, if not impossible, to tackle the task of developing a positive, healthy, and sustaining organizational environment without the establishment of both physical and psychological safety for the workforce.

Stabilization Strategies for Organizational Culture Change

The goal for this phase of intervention is to increase worker physical and psychological safety. Activities are focused on the current situation, in the "here and now".

The prerequisite for recovery for traumatized children and families is a safe external physical social environment and a secure internal emotional environment, which is no longer characterized by an automatic stress response to trauma triggers. Similarly, in order for a child welfare agency to establish a platform for staff to carry out the work of child welfare, the agency must first address the physical safety for workers, specifically the dangerous working conditions faced by workers—not only in the field as workers respond to reports in violent neighborhoods but in the office as well where

they may face hostile and violent family members. Strong, trauma-informed leadership will be essential to address these conditions. A variety of strategies have been developed by agencies over time which can be brought to bear in order to establish physical safety (Scalera, 1993). These include:

- Provision for team response in responding to reports in unsafe neighborhoods
- Creation of physical or secure barriers between waiting areas and staff offices
- Compulsory safety training, such as provided to law enforcement
- Protocols to assure worker safety in transporting clients
- Daily "check-in" by unit—unit supervisor and workers—to establish a culture of problem-solving for the day's activities and of worker support
- Worker safety committees
- Protocols for assisting and supporting staff who have been victims of violence
- Strategies to provide effective services in high-risk neighborhoods

The establishment of physical safety would seem to be a prerequisite for organizational environments.

In addition to the establishment of *physical* safety for workers, research has demonstrated that child welfare organizational culture is permeated by a philosophy, structure, and atmosphere in public child welfare agencies that is often poorly understood, overly hierarchical, and chaotic (Mor Barak, Levin, Nissly, & Lane, 2005; Smith & Donovan, 2003). This leads to low morale, preoccupation with lack of recognition or acknowledgement, and organizational culture that is characterized by punitive and withholding behavior.

Child welfare agencies today are charged with carrying out an overwhelming social contract to protect *all* children from abuse and neglect, an enormous and probably unrealistic mandate. Since their purpose and function is not well understood by the public, staff often function within a hostile social environment. Staff may themselves have insufficient understanding of the degree to which they are impacted by direct and indirect exposure to traumatizing events and conditions. Importantly, despite some very negative conditions in organizational cultures, many individual staff manage to function without stress and are not victims of vicarious trauma or secondary traumatic stress.

Strong, visionary leadership is required to change this environment and is essential to create *psychological safety* for staff. Interventions to support the creation of psychological safety are many and for purposes of discussion are divided into those requiring a more macro focus and those having micro or internal agency focus. *Macro* interventions are defined as those undertaken in conjunction with the external social environment to change structural conditions. *Micro* interventions are undertaken to address staff work conditions specifically and/or the internal working conditions for staff.

Macro Interventions to Increase Stabilization

An analysis of public child welfare agencies identifies organizations that can be defined as nuclear, closed systems, preoccupied with avoiding public scrutiny and negative media coverage. This stance parallels that of an abused, traumatized child, who is preoccupied with danger and safety on a daily basis. Just as traumatic experiences undermine children's sense of protection and safety and can magnify their concerns about dangers to themselves and others, so can the ongoing trauma exposure for staff in a hostile social environment magnify agency concern for protection and self-preservation. Three fundamental *macro* strategies are suggested for dealing with this phenomenon of agency isolation and reactive stance vis a vis the external environment.

1. Involve consumers at all levels of agency planning. The purpose is to develop a culture of social responsibility for children and families extending beyond that of the child welfare agency. While part of the focus should be on involving individual consumers, such as youth in foster care, foster or birth parents, partnerships with other external environment stakeholders will reduce the likelihood of blaming by external systems. Doing this will meet other goals as well. To the extent that agency isolation contributes to the lack of fit between the agency and children and families that are affected by historical trauma, partnerships with others agencies and community groups becomes critical.

   Involvement of consumer in child welfare is not without its difficulties. There are many challengers to child welfare of adopting a client-centered approach. While the most promising practice model is probably family group decision-making (Buford, Pennell, 2014), little has yet to be established for true consumer input. The experiences in other fields, notably health and mental health, underscore the challenges. In health care, the role of the consumer in evidence-based care has been explored. Results indicate that a shared definition of who the consumer is and how they should be involved is lacking (Jordan & Court, 2010). Likewise, a number of studies investigating the role of consumers in mental health services illustrate similar dilemmas. Bennetts, Cross, and Bloomer (2011), investigating the role of consumer participation in mental health services in Australia found a lack of clarity between service providers and consumers, about what consumer participation should look like. Barkway, Mosel, Simpson, Oster, and Allen (2012) found continuing role confusion after reforms of the mental health service system in Australia.

   However, promising collaborative community practices have been identified in a number of studies on disproportionality in child welfare and can inform the development of stabilization strategies (Busch, Wall, Koch, & Anderson, 2008; Marts, Lee, McRoy, & McCroskey, 2008; Richardson, 2009). Outcomes of the initiatives described in these studies include improved alliances between worker and family, improved family functioning and better outcomes for children, including a reduction in the number of children removed from their homes, an increase in those reunified, and an increase in the number of children placed in a

legally permanent home. Conditions and recommendations to achieve best practices in multidisciplinary collaboration and implications are discussed by Lalayants (2013) in her assessment of best practices in a public child protective services program.

2. Create a public media campaign to counter negative perceptions of child protective services and child welfare. Negative public perceptions of child welfare contributes to worker's intention to leave (Cahalane & Sites, 2008; Landsman, 2001). Media and public service announcements could be used to change attitudes and generate a more positive perception of child welfare.

   There is now evidence to support the success of mass communication strategies in changing attitudes in the efforts to reduce smoking in this country (Cohen, Shumate, & Gold, 2007), in Britain (Gagne, 2008) and in low- and middle-income countries (Mullin, Prasad, Kaur, & Turk, 2011). Developing partnerships with journalists who have been themselves traumatized in their coverage of both interpersonal and natural disasters may be a particularly fruitful strategy. Expectations of child welfare are out of line with the realities of the resources and limitations available to achieve society's mandate to protect children from abuse and neglect. A more informed public would conceivably reduce the level of misunderstanding about the role of child welfare in the social environment.
3. Develop interagency collaboration for "disaster" preparedness. Due to the unprecedented prevalence of both man-made and natural disasters, the notion of disaster readiness is becoming more widespread and communities are increasingly undertaking steps to prepare for the advent of a disaster. For child welfare, the likelihood of a child fatality "disaster" is predictable—it is not a question of if but of when. Building a strong network among agencies and organizations which interface with the same population of children and families that child welfare do is an important preventive measure. Typical members of such a network include consumers, schools, health and mental health providers, substance abuse treatment programs, child care centers, homeless shelters, and domestic violence shelters. Not only do such networks allow for closer coordination of mutual cases, but they also provide a forum for leadership collaboration that can set the stage for response after a child fatality. While organized to prevent such disasters, these collaborations can also be used to mobilize for a response to a child fatality disaster.

Micro Interventions to Increase Stabilization

The following discussion identifies management and training strategies that could be undertaken to establish both a trauma-informed workforce and a trauma-informed organizational culture. These strategies focus on trauma specific: (1) staff recruitment, (2) selection, (3) training, (4) supervision and support, and (5) professional development. The goal of the micro interventions is to assure that front-line workers are aware of and have mechanisms to deal with direct and indirect exposure to trauma and that supervisory and management staff are aware of and trained in strategies to

create a supportive and sustaining staff environment. While the emphasis in the discussion is on training, supervision, support, and professional development, the following is important to note in regard to recruitment and selection.

Recruitment and Selection

Research has identified some of the factors associated with positive staff functioning. Optimism, resilience, and hardiness are among the individual factors. Organizational cultures characterized by opportunity for professional growth, job change, and recognition and reward are among the organizational norms supporting higher functioning. Individual characteristics associated with a positive outlook and retention include personal commitment to clients and the profession, strong self-efficacy, compassion, and the ability to balance work and personal life (Ellis, Ellett, & DeWeaver, 2007; Westbrook, Ellis, & Ellett, 2006).

Strategies to aid in recruitment and selection might include the development of a trauma-specific selection protocol, based on the kind of generic screening tool already developed (Ellett, Ellett, Ellis, & Lerner, 2009), in which items related to compassion, personal and professional commitment, hardiness, and optimism are highlighted. Recent studies from research conducted with soldiers preparing for combat could inform selection in child welfare. In the military, it has been found that individuals with profiles reflecting resilience, optimism, and hardiness may do better. There is also some evidence that positive psychological capital (Schaubroeck, Riolli, Peng, & Spain, 2011) and problem-solving capacity (Skomorovsky & Stevens, 2013) contribute to resilience and assist soldiers exposed to trauma. The tendency to experience purposefulness in activities, to have a sense of control over life experiences, to attach positive meaning, and to perceive stressors as challenges in life, may protect individuals against stressful events. (Skomorovsky & Stevens, 2013). These may be important variables to consider in selection and training of child welfare personal.

A *micro* strategy aimed at dealing with the isolation of child welfare agencies would include a variation in current human resources hiring policy and practice. Generally, public agencies promote from within, starting at the supervisory level. This is broadly due to the perception that those from outside the agency will not have the requisite experience in front-line child protective services work to understand crucial policies and practices performed by child welfare workers. The effectiveness of this promotion strategy may be outweighed by the need in the current climate to become more trauma-informed, which could be accelerated through hiring of some "content' experts from outside child welfare, thus creating a more open structure and one more conducive to the development of trauma-sensitive supervision and management capacity. It is proposed that a certain percentage of positions at both supervisory and management levels be open for recruitment of candidates from outside the agency.

Training

There are a number of training areas that if emphasized would benefit staff and help move toward stabilization. These include training on secondary traumatic stress, on trauma-informed care, on resilience, client engagement, trauma-informed assessment, and collaborative relationships.

Trauma-Specific Skills Training

There is a developing evidence base to support the effectiveness of training aimed at increasing trauma knowledge and skills among staff. Conners-Burrows et al. (2013) found that trauma-informed care training increased knowledge of and use of trauma care practices. Research points to the kind of training support and supervision that would promote and support a trauma-informed, trauma sensitive work force. Psychoeducation about trauma in regard to the impact of traumatic events on clients, especially chronic and severe trauma, is crucial. In particular, the impact of triggers on children, adolescents and parents, including the tendency to respond with emotional and behavioral dysregulation, needs to be understood. The Child Welfare Toolkit, noted earlier and available at http://www.nctsn.org/content/child-welfare-trauma-training-toolkit-2013 is a useful resource.

Training in secondary traumatic stress (STS), including both how to identify STS and strategies for management and self-care, are emerging as critical. Other foci emerging from the research include training to establish a collaborative approach between the worker and client, an emphasis on worker strengths and resilience, and the inclusion of trauma-specific strategies for both pre-serving training and ongoing supervision and support. Preservice training in particular could include mandatory safety training—as provided to police - and stress inoculation or trauma-risk management training.

Cultivation of Resilience

The cultivation of resilience in workers is emerging as a fruitful area for exploration in combating secondary traumatic stress. Horwitz (1998), drawing on the work of Rutter (1987), identified four strategies to support resilience for child welfare staff: (1) risk reduction (reducing worker exposure to dangerous situations), (2) avoiding the negative chain reaction if an incident occurs through early identification and worker support, (3) a validating and supportive environment that develops staff self-esteem, and (4) supporting staff in developing an openness to life opportunities by providing professional development opportunities. Russ, Lonne, and Darlington (2009) discusses opportunities for organizational processes to promote resilience. He argues for the need to support committed and talented staff and to create a worker-friendly organizational culture. He too views the need for peer support groups as well as the need for supervision

The work of Frappell-Cooke, Gulina, Green, Hacker-Hughes, and Greenberg (2010) with combat soldiers suggests that the implementation of trauma-risk management, which is a training model to support help-seeking behavior after a traumatic event, is effective in its ability to act as a buffer against the development of posttrauma symptoms. Skomorovsky and Stevens (2013) found that both hardiness and problem-solving coping skills were predictive of resilience. This supports training that focuses on the both the development of problem-solving and the cultivation of "hardiness".

Recent emphasis in worker training to cope with the impact of trauma has focused on developing resilience. At the Administration for Children's Services in New York City, training has emphasized the development of three competencies associated with resilience: (1) optimism: helping staff to anticipate the best possible outcomes for a client situation; (2) collaboration: emphasizing that the nature of child protective work is collaborative in nature—within child welfare but with agency and community partners as well; and (3) mastery: the development of skills needed to perform one's particular role competently. (Training materials may be retrieved at: http://www.nctsn.org/products/nctsn-affiliated-resources/resilience-alliance-promoting-resilience-and-reducing-secondary-trauma-handbook).

Engagement Skills Training

Dumbrill (2006), in his study of parents' experience of CPS workers, found that those parents who experienced workers using their power with them, rather than over them, were much more likely to work with CPS, as opposed to fighting or "playing" along. Schreiber, Fuller, and Pacely (2013) in their study of parent perceptions of CPS workers found that workers who were viewed as competent, who used positive communication skills, and who provided either emotional or concrete support were thought to be the most effective. Healy, Darlington, and Feeney (2011) found that workers who were perceived as willing to listen, support, and provide for goal-focused plans facilitated positive outcomes. In a study of engagement of parents with children in foster care, both proximity to the agency and length of worker employment with the agency (and with the foster family) were positively associated with engagement (Alpert & Britner, 2009). Altman (2008), however, found little evidence between engagement and positive outcomes in a study of 74 client-worker dyads from a neighborhood-based child welfare agency.

Critically, there is evidence that lack of engagement skills is associated with lack of cultural sensitivity. Dettlaff and Rycraft (2010) found that cultural bias in staff was a barrier to equitable provision of services. Gone (2009) found that partnering with indigenous Native American clients was critical to the development of relevant goals and successful outcomes. Others emphasize the importance of training that is specific to the impact of historical trauma on African Americans, Latino American, Asian/pacific islanders, and Native Americans (Helms, Nicolas, & Green, 2010). Marts et al. (2008) focused specifically on engagement skills needed to solve the

disproportionality in African American and Latino/Hispanic populations in Los Angeles. These studies point to important qualities and skills to be emphasized in preparing staff to engage with parents.

Assessment Skills Training

In 2011 the adoption of the Promoting Safe and Stable Families Program established the need for an emphasis on screening and assessment of all children coming to the attention of the child welfare system, Griffin et al., (2011a, b). Greeson, Briggs, Kisiel, Layne, Ake, Ko,…, Fairbank (2011) make the case for the necessity of child welfare agencies to distinguish between a history of exposure to traumatic events, trauma symptoms, PTSD symptoms, and other mental health symptoms. Child welfare staff can be trained to screen for trauma histories; referrals to mental health may be need for assessment of the other three. Conradi, Wherry, and Kisiel (2011) offer suggestions for tools and techniques to help with both trauma screening and referral. Child welfare training that include methods of obtaining a child's history and current behavioral responses is necessary. In addition, the need to be able to conduct family, multisystem, and community assessments is viewed as critical to understanding and engaging with peoples of the Americas suffering from historical trauma (Brave Heart, Chase, Elkins, & Altschuler, 2011).

Interagency Collaboration

The interface of child welfare with trauma-informed courts, mental health services, schools, and substance abuse services will become increasingly necessary. As Henry et al. (2011) point out in their exploratory study of moving toward a trauma-informed child welfare system in Michigan and elaborates here in Chapter 14, systems will need to have a common language, the ability to undertake a comprehensive assessment of trauma in children and families, and a trauma-informed decision-making structure. These are all elements that could be built into staff training.

The linkage between child welfare and mental health will become increasingly important as the role for evidence-based trauma treatment for children in child welfare grows (Gyamfi et al., 2012; Pecora, 2010; Stewart, Leschied, den Dunnen, Zalmanowitz, & Baiden, 2013; Weiner, Schneider, & Lyons, 2009). Some have already begun to explore linkages between child welfare and mental health (Conradi et al., 2011) and training for staff will be needed to facilitate rapid and relevant referrals.

Integration Strategies for Organizational Culture Change

While supervision, support, and professional development are important for stabilization, they are elaborated here to illustrate how these structures can assist as well with the *integration* of trauma exposure for staff and inform the move toward workforce retention. The goal in this phase is to increase availability of structures and systems to assist staff with ongoing exposure to trauma. Activities are focused on "healing," creating optimism and competency through the integration of current and past traumatizing work experiences into a new organizational identity, thereby increasing the likelihood of retaining staff.

Supervision and Support

While training extends beyond the goal of psychological safety and can aid in the integration of daily trauma exposure that can motivate and nurture staff, thus achieving retention (permanency), we know from the literature on retention that supervision plays a major role and thus is conceptualized here as a beachhead for integration. In a meta-analysis of 27 research studies on supervision representing over 10,000 staff in child welfare social services and mental health, findings indicate a statistically significant associations between three forms of supervision—task, social-emotional and supervisory interpersonal interaction, and perceived worker benefits. Mor Barak, Travis, Pyun, and Xie (2009) conclude that task assistance, socioemotional support and positive interaction between supervisor and worker contribute to beneficial outcomes for workers. Zlotnik, Strand, & Anderson (2009), in a summary of research on recruitment and retention, identified the consultative and supportive components of supervision as critical to retentions, as well as competence and knowledge relevant to the clinical and treatment aspects of supervision. On the other hand, low supervisory support has been found to be associated with intention to leave (Nissly, Mor Barak, & Levin, 2005). As noted earlier, however, in a systematic review of effectiveness, Carpenter et al. (2013) found that few studies of supervision in child welfare met the criteria for determining a causal relationship between supervision and outcomes for workers, leading to their conclusion that support for supervisory effectiveness in child welfare is weak.

Collins (2008) makes a case specific to the role of support and supervision to combat stress in child welfare staff. He highlights the critical role of the organization in the provision of formal and informal support opportunities, noting the importance of both supervisory, co-worker, and team support. He also highlights the importance of systematic efforts for individual professional development. Strategies to enhance trauma-focused supervision include:

- Reinforcement of trauma concepts in case planning
- Support in facilitating referral to trauma-specific mental health services
- Use of self-reflective supervision to model self-reflective practice

Support beyond supervision can include a range of activities. Specific to the importance of integration is attention to historical institutional influences. Most public child welfare agencies have a history of child fatalities and other horrific incidents which may or may not have engendered media attention. In many instances, these high-profile cases have led to changes in state law and/or policy regulations. While these cases form a small minority of client experiences, they often have an inordinate influence on agency culture, usually in a negative way. Depending on the outcome and who was blamed, these cases can influence and reverberate in staff attitudes for years. Just as it is important for individual clients to process their emotional reactions, thoughts, and behavior resulting from trauma exposure, it is important for agencies to identify the ways in which the past history is impacting current agency functioning. It may be important for agencies to unpack the influence of the high-profile cases on their organizational culture. It is therefore recommended that agencies consider creating

- A forum for identification of impact
- Worker support groups to provide an opportunity to process daily interface with violence and cruelty to children
- Direct recognition and support of personal commitment of staff to the work
- Crisis debriefing after critical incidents
- Recruitment and training of resource parents in trauma-informed practices

Professional Development

Professional development is sorely needed in child welfare. The availability of systematic planning for individualized career goals connotes institutional value and recognition of the contribution of staff. There is first and foremost the need in child welfare to identify and support the possibility of career ladders for staff and in doing so ensure that there exist ongoing strategies for professional development that lead to the kind of trauma-informed staff needed to further the goals of the agency in achieving client well-being. Mentoring programs in child welfare have met with some success as professional development activities. Strand and Bosco-Ruggiero (2010) found evidence that a mentoring program was effective in increasing organizational commitment, developing leadership capacity, and providing opportunities for career and professional development. Burnside and Bond (2002) evaluated a program at a child welfare agency and found the most satisfying aspect of the mentoring relationship for most mentees was the psychosocial support they received.

Support for professional development within and outside of the agency is valued by staff. Activities can range from in-service training on specific problems and new practices to participation in certificate programs undertaken jointly with school of social work partners. To enhance trauma-informed professional development, strategies at a minimum might include (a) Plan and attend to ongoing professional development regarding trauma and its impact on clients and staff; (b) For supervisors, support trauma-related training, consultation available from content experts; (c)

Trauma-relevant management training systematically available for new managers and d) Consultation for team-building and selective hiring from outside the agency.

Consolidation Strategies for Organizational Culture Change

The goal for this phase is long range, to build flexible, adaptable organizations that incorporate new knowledge about effective intervention with traumatized clients and establish data-driven decision-making while keeping the primacy of working with traumatized clients at the forefront. To support this goal, agencies are encouraged to implement the 14-point component structure for effective organizations alluded to earlier (Allen & Farber, 2006).

Summary: Moving Toward Trauma-Responsive Systems

Creating more trauma-informed, supportive organizational environments is challenged by agency cultures which have become more deficit oriented in their appraisal of parents, have privileged safety over well-being, have been held hostage to computerized information systems driven by the need for accountability, and have had to curtail professional discretion in decision-making. These characteristics, interacting with the nature of the client population served and the subsequent impact on staff of serving that population, have often resulted in the risk-aversive and reactive organizational cultures which characterize many public child welfare agencies.

To meet this challenge regarding the need for organizational culture change, it has been suggested that first and foremost there is the need to establish a climate that promotes both physical and psychological safety for staff. Supervision must move to be more client centered and worker supportive to counter the emphasis on accountability that has come to characterize child welfare. Management needs to emphasize a culture of reward and recognition for good performance over punitive sanctions. Agency leadership needs to work aggressively within local communities to counter negative perceptions of child welfare.

More specifically, trauma content needs to be introduced into pre-service training curricula that are already packed, and agencies will need to establish ongoing training to build staff knowledge about screening, assessment, and the range of evidence-informed trauma treatments available in their community. Staff will also need ongoing support to cope with home visits in violent neighborhoods and dealing with hostile clients and reoccurring trauma exposure such as the occurrence of child fatalities and similar distressing events and situations.

What exists to guide an agency as they attempt to meet these challenges? It has been argued that using a trauma lens informed by trauma theory and knowledge to frame the desired outcomes of child safety, permanency, and well-being for children and families can inform the development of both trauma-competent direct practice

with children and families and a trauma-sensitive organizational culture. Strategies relevant to helping an agency stabilize its workforce, integrate the negative impact of high profile cases on organizational culture, support staff in their ongoing exposure to traumatizing events, and build toward a trauma-informed agency culture form the building blocks for organizational well-being have been described.

In the following chapters, examples of efforts to develop both trauma-informed child welfare services for clients and trauma-informed organizations for staff are highlighted. All have some evidence for success, and while these do not necessarily characterize the typical child welfare service or agency currently, they offer guidelines for what is possible.

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Chapter 4
The Role of Cultural Competence in Trauma-Informed Agencies and Services

Vivian H. Jackson

Introduction

This chapter explores the intersection between culture, trauma, and child welfare. The potential for trauma responses of children from immigrant and refugee families fleeing the violence of war or rampant criminal gangs is clear. In these situations, the child welfare system has had to respond to the needs of unaccompanied minors, cultural practices that are not aligned with the laws of the United States, and neglect or abuse related to parental or caregiver trauma experience. What may be less clear is the trauma that stems from the experience of marginalized cultural groups, such as Native Americans, African Americans, and US-born Latinos—the same groups that find themselves overrepresented in the child welfare system. Parents, caregivers, and their children in these groups may be impacted by historical trauma of their cultural group, present-day bias and discrimination, and the disproportionate exposure to negative factors linked to social determinants of health. Many families in these groups have had sufficient exposure to protective factors and support within their own cultural groups and mainstream society to provide safe and secure environments for their children. Other families have fallen victim to these negative forces. They have become overwhelmed with severe poverty, developed behavioral health disorders, been victims or perpetrators of intimate partner violence, or behaved in other ways that contribute to child maltreatment. For these families and their children, attention to the relationship of culture and trauma becomes an important approach to support the goals of safety, permanency, and well-being of the children.

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The inclusion of a "trauma lens" is an important advancement for the child welfare field. The perspective that invites the system to examine "what happened to you" in contrast to "what's wrong with you" (Child Welfare Information Gateway, 2015) and the natural consequences of those events allows for more tailored interventions. Trauma-informed practice reflects a shift in the way practitioners, organizations, and systems conduct business in order to promote a sense of safety and prevent re-traumatization. The Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) identifies six key principles to guide a trauma-informed approach: (1) safety; (2) trustworthiness and transparency; (3) peer support and mutual self-help; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) attention to cultural, historical, and gender issues. Effective adoption of each of these principles requires the application of a cultural lens. Indeed, marginalized racial, ethnic, cultural populations—the same populations that are overrepresented in the child welfare system—find that they have not historically experienced safety, trust and transparency, peer support, collaboration, empowerment, or acknowledgment and respect for their cultural experience from service systems they encounter. Trauma-informed care not only addresses the issues related to the particular trauma experience, but also, concurrently influences the impact of marginalization in this society.

The first part of this chapter will explore the intersection between culture/cultural identity, trauma, and child maltreatment. The second part of the chapter will describe the application of cultural and linguistic competence within child welfare services as a tool to address repercussions of culture-related trauma.

Culture, Trauma, and Child Maltreatment

Definitions of trauma focus on experiences or situations that overwhelm the capacity of an individual to cope. Consider the following definitions:

> Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being (SAMHSA, 2014, p. 6).

> Child traumatic stress occurs when children and adolescents are exposed to traumatic events or traumatic situations, and this exposure overwhelms their ability to cope (National Child Traumatic Stress Network, n.d.-a).

The following analysis explores the contribution of culture and cultural identity to the creation and experience of traumatic events and circumstances. While it seems to be understood that biological parents or caregivers may themselves be victims of a trauma history, the link to their cultural experience has been less clearly described (Chadwick Center for Children and Families, 2014; Child Welfare Information Gateway, 2015). Further, cultural factors that influence trauma can affect both the children and the adults in their world.

There are at least four pathways that describe the link between culture/cultural identity, trauma, and child maltreatment. The first relates to the experience of immigrants and refugees who experienced trauma in their home country and/or on their journey to the United States. The second relates to historical trauma wherein there has been a "cumulative and collective trauma over multiple generations" (Child Welfare Information Gateway, 2015, p. 2). A third pathway relates to present-day trauma due to bias, prejudice, and discrimination against targeted cultural groups. The fourth pathway relates to the consequences of institutional and societal oppression of cultural populations, which results in their disproportionate presence of marginalized populations in communities fraught with the adverse social determinants of health.

The Immigrant and Refugee Experience

Immigrant and refugee families encounter multiple situations that can expose them to traumatic experiences. As of 2014, there were over 42 million immigrants (foreign-born persons) living in the United States, representing approximately 13% of the US population (Zong & Batalova, 2016). A portion of this population came to the United States having suffered war, persecution, torture, forced labor, and lack of food and shelter. For many, the journey itself was a source of trauma due to physical and sexual assault, witnessing accidental deaths such as drowning or starvation, and separation from family members. And once they have arrived in the United States, they face stress related to the rules and procedures for resettlement and the predictable acculturation stress related to adjusting to a new environment. Finally, there is the stress associated with bias, prejudice, and discrimination they may face and/or the challenges of living in communities that may already be fraught with community violence (Acuña & Escudero, 2016; American Humane Association, 2010; Bridging Refugee Youth and Children Services, 2007; Foster, 2001; National Child Traumatic Stress Network, n.d.-b). The intersection of culture and maltreatment can appear in a variety of scenarios. In one scenario, parental behavior may be appropriate and safe in home country, but considered inappropriate in the United States (e.g., a 6-year-old child supervising a 2-year-old at home without adult presence). In another scenario, there may behavior such as father–daughter incest that is not considered appropriate in either society. A third scenario is that families may employ behaviors that are considered problematic in order to "protect" the child from negative US influences (e.g., handcuffing a 12-year-old girl to a bed to keep her from the "bad" youth in the neighborhood) (Korbin, 1981). In addition, families may come from societies in which family or child distress is handled differently by government institutions as compared to the institutions in the United States (Song, 2008). Individual members of immigrant families may handle the stress of acculturation differently from each other, increasing the risk for child maltreatment. At its worst, individuals may experience symptoms similar to PTSD such as an intense sense of loss, flashbacks, and nightmares (Beckerman & Corbett, 2008).

There are a host of factors that contribute to the stress of immigration. The level of stress and the assessment of trauma are dependent on the nature of the experience, individual characteristics, and levels of family and community support.

Of particular interest is the experience of children of Hispanic/Latino immigrant families. As of 2014, Mexico and Central America countries accounted for 46% of immigrants (inclusive of unauthorized persons and unaccompanied minors) to the United States, with primary destinations being California, Texas, Illinois, Arizona, and Florida (Zong & Batalova, 2016). This growth has contributed to the rise in the number of Latino children receiving child welfare services, but note that immigrants represent only 35% of the Latino/Hispanic population in the United States (Zong & Batalova, 2016). Curiously, although Hispanic/Latino immigrants may have suffered life-threatening border crossings, sexual assault, physical assault, and discrimination and maltreatment upon entry, they seem to have a lower rate of contact with child welfare systems as compared to US-born Hispanic/Latino families (Dettlaff, Earner, & Phillips, 2009). The US-born children of Latino/Hispanic immigrant families who do come to the attention of child welfare are subject to excessive discipline and physical abuse in environments of high family stress and low social support. The protective factors for other immigrant families seem to be the positive family dynamics, grounding religious practices, and strong social support (Ayón, Krysik, Gerdes, Androff, Becerra, Gurrola, Moya-Salas, and Segal 2011).

The considerations regarding the experience of trauma must be understood through the lens of potential cross-cultural differences in the values, beliefs, parental practices, gender roles, discipline, help-seeking patterns and opportunities, role of government, age of adulthood, spirituality, and culture-specific supports.

Historical Trauma and Intergenerational Trauma

The term "historical trauma" was coined by Brave Heart who defined it as "the cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences" (Brave Heart, 2003, p. 7). Native Americans experienced ethnic genocide in which they were attacked and massacred, land was stolen, treaties were violated, and they were forced to move to reservations (or permanent refugee camps). The moves disrupted their way of food production, spiritual practices, and language. Children were forcibly removed from their families and placed in residential boarding schools where their hair was cut; they were forced to wear western clothing and prohibited from speaking their language or practicing their religion. In these state-run or Catholic-run schools, they also endured both physical and sexual abuse (Denham, 2008; Struthers & Lowe, 2003; Weaver, 1998; Whitbeck, Adams, Hoyt & Chen, 2004).

The lingering impact of that trauma resulted in *historical traumatic response* (Brave Heart, 1999, 2000), in which the population experiences elevated mortality rates from heart disease, hypertension, alcohol abuse, and suicidal behavior.

People experience "anxiety, intrusive trauma imagery, depression, survivor guilt, cardiovascular disease, identification with ancestral pain and deceased ancestors, psychic numbing and poor affect tolerance, and unresolved grief" (p. 4). Additional characteristics include anger, violence, guilt, victim identity, insomnia, social isolation, exaggerated dependence or independence, survivor guilt, and obligation to share the ancestral pain (Denham, 2008). Sotero (2006) details the ultimate impact on Native Americans as follows:

- Alienation from society at large
- Isolation from society at large
- Experience self as "different" to mean "less than" other cultural groups
- Grief and sorrow about the experiences of the elders/forbears
- Shame about the experiences of the elders/forbears—they weren't strong enough, their way of coping was embarrassing
- Anger about the experiences of the elders/forbears
- Pride about the survival of the elders/forbears
- Total disconnect from the history—too painful/emotions too intense
- Copied the behaviors of the abuser—treated children in the same manner that they were treated in the boarding schools
- Chronic stress with the associated impact on the nervous system, hypothalamic–pituitary–adrenal (HPA) axis, cardiovascular, metabolic, and immune systems

The 2014 report of the Attorney General's Advisory Committee on American Indian/Alaska Native Children Exposed to Violence (2014) confirms the alarming continued presence of domestic violence, sexual assault, and child abuse within American Indian and Alaska Native Communities. Although the range of damaging responses is broad, it should be noted that there is a parallel resilient process that has occurred within the Native American community that highlights pride in the bravery and survival of the people.

Joy DeGruy (2005) expands upon the concept of historical trauma using the term, *Post Traumatic Slave Syndrome (PTSS)*, to capture the combination of historical and ongoing racial oppression suffered by enslaved Africans and their descendants in the United States. The traumatic history begins with the ten million Africans caught in the transatlantic slave trade. During the Middle Passage, many suffered torture, rape, and died from rebellion, suicide, disease, and starvation. The trauma experience continued during enslavement in which enslaved Africans and their progeny had no rights; people were separated from countrymen, and family members could be sold individually apart from each other. In addition to the trauma of enslavement itself, enslaved Africans were subjected to brutal punishment and rape. The trauma continued after emancipation and the short-lived Reconstruction Era with the passage of Black Codes, exclusionary acts, and subsequent entrenchment of the Jim Crow period of legalized segregation. In addition to "second-class citizenship," this period legitimized overt racism and established the context for hate groups such as the Ku Klux Klan and White Citizens Councils to flourish. It was also a period in which extra-legal lynching and white-on-black riots effectively traumatized African American communities (Equal Justice Initiative, 2015). The Civil

Rights movement of the 50s and 60s generated legal remedies to end legalized segregation; however, the social environment continues to foster discriminatory behavior (DeGruy, 2005). As of this writing, there is a public plea to address police violence against Black males—to affirm that "Black Lives Matter," to correct the overrepresentation of Blacks in the criminal justice system, and block the assault on voting rights (Alexander, 2012; American Civil Liberties Union, 2016; Black Lives Matter, 2016; Garcia & Sharif, 2015).

The intergenerational journey of survival within this racist social environment has taken its toll on African Americans. DeGruy (2005) asserts that the legacy of trauma is reflected in behaviors and beliefs that were necessary for survival, but undermine success today. The impact then is "vacant esteem – believing oneself to have little or no worth, exacerbated by the group and societal pronouncement of inferiority", "ever present anger" at the contradictions within this society that assert freedom and opportunity, but not for Blacks, and "racist socialization" that leads blacks to believe in their own inferiority. In the absence of countervailing forces, these attributes contribute to the risk for child maltreatment within the African American community.

Recent analysis examines the potential of transgenerational trauma as a factor to explain some of the challenges within the Latino community. Phipps & Degges-White (2012) suggest the possibility of intergenerational transmission of trauma for second-generation Latinos. They note that the children and grandchildren of persons who experienced traumatic immigration journey may suffer based on internalization of both the content and the emotions of the experiences of their parents and grandparents. In addition, the psychological distress of the parents may influence attachment and their ability to teach children how to regulate affect. They also note the biological risk related to cortisol imbalance as noted in other populations exposed to trauma.

In each of the populations discussed, there was an extraordinary and intentional harm invoked by a dominant group upon a defined subjugated population that attacked the body, mind, and spirit. The impact of that harm has been deep and long lasting and evoked historical trauma responses that laid the foundation for intergenerational transmission. The intergenerational trauma stories of Native Americans, African Americans, and even Latinos are consistent with the descriptions of trauma transmission for holocaust survivors and even the survivors of the September 11 tragedy (Sotero, 2006; Whitbeck et al., 2004; Yehuda and Biere, 2007; Yehuda, Bierer, Schmeidler, & Aferiat, 2000; Yehuda, Schmeidler, Giller, Siever, & Binder-Byrnes, 1998). Even though certain traumatic events took place in the past, those events continue to have an impact and may explain an apparent illogical response to current situations.

Denham (2008) poses at least four theories concerning the process of transmission from one generation to the next: psychodynamic, sociocultural, family systems, and biological. The psychodynamic theories suggest that the child experiences an "unconscious absorption of repressed and unintegrated trauma experiences" (p. 397). The sociocultural models highlight the learning of the child through direct observation of parents and members of the community. The family systems model

focuses on communication and parent–child interaction. "The impaired interpersonal relationships, flawed capacity to master life-skills, and impaired role performance made effective parenting difficult" (Sotero, 2006, p. 95). Finally, Denham includes the biological factors that highlight genetic and biological stress response. This intergeneration transmission of trauma can contribute to substance abuse, domestic violence, parental stress and mental illness, parental incarceration, and ultimately, parental death. The reverberations over multiple generations of trauma for persons who have not had the opportunity to be exposed to protective factors can influence their capacity to provide the nurturance and protection that children need to survive and thrive.

Bias, Stereotypes, Discrimination, and Prejudice

The trauma associated with bias, stereotypes, prejudice, and discrimination can be exerted and experienced at both the individual and societal levels. At the individual level, people may be subjected to direct acts of physical or emotional violence based on their cultural identity. At the societal level, institutions operate in a manner that individuals experience demeaned value, limited access to quality resources, and denial of opportunities for voice and choice. A normal reaction to such a biased or prejudicial environment includes, suspicion, distrust, fear, hostility, hypervigilance, and hyperarousal.

The suspicion and fear explains the hypervigilance and the "ever present anger" that DeGruy (2005) describes as a component of PTSS. In this post–Civil Rights era, some of the manifestations of bias are subtle and on the surface appear to be color-blind, while other manifestations are quite overt.

The 2014 Hate Crimes Data reports that of the reported offenses: 47% were racially motivated; 18.6% due to religious affiliation; 11.9% related to ethnicity; 1.8% for gender identity; 1.5% disability; 0.6% gender; and 18.6% due to sexual orientation (Federal Bureau of Investigation, US Department of Justice, 2015). The impact of this type of violence can be seen for youth who are lesbian, gay, bisexual, transgender, questioning, intersex, or two-spirit (LGBTQI-2S). They are more vulnerable to violent behaviors such as bullying, teasing, harassment, physical assault, threatening with a weapon as compared to their heterosexual peers. The trauma that they experience contributes to depression and suicide-related behaviors, such that they are twice as likely to have attempted suicide as compared to heterosexual youth (Center for Disease Control and Prevention, 2014). The "Black Lives Matter" movement erupted in response to a series of widely publicized deaths of unarmed Black males at the hands of police (Black Lives Matter, 2016). This movement represented the contemporary articulation of a longstanding complaint regarding aggressive policing toward Blacks (See Brunson, 2007).

The experience traumatic events related to cultural identity does not require physical violence to trigger a response that disrupts emotional well-being. Implicit or unconscious bias of "well-meaning people" exacts its own toll on the psychological

well-being of marginalized populations. Implicit or unconscious bias refers to a bias that is outside of a person's direct awareness and personal control. It emerges automatically and is triggered by the brain making quick judgments and assessments of people and situations based on personal background, cultural environment, and life experiences. (Dovidio, Kawakami, and Gaertner 2002; Kang, 2009; Lee, Bell, and Ackerman-Brimberg, n.d.; National Association of Social Workers, Presidential Task Force Subcommittee – Institutional Racism 2007; Staats, Capatosto, Wright, and Contractor 2016). In the discussion of the interaction between culture and trauma, bias (conscious and unconscious) is a factor that is made manifest in micro-aggressions. Racial micro-aggressions are "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color. Perpetrators of micro-aggressions are often unaware that they engage in such communications when they interact with racial/ethnic minorities" (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007, p. 271). One can infer that the same process applies to the interactions with populations marginalized by other factors such as gender, sexual orientation, religious affiliation, etc. Examples include explicit name-calling, avoidance, rudeness, derogatory statements about a person's culture, and diminishment of feelings or cultural experiences (Sue et al., 2007). Even though from the perspective of the perpetrator, the slights may seem harmless and trivial, they have significant effects on the target person or group, generating stress and anger, and ultimately feelings of invisibility, powerlessness, and marginalization. It is the cumulative impact of these independently small acts that leads to traumatic experience (Sue, Capodilupo, & Holder, 2008).

On a societal level, bias relates to values, policies, structures, and practices that lead to disparate experience of groups on the basis of their cultural identity. Even child welfare systems are not exempt from its influence. Both overt and unconscious bias are implicated as contributing factors to disproportionality of children of color in the child welfare system (Ards, Myers, Ray, Kim, Monroe & Arteaga, 2012; Harris & Hackett, 2008; James, Green, Rodriguez, & Fong, 2008; Lee et al., n.d.; Rivaux, James, Wittenstrom, Baumann, Sheets, Henry & Jeffries, 2008). Disparities in health, education, income, criminal justice involvement, housing, environmental exposure can be linked to policy decisions and implementation practices that have a more negative impact on some groups as contrasted to other groups.

It is within this environment that marginalized cultural groups exist on a daily basis. Their encounters with the dominant society is fraught with multiple instances of societal level prejudice, bias and discrimination, subtle assaults of micro-aggressions—intentional or unintentional—and experiences of direct physical harm, just as a function of their cultural identity.

The literature does not explicitly describe the mechanisms of the impact of racial or ethnic oppression on parenting and caregiving; however, Pachter & Coll (2009) offer a summation of the socio–physiological–psychological impacts of racism:

> According to the National Scientific Council on the Developing Child…toxic stress refers to 'a strong, frequent or prolonged activation of the body's stress management system. Stressful events that are chronic, uncontrollable, and/or experienced without the child

> having access to support from caring adults tend to provoke these types of toxic stress responses.' Racism should be conceptualized as a toxic stressor. Such stress results in allostatic load, or the "wear and tear" in the body's homeostatic systems (e.g., neuroendocrine, cardiovascular, metabolic, autonomic nervous, and immune systems). Allostatic load contributes to the occurrence of chronic diseases and conditions (p. 261).

The question, then, is how does that level of chronic, toxic stress impact parenting? First, racism is implicated in disparities in birth outcomes, including low and very low birth weight and preterm delivery (Nuru-Jeter, Dominguez, Hammond, Leu, Skaff, Jones, and Braveman 2009). In addition to the stress of racism, these parents are faced with the stress of parenting a child who may require special care. Further, the experience of racism or perceived racism has been shown to have a relationship with depression, anxiety disorder, obsessive-compulsive symptoms, and post-traumatic stress disorder (Carter & Forsyth, 2010; Pieterse, Carter, Evans, and Walter, 2010), conditions that can affect the capacity for effective parenting, parenting satisfaction, and parenting styles (Pachter & Coll, 2009).

In addition, the combination of historical oppression and contemporary exposure to interpersonal, cultural, and institutional racism contributes to *internalized racism or oppression* (David, 2014). This insidious form of oppression is associated with damaged self-esteem, depression, substance use disorders, and domestic violence—all contributors to child maltreatment. Further, the impaired assessment of worth contributes to delayed help seeking. Internalized oppression operates in a manner to promote negative acts against members of one's own cultural group, including family members (David & Derthick, 2014). Children are at risk of being maligned within their own family based on physical characteristics such as skin color, or hair type. They may be subjugated to demeaning attitudes, verbal abuse, failure to discipline or harsh discipline, or failure to protect.

Racism and other forms of bias, stereotypes, and prejudice create an atmosphere of chronic and potentially toxic stress that ultimately can damage the ability of parents and caregivers to effectively care for their children. The children themselves are also subjected to these forces, which can have an impact on their brain architecture and thus continue an intergenerational cycle of distress. As with all traumas, it is the presence of resilience and protective factors surrounding families and children that can make the difference between the development of symptomatic traumatic response and successful psychosocial functioning.

Social Determinants of Health and Mental Health

A fourth major intersection between culture and trauma is in the link between social location and social determinants of health and mental health. Prejudicial societal attitudes have contributed to discriminatory institutional practices over the years, which have resulted in the accumulated disadvantage of people of color, women, immigrants, and sexual minorities. These forces contribute to the wage gap between women and men, the job insecurity of sexual minorities, and low wage jobs for

people of color and immigrants. These jobs not only generate limited dollars available for basic necessities, but also disrupt a predictability and stability in that these jobs are frequently "at will," with limited or no benefits, and with variable hours. In this society, poverty pushes these populations into economically impoverished neighborhoods. For some, the state of being poor can affect emotional well-being—influencing sense of self, competence, efficacy, and hope. For some, their poverty is accompanied by low literacy and low self-esteem that impedes the ability to navigate service systems. Issues for some immigrant families include lack of recognition of professional credentials earned in their home country, limited English proficiency, prejudicial attitudes due to their immigrant status, and uncertainty regarding their rights related to their legal status (Compton & Shim, 2015; Dettlaff & Rycraft, 2010; Halfon, Larson & Russ, 2010; Nadan, Spilsbury & Korbin, 2015).

Place matters. Within impoverished neighborhoods, children and their families are more vulnerable to experience or witness traumatic events. In these communities, the housing conditions are poor, schools are under-resourced, public transportation is limited, access to quality food is limited, safe and appealing recreational spaces are limited, crime rates are high, and police relations are strained. Dettlaff and Johnson (2010) point out that regardless of the demographics of impoverished communities, the negative attributes of such communities seem to persist. However, due to the forces of societal and institutionalized oppression, marginalized populations are disproportionately located in these communities where they have a greater risk of being victims of crime, physically assaulted, witness violence, exposed to domestic violence, etc. The emotional fatigue experienced in trying to manage the environment actually may reduce their sense of accomplishment, damage self-confidence, and generate bitterness and alienation from society. Again, there is risk for intergenerational cycle, for these are not the attributes that foster positive, effective parenting.

Review

This discussion has focused on the intersecting factors of culture and cultural identity with trauma and child maltreatment. It has explored the role of historical trauma, contemporary racism, and social determinants of health as contributing factors to parental/caregiver trauma or increased distress, which in turn increases the risk of child maltreatment. Clearly, there are many members of these communities whose experiences of these factors are limited and/or whose parallel experiences with protective and nurturing factors shields them from problematic distress. Similarly, just because someone is struggling with behavioral health problems or poverty does not mean that he or she is engaging in child maltreatment. The important message of this section is to recognize the potential role of culture and cultural identity that may be at play for a family that is struggling with child maltreatment and with homeless and run-away youth. Viewing the issues through a cultural lens can help explain the behavior and offer guidance for effective interventions.

Intersection with Child Welfare System

Child welfare system's responsibility is the protection and well-being of children. It has responsibility to support families to achieve a safe, permanent, and nurturing environment for the well-being of the children. Given that many of the families are members of marginalized populations who may be (1) immigrants or refugees, (2) victims of historical, intergenerational trauma, (3) facing the pressures of overt and covert bias encountered on a daily basis, and (4) disproportionately exposed to toxic neighborhoods, how should the child welfare system respond? As noted above, given the social contexts of many of the families, it would be predictable that normal responses to a toxic history and environment could lead to behaviors that place children in jeopardy. How does understanding of this context influence approaches to the families and children to assure the safety, permanence, and well-being of children? The challenge is maintaining a stance that takes the external historical and societal factors into account while facilitating the protection of the child and the healing of the family.

The policies of the system and the behaviors of the workforce need to minimize, if not eliminate, the child welfare system's contribution to the trauma to the child. However, some have found that cultural bias in staff was a barrier to equitable provision of services (Dettlaff & Rycraft, 2010). There is evidence that child welfare workers' lack of engagement skills are associated with lack of cultural sensitivity and may contribute to racial and ethnic disparities in the child welfare system (Derezotes, Poertner, & Testa, 2005; Johnson, Antle & Barbee, 2009). By contrast, Dumbrill (2006), in a study of parents' experience of CPS workers, found that those parents who experience workers using their power with them, rather than over them, were much more likely to work with CPS, as opposed to fighting or "playing" along.

Indeed, the system should be experienced as a refuge for the child and hope for the family. The system's policies regarding workers' interaction with foster/resource families, kinship families, and biological families should be to promote healing and empowerment with full acknowledgment of the socially hostile environment in which these families exist. It is within this context that cultural competence is considered an important skill and strategy. The cultural competence of individual workers is one key vehicle. However, the policies and practices of the organization as a whole speaks to the issues of how well the system will support the needs of the family. In addition, the worker's effectiveness is limited or enhanced by the degree in which the organization/agency functions as a culturally competent organization.

Cultural and Linguistic Competence

As trauma-informed care shifts the conversation from "what's wrong with you?" to "what happened to you?" the response must incorporate the cultural perspective and interpretation of "what happened." What is it about the cultural identity and cultural

history of the parent, caregiver and the child, independently and conjointly, that contributes to the understanding of the traumatic events themselves, *and* the emotional response to those events? How do the historical and current cultural contexts influence parental attitudes and behaviors with the child and with formal systems? How does that analysis influence the content and process of the interventions that follow on behalf of the safety, well-being, and permanence for the child?

This section will provide general definitions of cultural and linguistic competence and describe practice considerations at the individual, organizational, and systemic levels. Indeed, culturally and linguistically competent practices overlap with trauma-informed principles of (1) safety; (2) trustworthiness and transparency; (3) peer support and mutual self-help; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) attention to cultural, historical, and gender issues (Substance Abuse and Mental Health Services Administration, 2014).

General Principles

At the practitioner level, cultural competence refers to a practitioner who possesses cultural awareness, cultural knowledge and effective cross-cultural skills, has engaged in self-assessment for biases and stereotypes, and views all behavior in a cultural context (Cross, Bazron, Dennis, & Isaacs, 1989; Sue, Zane, Nagayama-Hall, and Berger 2009). At the organizational level, "cultural competence" refers to organizations that value diversity; conduct self-assessment; manage the dynamics of difference; institutionalize cultural knowledge; clarify their vision; and adapt policies, procedures, structures, and practices as indicated (Cross et al., 1989; National Center for Cultural Competence, n.d.; Sue, 1998; Sue et al., 2009).

Cultural competence requires that interventions begin from the perspective of the person who is served, with a comprehensive understanding of his or her sociocultural context. Practitioners and systems are expected to adapt to the needs and preferences of the child and family, responsive to the implications of the client's cultural identity and language preferences. Their services and supports should be attentive to the impact of societal factors such as racism, sexism, heterosexism, ageism, etc., on the client, and to the role of social determinants of mental health and mental illness (Adler University, Institute on Social Exclusion, n.d.; Compton & Shim, 2015). This attention requires preparation, including self-assessment; the building of cultural knowledge and cross-cultural communication skills; work to address any and all attitudinal barriers such as bias and stereotypes; and adoption of a social justice and advocacy stance (Dyche & Zayas, 2001; National Association of Social Workers [NASW], 2013, National Association of Social Workers, Committee on Racial and Ethnic Diversity, 2015, Sue et al., 2009).

Cultural competence requires a certain type of attitude about self and others, knowledge and skills regarding both culture and language, and advocacy and leadership skills. All of these activities promote positive, authentic, engaging interactions

with children, youth and their families, and help move the agency toward stances that challenge negative organizational or systemic policies and practices.

Cultural Competence at the Individual Level in Trauma-Informed Child Welfare Practice

From the perspective of trauma-informed care, individuals need to engage with families and children in a manner that promotes safety and facilitates a partnering, solution-focused relationship. At the most basic level, there is the question of whether or not there is safety when family or child is from a marginalized group and the individual representing the agency is from a privileged group—by race, ethnicity, socioeconomic status, sexual orientation, gender identity, etc. Second, the ability to establishing a partnering relationship requires attention to how the worker addresses issues of power, knowledge and acknowledgment of the impact of cultural factors related to immigration and refugee status, oppression, toxic neighborhoods, etc. Partnership requires the ability to be authentic, transparent, and to offer voice and choice. Cultural competence at the individual level requires attention to attitude, knowledge, and skill development.

- Attitude

The attitudinal dimension of cultural competency requires individuals to be *intentional* in their goal to pursue a goal to achieve authentic relationships. It requires an intentionality to pursue cultural and linguistic competence. Self-study and *self-reflection* is critical to the process. Individuals need to review their own cultural history, reviewing key events, family migrations, and traditions, norms, beliefs that have guiding values of the family and cultural communities. This reflection reveals the backdrop for understanding the worker himself or herself as a cultural being, who brings a unique cultural history into the role of the helper. The ability to recognize the operations of cultural history in one's daily life increases the opportunity to recognize the same process operating in the lives of the children, youth, and families being served.

Attitude
- Intentionality
- Self-reflection
  - Cultural story
  - Stereotypes, biases, prejudice
- Cultural humility
- Social justice

In addition to reflecting on one's cultural history, the inward look requires the assessment of the personal *biases, stereotypes, and prejudices*. This is a difficult process for many members of helping professions, because they often see themselves as "good" people with good intentions and not "bad" people like those "racists" in hate groups. Even so, the seminal work by the Institute of Medicine in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, Stith, & Nelson, 2003) clearly documented that bias is a feature that operates in the medical community, challenging the asserted objectivity within the medical profession. Neuroscience offers an explanation of how it is that "good" people actually do stereotype and possess personal biases and prejudices. Stereotypes are preceded by a normal process of categorization or labeling required to manage the volume and complexity of data that the brain receives (Kang, 2009; Ridley & Hill, 1999). This categorization of people can lead to stereotypes, which are the traits that are generally associated with the category (by age, race, ethnicity, profession, etc.). The next level is the attitudinal stance that is undertaken in reference to the "category." The "attitude" is the content of the biases and prejudices that people possess. These biases emerge from lessons in the family and social environment (Bobula, 2011; Kang, 2009). According to recent neuroscience, biases are modifiable if persons are committed to change (Blair, Ma, & Lenton, 2001; Blair, 2002; Burgess, van Ryn, Dovidio, & Saha, 2007; Matthew, 2015).

Another attitudinal stance that is helpful is *cultural humility* (Tervalon & Murray-García, 1998). Cultural humility is a stance that requires continuous self-reflection and self-critique as life-long learners. It is a process to check the power imbalances between provider and client, and engage in mutually respectful partnerships with clients and cultural communities. This feature has particular resonance within the child welfare system, where power over the future of families is within not just the professional role as in health care, but is embedded in the legal and legislative mandates of the system. The manner in which workers balance the relationships with all parties with the exercise of the legitimate power of the agency is a measure of cultural competence.

Finally, an attitude that reflects a value of *social justice* contributes to the ability to make decisions and engage in advocacy that promotes prevention and remediation of conditions that contribute to child maltreatment. It provides an opportunity to perceive offending adults as both victims and perpetrators—a duality that improves the ability of workers to engage families as partners in solution-finding for their own families, improvements in the child welfare system, and change in the larger community.

- Knowledge

In addition to the knowledge that workers need to develop about themselves as cultural beings, workers need to develop knowledge about the population they are serving. Cultural and linguistic competence requires the practitioner to be ever mindful/knowledgeable of the role of culture in various aspects of the helping experience, including: (a) cultural beliefs and norms that define the role of gender, parents, elders, and children in the development, maintenance, and resolution of the issue; (b) the role of societal oppression and privilege, including colonialism, in

the development, maintenance, and resolution of the issue; (c) implications of cultural identity in the process of gaining access to quality care; (d) the structure and process of the helping encounter; and (e) implications for transference and countertransference in the helping relationship (Comas-Diaz & Jacobsen, 1991; Comas-Diaz, 2012; Jackson, 2015, Kirmayer, 2012; Willen, 2013).

Knowledge

- Personal cultural story
- Cultural story of cultural communities being served
  - Social and political history
  - Beliefs and norms regarding family, health, etc.
  - Beliefs regarding helping relationships
  - Service availability and accessibility
  - Role of societal oppression and privilege
- Potential for transference and countertransference
- Relevant community resources
  - Authentic spokespersons
  - Culture-specific services
  - Interpretation and translation services

Knowledge domains include knowledge of the history, the migration story, relevant community resources, strengths, challenges, and the sociopolitical experience of the group in the local and national contexts. Knowledge is required of practical matters such as the identity of authentic spokespersons in the community, culture-specific resources, and interpretation and translation services. Sources of knowledge include clients, cultural brokers, community leaders, and advisory councils. In addition to the formal texts, additional knowledge is gained through participation in community events and experiencing cultural entertainment, (such as books, theater, movies, music, magazines, etc.).

Workers must remember that the family and child are the "experts" in their own cultural story, but not experts on their culture as a whole. Honoring their experiences and perceptions is central to establishing relationships and partnering on solution-finding. The knowledge derived from external sources helps to place their story into a meaningful context.

- Skills

Workers must build *relationships* that are authentically respectful, nonjudgmental, strengths-oriented, clear, and honest. In the process, the worker is also engaging family members and other relevant parties to be authentic and realistic about their capacities and their limitations, their strengths, and their challenges. In recognition that many people are unaware of or are unable to articulate the links between

historical trauma, culture-based oppression and internalized oppression, workers may need to be *teachers*. As families and children become aware of their own context, they may more readily feel free to acknowledge and use their *strengths* and also feel hopeful about their own self-efficacy to manage their lives. The ability of workers to talk about racism, oppression, prejudice, bias, etc. with the families and children signals "safety" to discuss relevant concerns with the worker.

Skills
- Authentic relationships
- Engage in culture-related conversations
- Mobilize strengths
- Manage conflicts
- Ability to work with interpreters and translators
- Adapt communication to address low literacy
- Advocacy

Workers need to build their *conflict management* skills. Cross-cultural practice will inevitably surface differences in values, beliefs, practices, traditions, and so forth. Managing the dynamics of difference requires ability to engage in culturally informed conflict management.

Communication with persons with limited English proficiency is another important skill set. For persons who are bilingual, there is still the need to assess their capacity to communicate at the level required for the services performed. For those workers who have no fluency in the family member or the child's language, the skills involved in working with interpretation service via telephone, video, or in person are vital (NASW Committee on Racial and Ethnic Diversity, 2015).

Another communication skill relates to literacy. Reading, writing, and numeracy skills are important for family members to successfully navigate the child welfare and other service systems. Workers need to be able to identify challenges in *literacy*, utilize strategies to enable participation in services while facilitating genuine respect and mitigating any sense of embarrassment or shame. There should be no assumptions about what the child, youth, and family do or do not understand about the operations of the relevant systems or why and how they are to interact with them.

As a final example, workers need to develop *advocacy skills* on behalf of and alongside children, youth, their families, and the community. Workers cannot undo history, but they can work to limit the societal impact of that history. They can advocate to address social determinants of health and mental health toward the creation of healthy, nurturing communities. They can work against social injustice and institutionalized oppression. They can partner with clients and/or the client's community to support the voice of the community to challenge institutional and systemic factors that contribute to exposure to traumatic events. They can challenge the stereotypes, biases, prejudices of their peers and colleagues. They can be active allies to counter the negative effects of acculturation stress, historical trauma, cultural oppression, and toxic neighborhoods.

Cultural Competence at the Organizational Level in Trauma-Informed Child Welfare Practice

Organizational cultural competence is important to support individual practice and to establish the institutional environment that supports the needs of culturally marginalized populations. A trauma-informed perspective includes incorporation of policies and practices that incorporate trauma-informed principles. This effort requires *leadership* of those who occupy positions of authority within the organization. It also requires leadership throughout all levels of the organization from persons who can serve as *ambassadors* for the need for trauma-informed, culturally competent practice, and influence their peers. The work of cultural competence must be woven into the fabric of the organization in its policies, structures, procedures, behaviors, and attitudes.

Finally, the work toward cultural competence must be *intentional*. Any change stimulates resistance in organizations, but change related to culture stimulates an even greater level of resistance consistent with how issues related to oppression, discrimination, privilege, and so forth are emotionally charged issues in this society. Care must be taken to create a plan for change that motivates the staff and client base and maximizes the opportunity for success (Goode, Dunne, Jones, & Bronheim, 2007).

The Cross (1989) definition of cultural competence indicates that there should be congruent policies, structures, practices, behaviors, and attitudes to support and maintain effective cross-cultural practice. It specifies that organizations that do well in cultural competence value diversity, engage in self-assessment, successfully manage the dynamics of difference, institutionalize cultural knowledge, and modify policies and procedures as indicated.

Culturally and linguistically competent child welfare systems must ask and answer questions related to their core business. Consider the following questions:

1. How does the agency take culture and related culturally-based trauma into account in
   - Its decision-making process, re-substantiation, kinship care, foster care, group care, reunification, adoption, and transition to independence
   - Ability to identify the assets/strengths of the families and community
   - The role of family—biological, extended, fictive kin, fathers, and resource families in assessment, planning, decision-making, and implementation processes
   - Family team decision-making, family-finding activities
   - The diversity and the role of family peer partners and youth peer partners
   - Impact of neighborhood, schools, recreation services, community-based supports, etc.
   - Use of behavioral health services
   - Role of evidence-based treatments
   - The stability of placements and processes for physical transition from one household to another?

2. How is the agency supporting the staff to
   - Examine their attitudes toward people who are culturally different from themselves
   - Expand their knowledge base to include content on the history of their service population, their migration story (from one country to another, from one city to another), relevant values, traditions, and beliefs
   - Address cross-cultural issues among staff
   - Establish positive cross-cultural relationships with representatives of other public and the community-based agencies
   - Incorporate principles of safety; trustworthiness and transparency; peer support and mutual self-help; empowerment, voice and choice; and collaboration and mutuality in decision-making processes regarding safety, permanency, and well-being with families and children who are culturally different from the worker

Every aspect of incorporating the shift to a trauma-informed process requires an accompanying analysis of the role of culture and cultural identity. Agency leaders will need to be attentive to the manner in which the organization either reinforces and replicates culture-related trauma, or disrupts culture-related trauma and promotes healing for the children, families, and communities.

Additional considerations include a variety of basic organizational functions that should be addressed. Human resource policies and procedures are critical for workforce planning and support. The organization needs to have a diverse workforce that reflects the service population at all levels of the organization. Job descriptions, personnel evaluations, and staff recognition policies should all include content related to attitudes, knowledge, and skill in cross-cultural practice. Reflective supervision, coaching, and mentoring should be available to staff in addition to formal training opportunities. Agency budgets need to be developed to support the training, consultation, and materials required to support the professional development of the staff. In addition, it may require funds for cultural competence self-assessment, and quality improvement activities. Further, the budget needs to build resources for developing and implementing a language access plan to include resources for interpretation and translation services. Finally, the organization needs to consider how it can support the financial viability of the community by using its purchasing authority to buy goods and services available within cultural communities.

Another key element in the culturally competent organization is community engagement. Rather than outreach that is a unidirectional activity from the agency into the community, community engagement is a reciprocal partnership with the community. There is an assumption of assets and strengths within the community that are of value to the agency. Structurally, community representation can be incorporated in board membership, advisory boards, planning teams, hiring teams, evaluation teams, volunteer activities, and staff positions. These types of partnerships reflect approaches to repair the legacy of abuse of power perpetuated in distant and recent history—elements that are important to both cultural and linguistic competence and to trauma-informed practice.

Finally, the organization has a responsibility to establish accountability systems for organizations with whom they contract. This is of particular importance if the agency is not providing direct services, but contracting to private entities. The organization must establish contractual language that requires cultural competence and use its oversight authority to enforce that expectation (National Center for Cultural Competence, 2004).

- Cultural competence at the system level for trauma-informed child welfare services

The legislative and regulatory mandates that guide child welfare services can ameliorate or exacerbate the experience of trauma. The Indian and Child Welfare Act of 1978 is a response to the practices of removing children from their families and placing them outside of Native American Communities. The act attempts to establish conditions to preserve the cultural identity of the child. On the other hand, the Multi-Ethnic Placement Act and the Inter-Ethnic Placement Act establish framework in which the pace of adoption is accelerated and the role of race and ethnicity is limited. These policies are specifically culture specific; however, all the policies and procedures at the state and federal levels need to be examined for their intended and unintended consequences regarding addressing the impact of historical and intergenerational trauma, trauma as a target due to cultural identity, and increased trauma exposure due to social determinants of health.

Similarly, the policies regarding resettlement processes, unaccompanied minors, Medicaid expansion, gun control, sentencing guidelines influence the environment in which child welfare services take place and thus impede or facilitate the opportunity to provide trauma-informed, cultural, and linguistically competent services.

Concluding Observations

On the surface, trauma-informed practice should naturally improve care for all families and children who come into contact with child welfare services. However, race and racism have been historically difficult topics to understand and address in the US society and by extension, in our basic public institutions. As a corollary to that difficulty, it has been difficult to address other forms of marginalization by gender, gender identity and expression, sexual orientation, and so forth. Thus, it requires leadership to be intentional in the process to examine the role of culture and cultural identity in trauma-informed practice and then to move organizations to shift their practices accordingly. This perspective complements dedicated activities designed to address racial disproportionality in the child welfare system. One might conclude that incorporating cultural and linguistic competence into trauma-informed care may also influence disproportionality. That would be a good outcome, but not guaranteed due to factors external to practice that influence disproportionality. In the following chapters, we maintain a lens that enquires about the interaction between culture, trauma, and child maltreatment. This approach is designed to enhance the

understanding of the problematic behavior, but not to condemn or judge the person. The goal is to be able to use the understanding to establish a better relationship and engage in effective solution-finding. The solution-finding will include working through the trauma narrative as with other types of trauma, and like other types of trauma, it will incorporate the knowledge and utilization of elements related to resilience and the protective factors in the family and the community.

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Part II
Creating Trauma-Informed Agency Practice

Chapter 5
Culturally Relevant, Trauma-Informed Engagement Strategies for Child Welfare Workers: Moving Beyond Compliance to Engagement with Families Experiencing High Levels of Exposure to Trauma and Stress

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Introduction

This chapter provides the front-line child welfare caseworker (referred to throughout the chapter simply as worker or caseworker) with practical skills for successfully engaging parents and families. Caseworkers are tasked with engaging and supporting families, with the goal of improving intra-familial conditions such that both physical and emotional safeties are established for children. Altman (2008) describes the process of engagement as the creation of a safe and supportive helping relationship by the worker, within which the client can actively work toward change. Given the myriad stressors faced by child welfare involved families (for the purpose of this chapter, child welfare involved families includes those families who: (a) have an open case in the investigative stage; (b) are receiving preventive services; or, (c) whose children are in out-of-home placement), caseworkers must be prepared to

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engage and intervene in a trauma-informed manner, using strategies that promote adaptive coping, help families to modulate affective and behavioral dysregulation, and moderate the effects of stress. These strategies must support the caseworker in meeting both the safety and productivity requirements of their agency, as well as those needs presented by families.

The chapter begins with an overview of the literature on the challenges faced by caseworkers. The systemic issues that guide caseworker practice are presented, along with challenges faced by child welfare involved parents. Next, a modified version of an evidence-based intervention, the 4Rs and 2Ss for Strengthening Families Program (4Rs and 2Ss), is proposed as an intervention to support caseworkers in effectively engaging families. The 4Rs and 2Ss intervention uses a family-centered approach to managing difficulties that arise within the family unit. The intervention focuses on the following: (1) building sound Relationships within the family and with people who are important to the family; (2) promoting clear and Respectful Communication within families regarding Rules and Responsibilities that support healthy family functioning; and, (3) reducing Stress and increasing Supports. Finally, challenges to implementation, along with implications for child welfare policy and practice, are discussed.

Improving Family Stabilization by Addressing Successful Engagement versus Compliance

Caseworkers

Caseworkers are colloquially referred to as "those people who snatch your kids" in communities with high rates of out-of-home child placement. These workers execute the mandates of child welfare protection laws, while simultaneously being tasked with engaging families and promoting stable and safe placements for children. Understandably, these responsibilities periodically conflict and present caseworkers with unique challenges. Interactions with families can become fraught with tensions that provoke strong reactions from caseworkers and parents alike. Through inadvertent or systemic use of authoritarian styles of relating, equating, or approximating coercion (De Boer & Coady, 2007), worker-parent interactions may replicate previous traumatic experiences by inducing an intense sense of helplessness in parents. Conversely, workers may be frustrated and exhausted by efforts to reach a parent who seems distant, disinterested, or even hostile.

Parents

Parents entering the child welfare system often do so under conditions of extreme stress and are understandably on *high alert*. Often anticipating intense and negative interactions with workers and judgments or stigma from friends,

family, and their community, parents embark on the long and arduous journey to preserving or reuniting their families. Many parents have coined this journey the *STRUGGLE*.

Considerations of Class, Race, and Culture

Child welfare involved parents head families contending with significant socioeconomic stressors, institutional and societal biases, as well as contemporary and historical traumas. The impact of poverty on families cannot be overstated. Nationally, these families share some similarities, including: low education attainment, which limits access to steady and gainful employment; mental health and substance abuse issues; and histories of traumatic exposure (Abramovitz & Altrecht, 2013; Hughes, Chau & Poff, 2011; Marcenko, Lyons & Courtney, 2011; Smithgall, Decoursey, Yang, & Haseltine, 2012). Black and Latino families occupy an even more vulnerable position within the child welfare system, residing at the intersection of multiple identities that are marginalized and exploited within American society (Marcenko, Lyons & Courtney, 2011). For instance, exposure to traumatic events in poor, urban Black communities are documented at rates that far outpace those of the larger population (Alim, Graves, Mellman, Aigbogun, Gray, Lawson, & Charney, 2006; Boyle & Hassett-Walker, 2008; Schwartz, Bradley, Sexton, Sherry, & Ressler, 2005), making acknowledgement and treatment of trauma specific to these groups an ethical obligation on the part of the child welfare system.

Black, Latino, and mixed race families make up the majority, 53%, of the families represented in the child welfare system (Unites States Department of Health and Human Services [USDHHS], 2013). With culturally bound differences in parenting and disciplinary practices putting some families in the direct path of the child welfare system, interventions with these families must not only be trauma-informed, they must also be culturally relevant. Additionally, the lasting impact of historical trauma, particularly in the African-American and Native-American populations in the United States, means that many of these families are struggling financially, psychologically, and socially (Sotero, 2006) and, as a result, are at a greater risk of child welfare involvement.

Compliance versus Engagement

Prevailing caseworker attitudes toward parents often produce compliance in lieu of engagement (Altman, 2008; Lalayants, 2013; Smith, 2008). For example, Altman (2008) highlighted misalignment between parents' desires for clear and forthright messages from their workers, and the workers' apparent reluctance to provide those messages. In her research, parents' requests for clarity on what they need to do and where they need to be to get their children returned were often met with workers requiring confessions of responsibility and compliance (Altman, 2008). Workers may see compliance as a necessary component of "true" engagement (Altman, 2008).

Compliance may be defined to mean that parents accept responsibility for their situation, accept all recommended services, are cooperative instead of being angry and suspicious of workers, and refrain from blaming others for their situation (Altman, 2008). Emphasis on compliance encourages caseworkers to pressure parents to complete tasks, using their power to push for change through threats, mandates, and confrontation (Mirick, 2013). Moreover, some caseworkers operate under the assumption that compliance with service plan requirements manifests how worthy a parent is to have their child returned, based on how much parents are willing to "work" for their children (Smith, 2008). By this rationale, those parents who fail to comply with service plan requirements are viewed as not loving their children enough or not deserving to be a parent. A number of high profile media reports of court decisions associated with subsequent child harm have created a culture of fear among court and child welfare personnel, resulting in an excessive reliance on assessment tools, tasks that can be easily measured and documented, as well as a standard set of service requirements for families to achieve before reunification (e.g., psychological evaluations, drug/alcohol assessment, and parenting classes),regardless of actual need (Smith & Donovan, 2003).

Substantial anger and mistrust are generated among parents toward child welfare authorities and workers (Lalayants, 2013; Mirick, 2013) when parents often have to comply with court- and agency-ordered mandates. They feel helpless and fearful regarding the power with which caseworkers and the system at large wield against them (Lalayants, 2013). In reaction, parents often manifest anger, aggression, as well as non-compliance with existing service plans (Mirick, 2013). Without the use of worker skills that foster engagement, parents may "play the game" with caseworkers, manifesting overt behavioral compliance but not truly investing or committing to the change process (Dumbrill, 2006).

Genuine engagement in services is not only manifested behaviorally (e.g., attendance, task completion, and participation), but also by attitudinal markers, such as the belief that treatment is worthwhile and beneficial resulting in an emotional investment and commitment (Staudt, 2007). Without both behavioral and attitudinal features of engagement present, the success of services on actual behavior change will be compromised (Staudt, 2007). With recent acknowledgement by practitioners, policymakers, scholars, and parents that the quality of the relationship between worker and parent matters, Schreiber, Fuller & Paceley (2013) identified three worker skills that enhance parental buy-in: (a) perception of the worker as competent; (b) worker use of positive communication techniques; and, (c) worker provision of emotional or concrete support. The emergence of specific skills from research that can inform evidence-based interventions targeted at parent engagement is encouraging.

Caseworker workloads do not take into account the time needed for developing trusting and collaborative relationships with biological parents (Smith & Donovan, 2003), resulting in reduced incentive to do so. As a result, caseworkers prioritize tasks they are held accountable for (e.g., child visits, court appearances), and they can easily "give up on" parents who fail to initiate contact toward reunification,

those parents who require the most time investment to engage (Altman, 2008). Those parents who do receive caseworker attention are perceived as those who are most cooperative and proactive. In essence, any failure to engage is attributed to parental resistance (Smith & Donovan, 2003). Working with these parents is difficult. However, caseworkers can be encouraged that research supports the use of evidence-informed interventions (Kemp, Marcenko, Lyons, & Kruzich, 2014), and building collaborative, open, and respectful relationships (Gladstone, Dumbrill, Leslie, Koster, Young, & Ismaila, 2014) as ways of engaging these hard-to-reach parents.

The Caseworker-Parent Dyad

Engagement strategies that align with family-centered practice principles sharply contrast with existing work routines and power imbalance inherent within child welfare practices (Smith, 2008). The court system drives compliance-based approaches by mandating that child welfare organizations prioritize documentation of service completion as proxy for client change, rather than actually measuring behavior change (Mirick, 2013; Smith & Donovan, 2003). Acknowledging the limitations of the existing structure of engagement in the child welfare system sets the stage for the introduction of a trauma-informed approach, which emphasizes a leveling of the inherent imbalance in power that exists throughout the child welfare system.

Adopting a trauma-informed approach (TIA) would involve recognizing that most of the people being served by, and some of those working within the system, have been affected by trauma in some significant way (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). To counteract the pervasiveness of exposure to trauma, the child welfare workers would be introduced to a trauma-informed approach which prioritizes the following: (1) starting from a collaborative stance when working with parents; (2) using the awareness of the ubiquity of trauma exposure to commit to doing no harm during the course of their work; and, (3) and prioritizing safety first (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

People who have been traumatized often develop self-preserving behaviors along with posttraumatic symptomatology. Elliott, et al. (2005) noted that parents may experience their encounters with workers as overwhelming and potentially threatening. As such, caseworkers must proactively engage with issues related to power control in their relationship with parents. Workers who adopt a flexible style around authority will be better positioned to partner with parents around goal setting and those who use language that invites parents into a collaborative space will make greater gains (Harris & Fallot, 2001). Consequently, services from engagement through permanency planning would prioritize safety in the relationship, collaboration, and enhancement of family strengths.

The 4Rs and 2Ss for Strengthening Families Program (4Rs and 2Ss)

The 4Rs and 2Ss intervention (Chacko, Gopalan, Franco, Dean-Assael, Jackson, Marcus, Hoagwood, & McKay, 2015; Franco, Dean-Assael, McKay, 2008; Gopalan, Small, Fuss, Bowman, Jackson, Marcus, & Chacko, 2015.; McKay, Gopalan, Franco, Dean-Assael, Chacko, Jackson, & Fuss, 2011; McKay, Gonzales, Stone, Ryland, & Kohner, 1995) promotes engagement by approaching families with a willingness to partner in problem-solving. Families are strengthened through a focus on six core elements (Rules, Responsibilities, Relationships, Respectful Communication, Stress (management), and Social Support), using a multi-family group format, traditionally offered over the course of sixteen weeks. Together, the worker and the parent tackle common stressors for families, including the safe and effective handling of discipline and improving intra-family communication (Gopalan, Fuss and Wisdom, 2015). The same manual is used by both workers and families during voluntary weekly group sessions. The weekly meetings provide opportunities for families to role play and problem solve around a potentially difficult family while homework assignments provide opportunities for families to continue the work outside of the group. Table 5.1 details specific skills that the caseworker will demonstrate once trained in this intervention.

Its selection for use in child welfare settings is based on evidence that this intervention can successfully engage families who are often deemed difficult to reach. Moreover, improving family functioning through reducing parental stress and child behavioral difficulties can further decrease the risk of future maltreatment and out-of-home placement (Barth, Wildfire, & Green, 2006; Barth, 2009; Videka, Gopalan, & Bauta, 2014). For instance, a family that is receiving services to prevent out-of-home placement could be offered the opportunity to participate in the group if they describe that one of their children is getting into frequent fights at school. A scenario such as this could result in a parent becoming very frustrated with their child, potentially resulting in an allegation of maltreatment if that frustration and stress is not managed well.

Meals and child-care for very young children are routinely provided during group meetings so that family members can sit together and work through establishing effective and consistent rules, equitably distributing family responsibilities, nurturing positive and healthy relationships between family members, as well as practicing effective and respectful communication skills. Other families participating during group sessions are able to offer helpful strategies of their own. Families with multiple, conflicting demands on their time, due to the many services they are mandated to receive (Ansen 2002; Dawson & Berry, 2002; Harrison, McKay, and Bannon 2004; Kemp, Marcenko, Hoagwood, & Vesneski, 2009; Kerkorian, Bannon, and McKay 2006), can be offered this intervention in-home. This allows the caseworker a chance to relieve some of the stress families face in meeting outside appointments and provides opportunities to engage with the families in a more collaborative and voluntary fashion.

Table 5.1 4Rs and 2Ss targets, goals and worker skills

4Rs and 2Ss target	Empirically supported concepts	4Rs and 2S goals	Caseworker skills
Rules	Family organization Consistent discipline	Clarify rules, consequences and rewards for each family unit within the multiple family groups.	Provide examples of family rules. Facilitate the sharing of ideas for families to develop rules specific to their needs.
Responsibilities	Family interconnectedness Positive behavioral expectancies	Clarify responsibilities, expectations, supports needed and acknowledge contributions	Open up a discussion that emphasizes that all members of the family have responsibilities they need to take care of. Assist families in identifying areas where they are demonstrating strength. Counteract reflexive dismissal of efforts and achievements. Normalize the need for support.
Relationships	Family warmth Within family support, time spent together	Schedule and keep time for positive family interactions	Active problem solving with families to protect positive family time. Provision of information or resources for families to access free or low-cost activities that are accessible to them. Checking in on the importance of positive family time.
Respectful communication	Family communication and family conflict	Listening and talking skills for parents and children	Facilitating role-plays of difficult conversations where families can practice the skills for active listening. Model active listening and reflective talking with families within the group setting. Using difficult moments that emerge within the group as opportunities to practice these skills.

(continued)

Table 5.1 (continued)

4Rs and 2Ss target	Empirically supported concepts	4Rs and 2S goals	Caseworker skills
Stress	Parenting hassles and stress, life events	Identification of stressors undermining family change, promotion of positive exchanges	Acknowledging to parents that this can be a difficult topic to open up about. Normalizing that having a reaction to stress is a normal occurrence. Including stress management as normal part of this discussion.
Social support	Social isolation	Internal and external family support plan to counteract isolation	Provide resources available through the child welfare system and in communities as options for the external support plan. Thinking with families about the appropriate roles each member of the family can play in the internal support plan. Troubleshooting how to activate potential members of the support plan from the community and the extended family network.

Note: Reprinted from "Improving child behavioral health using task-shifting to implement Multiple Family Groups in Child Welfare", by G. Gopalan, 2016, Pilot and Feasibility Studies, 2(21). Copyright 2016 by the copyright holder. Adapted with permission

Staff Qualifications

While the 4Rs and 2Ss intervention was designed to be delivered by master's level mental health practitioners, an ongoing research study funded by the National Institute for Mental Health (NIMH; R21MH102544; Principal Investigator: Geetha Gopalan) has been undertaken to adapt the training to be used by entry level child welfare caseworkers. This study involves partnering with community stakeholders (e.g., parents, caseworkers) and treatment developers to adapt the 4Rs and 2Ss for child welfare services focused on preventing out-of-home placement among high-risk families already investigated for child maltreatment (also called In-Home Family Preservation or Preventive Services). Caseworkers are trained specifically in applying the 4Rs and 2S core concepts in this adapted model (see Table 5.1).

Weekly meetings of the 4Rs and 2Ss are facilitated by two caseworkers. An essential component of the modified version of the 4Rs and 2Ss is the provision of ongoing supervision, by an experienced mental health clinician, to support caseworkers in managing difficult situations that emerge in the group setting and to build on any progress made from week to week. This adherence to quality and regular supervision aligns with best practices for retaining workers in child welfare settings (Chen & Scannapieco, 2010).

Population Served

Caseworkers are able to determine whether a family would benefit from the 4Rs and 2Ss during the routine course of an intake appointment. While families with children who have a diagnosis of moderate to severe behavioral disorders when they enter the child welfare system automatically qualify, other families struggling with any of the 4Rs or 2Ss (family Relationships, Respectful communication, Roles, Responsibilities, Stress and in need of Support) could be considered for inclusion. Families need to be assessed for their readiness and appropriateness to participate in the group modality. Those not able to participate in groups may be engaged with the intervention as a single-family unit. This more inclusive approach removes some of the heavy reliance on assessments mentioned previously that are more indicative of compliance and refocuses the worker and families on engagement based on demonstrated need.

Program Components

The 4Rs and 2Ss intervention utilizes evidence-based engagement strategies that are known to improve retention among socioeconomically disadvantaged families. These strategies include active and joint problem-solving around barriers to service utilization, as well as coverage of transportation costs. For instance, many appointments that parents need to attend directly conflict with any efforts they are making to either find or maintain employment. The 4Rs and 2Ss intervention schedules appointments that are less likely to conflict with work, either in the evenings or on weekends. Because the group usually falls during the dinner hour, both food and child-care are provided. Parents are able to show up, know that children are both safe and fed, and can give their attention to the content of the group. The provision of these concrete supports align with Schreiber, Fuller & Paceley's (2013) research on the three skills that parents value most in their relationship with their worker.

Though seemingly simple problems to some, small issues like the timing of an appointment, can present as insurmountable barriers to families. Eschewing the stance of service provider as "expert," the trained 4Rs and 2Ss caseworkers are skilled at respecting and utilizing the existing expertise of families. While openly

acknowledging the power imbalances inherent in the caseworker-parent relationship, the co-facilitators capitalize on families' strengths and create an atmosphere of safety and respect. They do so by actively acknowledging and utilizing the abilities and expertise of parents in relation to their children, calling upon them to act as co-collaborators and mutual support providers within the group setting (Franco, Dean-Assael, & McKay, 2008; McKay et al., 1995).

Effective 4Rs and 2Ss facilitators also possess the knowledge and skills to address the greater contextual factors that act as barriers to successful parenting (Franco et al., 2008; McKay et al., 1995). The intervention emphasizes and attends to the impact of racism, poverty, and community violence and how these environmental factors influence parents and children (Franco et al., 2008; McKay et al., 1995). This is achieved through the input from multiple generations of several families meeting together over the course of the intervention. Families share their knowledge of the realities that they face in their homes and their communities and can offer each other practical tools they have found useful in resolving those problems. Understanding how a family's context influences their ability to parent is a critical component of treatment for child welfare involved families, and allows the caseworker additional opportunities to understand and align with the families.

Strategies

Caseworker Competencies

The values of collaboration and partnership are foundational to the 4Rs and 2Ss intervention, and represent a cultural shift from the traditional child welfare approach. Using this intervention, caseworkers are afforded ample opportunities to demonstrate commitment to the safety, respect, and empowerment of children and their families. Equipped with an awareness of how trauma impacts family's behavior, relationships, and coping strategies, caseworkers integrate that understanding into their service planning (National Child Traumatic Stress Network [NCTSN], 2008).

Through adopting a strengths-based perspective, workers actively identify and highlight areas where parents are, in fact, being good, protective factors for their children, in spite of existing issues being addressed through their child welfare involvement. For instance, a worker may use positive communication (Schreiber, Fuller & Paceley, 2013) to explore issues related to strict and overprotective parenting. The worker may express a willingness to hear how the parent's approach may have been adaptive either to the environment that the family lives in, perhaps involving significant community violence, or to avoid potentially violent situations within the family. By reframing difficult interactions and reactions and identifying where vulnerability emerges as defensiveness, the caseworker emerges better prepared to engage the parent with the issues that the parents see as being of greatest concern (Jennings, 2004). The trauma-informed caseworker is able to identify that irritability,

emotional lability, and even, at times, a servile attitude, may be characteristic of people who have experienced prolonged exposure to traumatic events (Herman, 1992) over extended periods of time.

The effective and trauma-informed caseworker is also particularly sensitive to the potential for re-traumatization faced by families when engaging with larger service systems. This is especially salient in regard to the power and control dynamics that may be re-enacted between service systems and trauma-impacted families (Elliott, et al., 2005). Trauma-informed caseworkers, therefore, create transparent and genuine collaborative relationships with families, highlighting and building upon their strengths and capabilities (Jennings, 2004; Raja, Hoersch, Rajagopalan, and Chang 2014). This includes being frank with parents even in difficult situations. For instance, a parent may be perceived as not prioritizing an issue that is of great concern to the worker. The worker who has developed a relationship with the parent is better positioned to tell that parent that their children will not be returned until they make some progress in that specific area. Though difficult to take in, this kind of communication is frank and useful to parents. This transparency solidifies trust in the relationship, as well as communicates to the parent that the worker is trying to help and is *on their family's side*.

The ability to assess for a range of traumatic experiences and trauma symptoms is important for caseworkers (Griffin, McClelland, Holzberg, Stolbach, Maj, & Kisiel, 2011; Kisiel, Fehrenbach, Small, & Lyons, 2009). Because trauma-exposed children frequently present with features that fall outside of the posttraumatic stress disorder diagnostic criteria, child welfare workers must be trained to recognize and appropriately assess the diverse permutations of chronic and/or multiple interpersonal traumas presented by children and their parents (Kisiel et al., 2009). Moreover, caseworkers should also acknowledge that trauma exposure holds the potential to shape the ways in which they interact with all systems (Stephens, 2015; Smithgall et al., 2012). Skilled trauma assessment, in tandem with knowledge of available trauma-specific resources and services, helps the caseworker to build relationships with traumatized families, engage them in services, and to connect them with the specific resources that best meet their needs (Harris & Fallot, 2001; Raja, Hoersch, Rajagopalan, and Chang 2014).

Whereas traumatic events are so replete in some communities as to be normalized into the fabric of daily life, the skilled caseworker is able to recognize areas where horrific events are dismissed or minimized and find the appropriate time to address this with the family. For instance, parents may recount in regular conversation "oh yeah my nephew's friend got shot in front of our building two weeks ago" and move on without acknowledging the impact this has on the family, and the community. The group format offered by the 4Rs and 2Ss can potentially provide safe settings where families can support each other in acknowledging these difficult events. Finally, trauma-informed caseworkers also understand the impact of trauma on themselves and their work. In addition to having knowledge about secondary trauma exposure, caseworkers are self-reflective and understand how their own experiences of trauma may affect their work (van Dernoot Lipsky & Burk 2009).

Special Consideration: Secondary Traumatic Stress (STS) and Child Welfare Workers

Secondary traumatic stress refers to the cognitive, affective, somatic, and behavioral effects of working with those who have been traumatized (Sprang, Craig, & Clark, 2011). Child welfare workers providing services to vulnerable families are at an increased risk, up to 50% of workers, of developing secondary traumatic stress (STS) (Cornille and Meyers 1999; Conrad & Kellar-Guenther, 2006; Sprang et al., 2011). Left unaddressed, STS can result in decreased feelings of self-efficacy, feelings of hopeless, and helplessness that can ultimately result in high turnover in the workforce (Depanfilis & Zlotnik, 2008). Due to ongoing exposure to distressing material during contact with trauma-impacted families, child welfare staff can experience changes in their beliefs about the world, their emotions, their interpersonal relationships, and their daily lives (NCTSN, 2008). Caseworkers experiencing STS may have reactions similar to those of their traumatized clients such as re-experiencing symptoms, increased arousal, and/or avoidance symptoms (Figley, 1995; NCTSN, 2008).

Risk Factors

While all staff members working with trauma survivors are vulnerable to STS, certain worker and organization-specific factors can increase this risk including a prior trauma history (Bride, Hatcher & Humble, 2009); caseloads with large numbers of traumatized clients (Craig & Sprang, 2010), being socially or organizationally isolated (Bride, Hatcher & Humble, 2009); and inadequate training and supervision (Craig & Sprang, 2010).

Protective Factors

Studies of STS indicate that there are many factors that can buffer caseworkers from the effects of exposure to traumatic material (Sprang et al., 2011). The consistent use of self-care practices can mitigate the effects of secondary traumatic exposure (Craig & Sprang, 2010). Beneficial self-care practices include: (1) finding a healthy work/life balance; (2) regular use of stress-management practices; (3); and having a network of friends, family, and co-workers that provides connection and support (NCTSN, 2008). Evidence suggests that self-awareness and a worker's ability to self-reflect are key to preventing and working through STS (Newell & MacNeil, 2010). Additionally, effective supervision provides an important safeguard for caseworkers (Barak, Travis, Pyun, & Xie, 2009) especially when

it is also trauma-informed (Craig & Sprang, 2010). Together, self-awareness and ongoing supervision are critical, as providers do not often recognize the impact of the work until multiple symptoms of STS are present (NTSCN, 2008).

Larger child welfare systems also promote staff resiliency when they are informed about the risks and consequences of STS and implement supportive policies and practices. This may entail allocating agency resources for STS training, as well as modifying policies that exacerbate STS effects (NCTSN, 2008). It is also imperative to create a wider milieu where STS is openly acknowledged, discussed, and dealt with by all members of the system (NCTSN, 2008). Finally, child welfare systems that endorse and utilize evidence-based interventions also protect staff from STS. Research on protective factors demonstrate that the use of evidence-based practices (EBPs) by service providers helps to buffer the effects of secondary trauma exposure (Craig & Sprang, 2010).

The acknowledgment of the potential impact of near constant exposure to highly traumatized families on caseworkers is required if the child welfare system expects to address the extraordinarily high rates of staff turnover currently taking place. The expense of adopting trauma-informed systems could be recouped by retaining well-trained, highly motivated, and supported staff to work with families. Costs would be cut in the areas of recruitment, hiring, and onboarding. A common complaint among parents is that they have to adjust to the constant stream of new workers with worries that important information is lost with the loss of caseworkers – often taking place several times in the same year.

Through its emphasis on recognizing the roles of stress and support in the lives of child welfare-affected families, the 4Rs and 2Ss makes the discussion of stress a part of both the group discussion and supervision for workers. Workers are provided with weekly supervision as an essential component to the success of the intervention. Supervision provides opportunities to explore approaches the worker would like to take, those that worked well, and to review situations that did not work well. The worker must be sufficiently supported, with avenues for discussing the challenges inherent to the work, if they are expected to execute the intervention and support families.

Beyond Cultural Competence to Cultural Relevance

The 4Rs and 2Ss intervention was constructed taking into account the impact of stigma and marginalization on engagement. Many minority families, who have historically avoided mental health services due to stigma and fears of being blamed for their children's difficulties, may be more likely to access groups which focus on sharing and support as more acceptable than traditional approaches to service provision (McKay & Bannon, 2004). The group format provides the setting for the validation of strengths, normalization of family struggles, as well as the much-needed provision of social support. Two examples are provided below highlighting how the 4Rs and 2Ss are relevant to the parents interfacing with the caseworker.

James: Parent, James, works on a part-time, as-needed basis at his construction job. He has been warned by his boss about being late on several occasions and his boss has told him he "doesn't want to hear about any other appointments" – his next lateness will result in him being fired. James' caseworker is frustrated that James missed his last appointment where she specifically told him that they would be setting up visitation with his three children who are in foster care. Frustrated, the caseworker begins to question whether James really cares about his kids or even wants them back.

James' situation is not unfamiliar to many parents. In the above example, James' worker may not be aware that keeping his appointment with her means that he had to decide between two extraordinarily important things in his life, visitation with his children and maintaining his employment. The strong reaction elicited in the caseworker by circumstances like James' may result in the worker adopting a more authoritarian style in order to achieve a greater sense of control. The worker may begin to adopt a "Do as I say or else" stance without realizing the limited choices James has. Adoption of this style of interaction has been identified as one of the roots of coercion that permeates the worker-parent relationship (Bundy-Fazioli, Briar-Lawson, & Hardiman, 2009; Hughes, Chau & Poff, 2011).

Additionally, James may be experiencing feelings of shame and guilt associated with being involved in the child welfare system. Parents struggle under the burden of the stigma of being system involved, feeling judged on all sides, and, at times, unable to turn to their usual supports for help. The absence or limitation of access to usual social supports can result in social isolation, which, in turn, increases parental stress. Needless to say, James' worker is meeting him at a precarious point in his family's life.

Using the 4Rs and 2Ss to guide engagement, the worker would acknowledge the missed appointment and try to elicit from James what contributed to it. The worker would be able to provide information on the 4Rs and 2Ss as a way of meeting several of the needs presented. The family could spend time together in a voluntary and supportive environment. Efforts would be made to work around James' employment so that his job would not be endangered and he would no longer have to choose between the two. James and his children would have the opportunity to benefit from the peer support provided by other families and potentially increase his support network. The caseworker in this scenario is seen as actively working with James to support his family, thus increasing the likelihood of James engaging in the helping relationship.

Simone: Parent, Simone, enters the preventive service center gripping her 8-year-old son's hand. She appears slightly disheveled and visibly upset. Once she enters the worker's office with her son, she sits quietly seething, seeming to assess her worker from head to toe and eventually rolls her eyes and says "I don't really want to be here – so what I gotta do to get this over and done with.

The emotional lability and reactiveness, which may present as a mother barely controlling her temper at a worker's desk, are often and understandably experienced negatively by workers. These interactions can engender very strong reactions on the part of the worker, ranging from feeling overwhelmed to wanting to exert absolute control over a parent who is appearing to be rude and provocative. Using the 4Rs

and 2Ss as an engagement tool, the caseworker would assure the parent that her participation is completely voluntary and would highlight the potential benefits of the intervention. One way to try to align with Simone would be to encourage her to attend one session with her son. There would be no cost to her, if she and her son enjoy the group they would be welcome to continue. If they do not, they would only have spent about 2 h in the process and would not be required to return. This affords Simone choice in the direction she can take with her son, and offers the worker an opportunity to provide an evidence-based intervention to this family.

> *Worker: "Simone – I am really glad that you made it in. I know you have a lot on your plate right now, including picking all of your children up after school and finding care before you come to meet with me. I think there may be a group that could help us meet while providing your family some support… there is a new group called the 4Rs and 2Ss that will begin in a week."*

General Implementation Concerns in Child Welfare

The ongoing study represents a first step toward understanding the factors that may contribute to the successful implementation of the 4Rs and 2Ss in placement prevention services. However, successful implementation and sustainability may be hindered by additional realities within child welfare settings. Caseworkers have sizeable workloads and multiple responsibilities, with few available avenues to support knowledge sharing (Aarons, Hulburt, and Horowitz 2011; Yoo, Brooks, & Patti, 2007). Moreover, the highly bureaucratic nature of child welfare systems may hinder the adoption of new practices (Aarons, 2004). Child welfare organizations tend to have limited financial resources making additional training, ongoing supervision, and other supports for caseworkers difficult to accomplish. For example, prior attempts to integrate Family-Centered Practice (FCP) principles (e.g., focus on family strengths, culturally informed, prioritize empowering families to address their difficulties, driven by family's needs and priorities, involve a collaboration between families and providers within child welfare services; Michalopoulos, Ahn, Shaw, & O'Connor, 2012) have been stymied by the organizational constraints characteristic of child welfare practice. Specifically, major implementation barriers cited by caseworkers included lack of resources (time, high expectations, financial, staffing, transportation), lack of coordination of services, additional administrative requirements, lack of training on culturally competent work with child welfare involved families, as well as insufficient supervisory support (Michalopoulos et al., 2012).

Despite the many potential barriers to successful implementation, the potential benefit of including highly engaging programs, like the 4Rs and 2Ss, within placement prevention services is significant. With substantial and lasting improvements obtained in reducing child behavior problems, improving communication, increasing support and reducing stress for families, using a trauma-informed lens to transfer behavioral parent management skills may be helpful to many of the most

marginalized families served by child welfare. While not created as a trauma-informed treatment, the 4RSs and 2Ss already share many of the foundational values and practices espoused by trauma-informed care including facilitating parent empowerment, emphasizing strengths and resiliency, validation, and promoting trust and collaboration between parents and caseworkers (Gopalan, Small et al., 2015; Elliott et al., 2005). Therefore, trauma-related modifications to the content and processes can make the intervention compatible with a trauma-informed framework. These suggestions include augmenting the current training, treatment manual, and supervision to include specific information from the extant research on trauma faced by those children and families being served and the potential impact on children, families, and facilitators. This may include education about types of traumatic experiences, trauma symptoms, and the effects of trauma on child behaviors and parenting. Child welfare workers providing the modified treatment can also build their knowledge of available trauma-specific services and resources, many available through the National Child Traumatic Stress Network (NCTSN), subsequently linking families to these services as needed.

Preliminary Evidence for Success

Preliminary findings from the aforementioned NIMH study give cause for cautious optimism. Most benchmarks for high feasibility and acceptability by both child welfare staff and parents were met, including: family-centered approach model, training, supervision, staff capability, logistical support, program duration, ease of use, accessibility of the manual, and families' satisfaction with the program. Challenges to feasibility and acceptability included staff concerns regarding caseload management, conflicting roles/values between child welfare and mental health services, and child eligibility criteria. Implementation factors related to ease of uptake, logistical and supervisory support, and the family-centered nature of such programming increase both family and child welfare staff's sense of feasibility and acceptability. Results based on more robust qualitative and quantitative data analyses of study findings are forthcoming.

Policy and Practice Recommendations

Caseworkers who interact with families during some of the most emotionally fraught moments in their lives are major stakeholders in any proposed intervention and have the power to influence client outcomes. Worker perseverance, flexibility, and experience impact their openness to the adoption and effective execution of the intervention. As a result, it is important to ensure that workers are properly trained and supported as an essential component of any trauma-informed approach like the 4Rs and 2Ss. Additionally, including information in trainings on the worker

characteristics most helpful in building a collaborative relationship, such as dedication to doing meaningful work, can also help to promote the working relationship necessary to support strong parent-worker relationships that strengthen families.

Unfortunately, applying trauma-informed principles when engaging families may conflict with organizational priorities and the culture of compliance inherent in child welfare services. As a result, caseworkers must be properly supported within their work settings in order to be successful. Existing research has demonstrated positive interactions between caseworkers and parents are possible in child welfare settings. Despite the inherent power imbalances between workers and clients, parents have reported they are able to engage with caseworkers when they perceive them as using their power as a form of support and advocacy (Dumbrill, 2006).

Adopting indicators of long-term behavior change (e.g., substance free, decreased depression) and engagement (e.g., parental outreach to a worker in an effort to avert a crisis in the home) systematically may serve to undercut the pernicious influence of a compliance-driven system. The pervasive belief that compliance equates with motivation for reunification must be countered with more accurate accounts from parents who view non-compliance with child welfare service plans as multi-determined. Child welfare as it currently operates does not meet the needs of families in a culturally relevant and trauma-informed manner. Implementing some of these changes would be the first step in improving the culture to make it both more trauma-informed and supportive of family engagement.

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Chapter 6
System Change Designed to Increase Safety and Stabilization for Traumatized Children and Families: Trauma Systems Therapy

Adam D. Brown, Susan Hansen, and Glenn N. Saxe

Goal/Purpose of Intervention or Service

Multiple challenges are involved in considering how best to help the child welfare system work more effectively for traumatized children. Truly impacting the quality of care of such children requires successfully addressing three difficult realities: (1) clinical and practical needs; (2) organizational needs; and (3) human services worker needs. Until these needs are met, children with abuse or neglect histories, who are placed into the child welfare system, will continue to be underserved and inadequately cared for. Trauma System Therapy (TST) was created to meet the challenges identified above. The early phases of TST interventions described here are designed to keep children safe and stabilize families.

The Clinical and Practical Needs of Children and Families

The children and families served by the child welfare system have multiple needs that span different service systems. The mental health needs of children and families who receive child welfare services can be severe and frequently are multigenerational, with many parents having their own experiences of trauma as children and/or adults. Families may have multigenerational involvement with the child welfare system that often leads to mistrust in the system and a lack of engagement in services. Families are often from different cultures and racial groups than either their child welfare or mental health providers, and may have quite different culturally endorsed notions about parenting, child protection, and mental health. These differences can also contribute to a lack of engagement. Children and families in the child

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welfare system may also face many practical barriers to engagement in recommended services, such as a lack of resources for transportation, childcare for other children, lack of flexibility in scheduling related to employment, and issues related to literacy and language for understanding recommended services and engaging in these services. These practical barriers are compounded as families frequently need to engage with multiple providers across different service systems. Importantly, while a child or family's involvement with the child welfare system may address physical safety concerns, that same involvement may be a source of ongoing traumatic stress, particularly for children in foster care and their parents. Finally, children and families often move in and out of the child welfare system or between different parts of the system, which makes maintaining connections with providers and providing consistent services to them challenging.

Organizational Needs of the Agencies that Serve Children and Families

Treatment and service approaches are provided within and between organizations that have their own needs and mandates. Over time, organizations develop cultures related to the conduct of their work. The public mandate of the child welfare system – a compulsory system – is quite different than the mental health system – a voluntary system. Accordingly, providers within these systems will prioritize different aspects of the work and have different relationships with families. Addressing trauma-related mental health needs of children in the child welfare system requires effective approaches to integrating the two systems. Additionally, addressing the trauma-related needs of children is not solely about linking them with appropriate treatment services. Rather, many different child welfare practices and activities exist, such as preparing foster parents to work with other stakeholders such as the judicial system – a system that must also be informed by the impact of trauma. Given the different mandates and workplace cultures between child welfare and mental health, successful approaches must also be able to "speak both languages" and provide value to the needs of both child welfare and mental health professionals and the organizations for which they work.

Needs of the Individuals Who Serve Children and Families

The work of providing service in the child welfare system repeatedly requires providers to face issues related to a terrible reality: a parent who may have caused harm to her/his child and the potential impact of that harm. This reality is in the everyday mix of work for both child welfare and mental health providers. Child welfare providers are called upon to make decisions that are amongst the gravest that a human

being can be asked to make: whether to remove a child from her or his family in order to protect him or her from potentially lethal harm. Further, child welfare workers are frequently overextended with caseloads and undertrained in the mental health/trauma-related needs of the families they serve. Foster parents, who are not formally considered part of the child welfare workforce but nevertheless bear much of the burden for caring for children in the system, often do not receive the training and support necessary to help children both recover and flourish. Mental health providers must work to understand the meaning of the trauma from the child's point of view and do their best to have empathy for the people with whom they work. Mental health providers are also frequently undertrained in the legalities of child protection, the court system, advocacy, and ways to access the needed services. This work is extremely difficult and may have considerable personal cost to all providers. Treatment and service approaches used by such providers should acknowledge these costs and have processes in place to help providers to best cope with the realities they must face.

The Current Status of Clinical Treatment and Service Integration in the Child Welfare System

The most important question to ask about the current status of clinical treatment or service integration within the child welfare setting is, "What do children and families identified as needing clinical treatment and services typically receive?" Considerable evidence exists that the majority of children with mental health problems – trauma related or not – do not receive ANY clinical intervention. Using data from the National Survey of Child and Adolescent Well-Being, Burns et al. (2004) found that only one in four children investigated by child welfare agencies who had an identified mental health need received mental health care services. Likewise, Bai, Wells, and Hillemeier (2009) found a large disparity between the number of children with serious mental health needs and the number of children receiving services. The most worrisome is data on the status of clinical treatment for *very young children* with mental health needs. A recently published study of the mental health needs and service access of 1117 children aged 12–36 months who were seen in child welfare agencies around the United States examined information contained in the second National Survey of Child and Adolescent Well-Being (NSCAW II) and found that only 2.2% of those who were defined to need treatment received any clinical intervention (Horwitz et al., 2012). *Why are these data so worrisome*? Evidence indicates that exposure to child maltreatment can deleteriously influence brain development (De Bellis et al., 1999; Navalta, 2011). The brains of young children are particularly vulnerable. As Horwitz et al. (2012) have discovered, the needs for clinical intervention for such children can be readily identified. That such children do not receive the needed interventions and services is a tragedy of national proportion.

In addition, a wide variety exists in the types and quality of mental health services available to children and youth involved in child welfare systems and in how such services are delivered. On one extreme, some systems are completely reliant on the community mental health system and do not have much leverage in the amount, type, or quality of available services. Other child welfare systems are under the same agency leadership as children's mental health, which helps with the coordination of services. Others rely on external providers, but have more control over funding streams, which gives administrators a stronger role to play in the availability of mental health services.

Trauma System Therapy (TST) enables clinicians and clinical teams to consider child traumatic stress in all its complexity and to translate the complexity into the specific therapeutic actions that will help a child given their needs. Theoretically this is a systems process (hence the name Trauma *Systems* Therapy). A trauma system is defined as:

> *A traumatized child who experiences Survival-in-the-Moment States in specific definable moments;*
>
> *and*
>
> *A social environment and/or system of care that is not able to help the child to regulate these Survival-in-the-Moment States* (Saxe et al., 2016).

"A survival-in-the-moment" state is defined as:

> *An individual's experience of the present environment as threatening to his or her survival with corresponding thoughts, emotions, behaviors, and neurochemical, and neurophysiological responses* (Saxe, Ellis, Brown, 2016, p. 10).

As previously stated, this conceptual framework is what sets TST apart from other child trauma models. This interactive duality of internal and external factors forms the core approach to understanding and treating child traumatic stress within TST.

Description of Intervention or Service

Population Served

Trauma Systems Therapy can be used with children and families across the continuum of child protective, preventive, foster care, and adoption child welfare services. Its focus on child safety – both physical and psychological – within the social environment makes it particularly relevant for children just reported to Child Protective Services (CPS), who then remain in the home but are referred for services. Children and their families placed in out-of-home care as a result of a CPS report are also ideal candidates for TST.

Staff Qualifications

The TST team is typically comprised of home-based clinicians, a psychopharmacologist, psychotherapists, a legal advocate, and a supervising clinician with trauma treatment expertise. The intent is for TST to provide a team approach involving all

systems of care with which a traumatized child is involved. These providers, in turn, are engaged with the various parts of the child's social environment (i.e., home, neighborhood/community, school, etc.). We set out to develop not only an effective treatment model, but also one that could be successfully disseminated across a variety of "real world" settings.

TST provides a central organizing structure that brings together different service systems that are involved in a child's care In order to provide TST, a service system must be able to provide four types of services:

- Individual skills-based, trauma-informed psychotherapy (emotional regulation and then cognitive/trauma processing skills)
- Home and community-based care
- Legal advocacy
- Psychopharmacology

The configuration of a team providing these services differs by community and is typically *built out of existing resources* by surveying services already provided by a given agency that can be integrated, or that are already provided by other agencies in a region and can be integrated through interagency agreement.

TST's clinical model has a very specific assessment, treatment planning, and treatment engagement approach that selects specific sets of interventions in a phase-based way, depending on the needs of the child and family at a given point in time. All children are assessed based on the interface between the degree to which they become emotionally and/or behaviorally dysregulated and the degree to which those around the child can help the child stay regulated. At the extremes, the child may be in an environment in which they are currently experiencing harm or danger (e.g., maltreatment, exposure to family violence) and/or the child's dysregulation can be reflected in dangerous behaviors (e.g., violence, self-destruction, impulsive risks) and danger in the child's Based on this interface between the child's dysregulation (including risk of harm to self and others) and the environment's capacity to help and protect (including risk of harm to the child), one of three phases of treatment are selected, with defined intervention protocols within a given treatment phase: (1) *Safety-Focused Treatment:* This phase is selected when there is significant risk from the child's behavior and/or for the child to be hurt from those around them. Interventions include case management, advocacy, behavioral, and occasionally psychopharmacological intervention to establish and maintain safety in the child's environment. (2) *Regulation-Focused Treatment:* This phase of treatment is selected once the child is in a safe enough environment. At this point, the child may still have significant difficulties regulating emotional states. The primary focus of intervention in this phase is well-defined, evidence-based emotional regulation skill building. (3) *Beyond Trauma Treatment:* This final phase of TST is selected once the child's environment is safe enough and the child has built sufficient emotional regulation skills. This phase focuses on children's capacity to put the trauma in its rightful place in the child's past and to focus on living happily and productively in the future.

Each of the three phases of treatment has a distinct focus and is accompanied by two guides that anchor and organize the work of the TST team:

(a) *Safety-Focused Treatment:* The goals of this phase are to ensure the youth is in an adequately safe environment, and to diminish the likelihood a child will shift

into a dangerous survival state by improving his or her ability to recognize and manage their reactions, and/or by improving the caregiver's capacity to be helpful and protective, or help get the child to an environment that has the capacity to provide sufficient help and protection for a child with dangerous survival states. Services advocacy is often the main focus of intervention in the safety-focused phase. Safety-focused treatment is typically provided in the home and/or community. Two guides are used in this phase: the Safety-Focused Guide to organize and coordinate the work of the team, and the HELPers Guide, to be used directly with the caregiver to help them build skills and get support to manage their own needs (Saxe et al. 2016, pp. 441–455).

(b) *Regulation-Focused Treatment*: The focus of this phase is building children's emotional regulation skills so that they don't switch to survival states when a threat signal is perceived – or, if a survival state begins, they are able to use skills or accept help to return to a regulated state. A child in this phase is not at risk of engaging in dangerous behavior if triggered, and the environment is not harmful to the child. Regulation-focused treatment is centered on psychoeducation about trauma and trauma reactions, and the building of skills to recognize and manage survival states. These skills are taught to the child, and the child's plan for using these skills is shared with key adults in that child's life who are in a position to help that child to cope. Regulation-focused treatment is typically provided in an office, as home-based stabilization is no longer required. Engaging caregivers in regulation-focused treatment is critical. Two guides are used in this phase: the Regulation-Focused Guide, which helps to coordinate the work of the team around choosing appropriate skills and planning to share these coping strategies with others, and the Managing Emotions Guide (MEG), which helps a child learn to understand that there is a pattern to their survival state reactions that they can learn to recognize. The MEG is organized around providing psychoeducation to youth and their caregivers about how the child's affect, action, and awareness (referred to as the 3 A's) shift across four distinct states of regulation (the 4 R's), and helps a child learn to recognize and manage changes in their emotional state. Both guides can be found in the TST Manual (Saxe et al. 2016 pp. 456–466).

(c) *Beyond Trauma Treatment*: A child in the Beyond Trauma Phase no longer experiences survival states, and lives in an environment that is helpful, protective, nurturing, and safe. This does not mean, however, that there is no longer a need for intervention. The child may still be impacted by their prior experiences of both traumatic events and survival-in-the-moment states. Children may be plagued by negative views of themselves, others, and their future. Similarly, caregivers may harbor beliefs that their child is damaged or may never have a normal life. The primary goals of beyond trauma treatment are to help a child and their caregivers move forward from the trauma, so that it does not define the child's sense of self and others, and that the child does not feel limited by or held back by their past. This phase also addresses how the child and family can achieve lasting meaning from the experience of trauma, which can help to develop a positive and hopeful sense of future that does not require the ongoing

involvement of a treatment team. Two guides are used in this phase: the Cognitive Awareness Log (CAL), which the mental health clinician uses to teach the youth to recognize and correct problematic cognitions, and the Beyond Trauma Guide, which guides the mental health clinician in structuring the treatment in this phase, including a specific format for creating a trauma narrative (one format for single incident trauma, and one for complex trauma), and for helping the youth to process their cognitions related to the narrative, and to make meaning of their experience.

Specific guides exist to clarify and support the role of clinicians, case workers, parents, and foster parents specific to each of the three TST phases. Foster care workers collaborate closely with mental health clinicians to determine patterns of triggered survival states, develop a treatment plan, and coordinate service provision across the phases. Throughout the three TST phases, we continually address the needs of family members and foster parents.

All of these interventions are provided within a specific organizational process where teams of providers are trained to provide this integrated care in concert. This is conducted within a defined planning process where such issues as sustainable finances, interagency collaborations, supervision and training needs, and secondary traumatization are carefully considered.

Fit for the Child Welfare System

TST addresses the *clinical and practical needs of children and families* in that treatment targets not just an individual child but a "trauma system" (defined above). TST effectively engages traumatized youth and families by utilizing specific strategies and tools to uncover a youth and family's "major source of pain" (Saxe et al., 2016); identifying specific goals and solutions designed to achieve these goals; and specifying the role of all involved, including youth, family, clinicians, case workers, and all relevant members of the team.

TST also addresses the *organizational needs of agencies that serve traumatized youth and families* by addressing barriers that have repeatedly interfered with the dissemination of trauma-focused, evidence-based practice in front-line service settings. TST's development has included the principle of *"disseminate-ability"* or the ability of an intervention to be successfully diffused to different service sites. TST is *both* a clinical model *and* an organizational framework. The dissemination of TST requires a defined Organizational Plan crafted in collaboration between agencies leaders/stakeholders, community partners, and TST trainers/developers. This Organizational Plan describes how an organization's resources will support and sustain the TST program and also includes a financial plan.

TST acknowledges the *human needs of those serving youth and families* by engaging staff members at all levels as equally important members of the TST treatment team. Front-line workers often feel their role is elevated in that the TST

assessment and treatment planning process requires their participation and, in fact, cannot be effective without the involvement of all team members at every level. TST also takes into account the impact of vicarious trauma on those providing service and incorporates an emphasis on self-care and mutual support.

TST uniquely addresses the specific needs of child welfare programs by creating a structure for integrating the various service system providers to facilitate them working together as an integrated team. TST provides a common language for understanding the needs of child welfare-involved youth and families, and requires that they all participate in the TST treatment team meetings, with team members from various parts of the system each providing a specified role in addressing the manner in which factors in the social environment trigger the youth to shift into survival states in ways that interfere with the youth's ability to reach their goals (this is the TST priority problem). In addition, we have developed specific tools to train case workers and foster parents to use the TST approach to understand and meaningfully impact the children in their care (Saxe et al., 2011).

Example of a Specific Practical Benefit for Child Protection and Child Welfare Case Workers

One of the most beneficial aspects of the TST approach is that it combines a theoretical understanding of the needs of the traumatized youth with the specific, actionable tools and strategies for meeting these needs. TST has a specific focus on safety for youth identified in the Safety-Focused phase of TST treatment (described above). Safety-focused treatment in TST is designed for youth who live in a harmful environment, or whose caregivers are not able to sufficiently help and protect that child who shifts into dangerous survival states, and may thus cause harm to themselves or others. One of the very practical elements of TST that child protection and child welfare caseworkers find very useful is the concept of a "safe enough environment," defined as an environment in which:

- *Caregivers are able to protect their child from actual threats, and*
- *Caregivers are able to help their child regulate dangerous survival states*
- *And protect their child from stimuli that provoke those dangerous survival states* (Saxe et al., 2016, p. 236).

Safety-Focused treatment in TST has three components:

1. Establishing Safety: This component of Safety-focused treatment involves activities that ensure the current environment will become safe enough in a time frame that is appropriate for the level of risk, or gets the child to a safe enough environment if the current environment cannot become safe enough in the time frame required. There are also specific guidelines for assessing whether and when it is appropriate to return a child to the environment they were removed from. One of the tools to support workers during this phase is the Safety-Focused Guide, which involves five steps:

(a) Appraise whether the current environment is safe enough.
(b) Develop the plan to establish a safe enough environment (the safety plan).
(c) Determine the risk in establishing safety in the current environment (with the safety plan).
(d) Reach the decision on whether to keep the child within the current environment, based on the risk.
(e) Reach the decision on whether (and under what conditions) to return the child to the environment, based on the risk (for children who have been placed in a new environment).

Child protection and casework staff find these processes extremely useful in helping them to make the difficult decisions about what constitutes risk for a given child, what can be done short of removal to make the environment safe enough whenever possible, and what to do if a child needs a different environment.

2. Maintaining Safety: This component of Safety-focused treatment involves activities that support the continuation of the safe enough environment until providers are confident the changes are real and can last. These strategies have proven useful for helping to maintain foster care placements. The three main activities in this phase are:

(a) Identifying and removing or minimizing traumatic triggers in the environment
(b) Supporting basic regulation of emotional states
(c) Advocating for needed services

3. Caring for Caregivers: This component of Safety-focused treatment involves activities that support caregivers for what they need to do to establish and maintain a safe enough environment. It includes specific criteria for helping caregivers to establish a safety plan, including the determination of what constitutes an emergency, what can be managed in the home, and helping caregivers to identify what they can do both to help the child, and to take care of themselves so that they can parent to the best of their ability. The TST team works with caregivers to develop specific strategies both for what the caregiver can do to prevent and respond to survival state behavior, and what they can do to maintain their own regulation and get the support they need. Caseworkers find these strategies very useful to help caregivers who are struggling to feel more effective and hopeful. Workers use the Helper's Guide to support this part of the work, which is structured around four sections.

(a) Handling the difficult moments. Helping caregivers stay regulated in the face of their child's dysregulation.
(b) Enjoying their child. Reestablishing a loving relationship between caregivers and children; fostering stronger attachment.
(c) Learning parenting skills. Helping caregivers develop parenting skills to reduce stress in the home and encourage positive child behaviors.
(d) Planning for emergencies. Establishing a concrete plan for emergencies, and
(e) Clarity around what constitutes an emergency.

The phase-based aspect of TST helps to clearly delineate which members of the team are responsible for specific processes and interventions at specific stages in the process. Child Protective Services (CPS) workers and child welfare case managers, whose charge it is to evaluate and ensure safety for youth and families, benefit greatly from the specific processes embedded in the Safety-Focused Phase of TST treatment.

What Makes TST Trauma Informed?

In our experience, many children with traumatic stress in the child welfare system have problem lists that may be exceedingly long. These long problem lists come from the great many possible determiners of the child's problems. TST begins with an assessment process that considers all possible determiners and concludes with an understanding of the most important ones to address in treatment. How does TST do this? First, we understand that biological systems related to trauma have evolved to promote survival in the face of threat. Accordingly, our first pass at understanding the child's emotional or behavioral responses to trauma is to consider how these responses relate to survival preservation. Next, we understand that the child's social environment following trauma is usually no longer threatening but children will often respond to their environment as if it is threatening in certain situations. In cases where the child's environment is actually threatening, treatment is fully dedicated to preserving safety. Third, the child's emotional, behavioral, and cognitive shifts to survival-in-the-moment states in response to their current environment as if it were threatening is the defining feature of traumatic stress responses. We understand that *survival-in-the-moment* states do not occur randomly, but are in response to environmental signals that the child perceives (consciously or unconsciously) as threatening. Usually these signals have some knowable connection to the child's experience of trauma, but this connection may not be readily apparent and is understood through the process of assessment. The occurrence of the child's survival-in-the-moment responses in the context of specific threat signals usually defines the episodes for which the child needs treatment. These signals may be very subtle (e.g., a type of glance or tone of voice). Accordingly, a key part of the assessment process is to identify patterns by which threat signals lead to survival-in-the-moment states. Threat signals may come from any area of the child's social environment (e.g., home, school, peer group). TST will focus on areas of the social environment in proportion to the degree that threat signals are found. Finally, it is the identification of these patterns of links between threat signals and survival-in-the-moment responses that define the clinical problems to be addressed in TST treatment. This will usually result in a small number of high value problems that become the focus of treatment out of the great many possible problems that could have been the focus of treatment.

How Does TST Advance Cultural Competency?

TST places a strong emphasis on engaging families in treatment utilizing specific strategies to develop the treatment alliance and troubleshoot practical barriers to treatment engagement. A critical element of treatment engagement is the *family's culture-based understanding* of trauma, emotion, mental health, and mental health intervention.

Challenges to Implementation

One of the biggest challenges to effectively implement a model in a service system is creating a balance between maintaining model fidelity, while encouraging adaptations designed to meet the needs of specific populations and the various settings where services are delivered. The TST development team has addressed this important need by creating a process of collaborative innovation. Based on the concept of Lead User Innovation (von Hippel, 2005), we believe that adaptations to our (or any) treatment approach are best conceived of by the people implementing that model in real-world settings.

We have developed a "community of innovators," who, through collaboration with the development team, have developed a number of TST adaptations. At the time of this writing, TST has been disseminated and is being currently implemented in 12 U.S. states, the District of Columbia, and the country of Singapore. Adaptations have been developed for specialized populations including refugee children and families, traumatized youth with comorbid substance abuse, and unaccompanied alien minors. TST has been adapted for various service settings as well, including child welfare, residential treatment centers, hospitals, outpatient clinics, shelters, community-based prevention programs, juvenile justice, and school-based mental health programs. Each adaptation adheres to the key features of TST, while making crucial changes where necessary to meet the individualized needs of the population and setting, demonstrating the concept of "flexibility within fidelity" (Kendall & Beidas, 2007).

Another challenge commonly encountered when implementing treatment for childhood trauma, is lack of commitment and follow through with the treatment process on the part of both children and caregivers. It is common to attribute this to qualities of the youth and families. While this may be true in some cases, it is equally important to consider whether there has been a failure on the part of the clinician to adequately engage these children and their caregivers in the treatment process. To address this, TST includes a specific engagement strategy, called *Ready Set Go* (RSG). This begins during the assessment process, and includes gathering detailed information from both the child and caregiver about their goals and priorities. In order to engage someone in a meaningful way, it is imperative to know what is most important to them, and what gets in the way of achieving

what is most important. We refer to this as the person's "major source of pain." (Saxe et al., 2016). If the child and caregiver come to believe that working with the team will help to alleviate their source of pain and achieve their goal, they are much more likely to trust the team, keep commitments, and engage fully in the process. True treatment engagement in TST is achieved when there is a mutually agreed upon understanding of the problem, and the way in which the team will work together to solve the problem. This agreement is captured in writing on a form called the *TST Treatment Agreement Letter*. This is a document that is initially drafted by the treatment team, based on their work with the family. It is then shared and reviewed at a meeting with the child and caregivers. If anyone has objections or suggestions, changes are made. Once there is full agreement, all team members sign the letter, and it becomes the guide for the rest of the work.

The specific nature of service provision within TST presents several unique challenges. These include the provision of home-based and office-based services, as well as the creation of a closely integrated multidisciplinary team. These elements are required for TST, and are funded by leveraging existing resources, so as not to require grant funding, which is typically not sustainable. The provision of multiple services is often accomplished via creating interagency agreements

Evidence of Success

The first study that initially demonstrated TST's efficacy was an open trial conducted at two sites: a child psychiatry outpatient clinic of a large, urban general hospital and a joint program of county-wide departments of mental health and social services in rural upstate New York (et al., 2005). Each site had a team trained in TST, which was implementing the model prior to the study. One hundred and ten children aged 5–20 years old (mean age = 11.2, SD = 3.6) and their families were enrolled in the treatment. The Child and Adolescent Needs and Strengths-Trauma Exposure and Adaptation Version (CANS-TEA; Kisiel et al., 2009) was used as the primary treatment outcome measure after TST had been delivered for 3 months. Of the children who remained in treatment (n = 82; 72% of the enrolled sample), improvement was found in PTSD symptoms, emotion regulation, behavior regulation, caregiver's physical and mental health, caregiver psychosocial support and stability, and social environmental stability. Positive changes in children's functioning were also strongly and positively correlated with changes in dimensions that are specifically targeted by TST (e.g., emotional regulation and stability of the social environment). Moreover, 58% of the children transitioned from more- to less-intensive phases of treatment during the 3 months of the study.

The aforementioned joint program in upstate New York was the end result of the first successful TST dissemination (Hansen, Saxe, & Drewes, 2009). The adoption and implementation of TST came to fruition after the program's realization that (1) the primary reason for referral was "environmental/family dysregulation" as opposed to more isolated psychiatric disorders in the child being referred for

services (e.g., oppositional defiant disorder, conduct disorder, PTSD); (2) the majority of referred cases had histories of trauma, including abuse, neglect, and extreme poverty; (3) the clinical model used at the time had proven to be ineffective at providing services to these families, who presented as stressed, unable to organize themselves, and unable to keep members safe; and (4) resource barriers for the families (e.g., lack of childcare and/or transportation) and a general mistrust of the system that resulted in poor engagement in therapy. As a consequence, the program decided to incorporate TST into its overall treatment framework, which also included aspects of play therapy and cognitive behavioral therapy. Recent evaluation data provide empirical support for the program's clinical as well as cost effectiveness (Ellis et al., 2011). Across a 15-month period, 124 children between 3 and 20 years of age who had experienced three to nine potentially traumatic events received TST. Measures of clinical course, (hospitalization, need for intensive vs. office-based services) children's psychiatric and psychosocial functioning, and social-environmental stability were taken at intake, 4–6 months (early treatment), and 12–15 months (late treatment). Cost savings were evaluated through a comparison of pre- and post-implementation hospitalization rates and lengths of stay for all children under the care of the county mental health department. Emotion regulation, social environmental stability, and child functioning/strengths improved significantly over the course of treatment.

Early treatment improvement in child functioning/strengths and social environmental stability were associated with overall improvement in emotion regulation across the duration of the intervention. Children who were able to transition from crisis-stabilization to office-based services during early treatment tended to stay in treatment and improve through late treatment. For the 72% of youth who completed treatment, the need for crisis-stabilization services at 15 months was reduced by over 50%. Compared to children served prior to the implementation of TST, hospitalization rates were 36% lower and the average length of stay was 23% lower.

Such short- and long-term gains cannot be attained unless children and families are actively engaged early in treatment. Initial findings indicate that "Ready-Set-Go!," the engagement approach used in TST, is associated with high levels of treatment retention (Saxe et al., 2011). In a small, randomized controlled trial of traumatized youth (N = 20), 90% of TST participants were still in treatment whereas only 10% of "treatment as usual" participants remained at the 3-month assessment (Saxe et al., 2011). While preliminary evidence for the effectiveness of TST is promising, the initial RCT could not be completed since 90% of the treatment as usual sample did not complete treatment. Although the results of this study were encouraging about treatment engagement, no conclusions can be drawn about outcomes.

A large, clinical trial of TST has recently been completed in Kansas by the independent evaluation company Child Trends and demonstrated significant improvement in mental health status and foster care placement stability amongst the 1500 foster children whose care was evaluated (Murphy, et.al, 2017; Redd, et.al, 2017). Perhaps the most important finding in this 5-year evaluation – which was conducted with a rigorous quasi-experimental design but preserving the real-world complexity

and diversity of foster care settings – is that improvements in mental health outcome and foster care placement stability were strongly associated with adherence to TST fidelity standards by clinicians, case workers, case planners, supervisors, and foster parents. In collaboration with the Annie E. Casey Foundation, TST is now being adapted for foster care and implemented in public child welfare systems in Ohio and Maryland.

Application/Strategies

One critical strategy that we used in the development of TST was to create a model that is "disseminate-able" and that incorporates services that are available in most regions of the United States. TST is provided via a traditional multidisciplinary team that also possesses two unique members – a home-based clinician and a legal advocate. A second feature of TST that supports its successful adoption and implementation is that the model is fully operationalized in a published manual (Saxe et al., 2016), which is in line with other empirically supported, manualized, social-ecological models (e.g., Multisystemic Therapy; Henggeler, Schoenwald, Rowland, & Cunningham, 2002). Another feature of the TST model is the development of a treatment adherence approach to help ensure that treatment is delivered with sufficient fidelity. Specifically, fidelity is guided by adherence to a well-articulated approach to assessment, treatment planning, child and family engagement, and intervention centered around three phases of treatment, and is consistent with the notion of "flexibility within fidelity" to lead to a child-centered, individualized treatment approach (Kendall et al., 2008).

Clinical model implementation requires a clear conceptual underpinning to support not only organizational planning for specific agencies, but also strategizing for larger system change. As discussed in Chap. 1 of this book (Strand, 2018), the typical mental health stage-oriented approach aligns well with desired child welfare system outcomes. Child welfare outcomes of safety, permanency, and well-being are achieved by addressing the mental health stages of stabilization, integration, and consolidation. TST has provided a model that supports these system outcomes while providing a trauma-informed lens through which these goals can be realized.

Application of TST with Child Welfare Populations

The TST model and its framework has served to align with these goals while helping integrate mental health and child welfare service systems in various regions throughout the country, and in child welfare in Singapore. Two systems of note are the Ulster County TST NEXIS Program and the current work being done in the District of Columbia with the Department of Behavioral Health (the public mental

health system) and the Child and Family Services Administration (the child welfare system). These two projects share common implementation goals including:

1. System transformation, not simply organizational model fidelity
2. Involvement of all levels of agency staff in the planning, training, and implementation process for each of the departments
3. Focused, organizational planning processes:
   (a) To address larger, systemic issues
   (b) To focus on concrete model training and implementation including identification of all aspects of implementation and model sustainability including populations to be served, agency priority issues/goals to be addressed, program and operation components, as well as a focus on sustainable financing and data collection
4. Involvement of both child welfare and child mental health agencies based on the belief that a shared model, creation of common assessment tools and language, and staff cross-training would serve to improve outcomes
5. Emphasis on family and environment-based intervention and not simply child-focused intervention

Ulster County TST NEXIS Program

In 2004, the Ulster County Department of Mental Health along with the Department of Social Services and a not-for-profit agency in the county all joined forces to create what later became known as the TST NEXIS program. After months of organizational planning and leadership meetings, it was determined that the Child Welfare and Child Mental Health staff would become integrated into one TST team and would jointly collaborate with families from early assessment through TST phase-based intervention.

Ulster County's systemic shift was sought due to large mental health wait lists, extremely high mental health no show rates, long lengths of stay with little demonstrated treatment effectiveness, serving complex, chronically traumatized family systems, as well as mental health/child welfare collaboration challenges. It was determined that in order to support true system change, a common assessment, true cross training of child welfare and mental health staff, and integration of staff at the intervention level were all needed. TST was identified as the model to provide this joint training and support collaboration within this cross-pollinated team. Its focus on both psychotherapy and community-based intervention for families requiring more intensive service provision was seen as the ideal approach for the cross-system involved families for whom this team was being formed.

The organizational planning process involved months of cross system dialogue with local child welfare, mental health and not-for-profit agency administrators, supervisors and front-line staff. This atypical full-spectrum planning

process involved discussions about how to truly integrate a team of child welfare, mental health, and community case managers to support not only a common language, but to allow for true collaboration and intervention involving all levels of each discipline. The goal became creating a team, where in the context of discussing case material it would be indistinguishable who the mental health and child welfare worker was. In other words, the mental health worker would be versed in child welfare practice and the child welfare worker would be informed of mental health concepts and practice, using the TST model to infuse a common language to cross the typical silos This focus was in line with the system commitment to shift from a child pathology focused practice to a more family-focused intervention service system. Acknowledging the level of complex trauma inherent in the lives of the families this program was being created to serve, it was also clear that without intervention at the community-family level, there would continue to be little in the way of child effectiveness outcomes. The system administrators, supervisors, and front-line staff all articulated a desire to truly intervene at the family level by more effectively engaging families for who services had typically resulted in high no-show rates. This resulted in a more collaborative system and the TST model provided a vehicle for the system shift. This project has demonstrated positive outcomes (described above) that continue to this day Saxe, et. al., 2005.

District of Columbia Department of Behavioral Health (DBH) and the Child and Family Services Administration (CFSA)

In 2013, TST training began for the DC CFSA staff. DC had chosen TST as the model to help shift its focus to trauma-informed family intervention for children removed from their families of origin due to allegations of neglect and abuse. DC committed great resources to organizational planning and system efforts to revamp their concept of team meetings, collaboration with outside agencies, and internal planning for removed children. In 2015, due to recognition of the positive changes underway in the city's child welfare system, DC's mental health system committed additional resources to identifying a first cohort of DBH agencies to be trained in TST to create the beginning of a common model to support greater system collaboration. Two separate organizational planning processes occurred and a variety of multi-agency system integration meetings and regularly scheduled consultation calls occurred to address the larger system collaboration issues. Issues to be addressed included identification of a single trauma assessment tool for both the child welfare and mental health systems; referral processes between the respective systems; streamlining identification of model choice within the DC system; guidance around running joint team meetings; protocol development for communications between staff within the different service systems; and collaborative safety planning.

Staff at all levels within both systems have been integrally involved in this planning and implementation process. Given the complexity of the DC system, feedback from all levels has been pivotal in both planning and implementation.

The result is the beginning of an overall system shift. Cross-system collaboration and integration has begun to transform the system by providing a framework for case conceptualization as well as structuring the discussion around developing communication protocols between agencies and streamlining the referral processes. In real time, the result is that we are now beginning to see more joint agency planning as opposed to simply notifying each other of decisions each department has made. True joint treatment planning is the long-term goal and realizing this goal will require continued effort on the system front. However, there are now families who are currently benefitting from greater joint treatment planning while safety planning has begun to be more inclusive and involve both the CFSA and DBH staff in its development and ongoing monitoring. There are now families throughout the DC system where cross-system collaboration allows for more family engagement, more team strategizing, and utilization of a common language geared toward efficiency of service provision as well as a greater treatment planning focus for the families served.

These are but two examples of the way in which Trauma Systems Therapy is helping to shift the approach to child welfare service delivery across the USA and beyond.

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Chapter 7
Use of a Structured Approach to Assessment Within Child Welfare: Applications of the Child and Adolescent Needs and Strengths-Trauma Comprehensive (CANS-Trauma)

Cassandra Kisiel, Elizabeth Torgersen, Lindsey E.G. Weil, and Tracy Fehrenbach

Goal/Purpose of Intervention

Recognizing the range of trauma-related responses that may be manifested among children and adolescents in child welfare settings requires that we broaden the way we assess and monitor outcomes, and offer services to children and families. Providing a comprehensive assessment is a key step in identifying and determining how to best address the needs of traumatized children and families, as well as delivering trauma-informed services and interventions within child welfare settings. A comprehensive and trauma-informed approach to assessment gathers information across several key domains, including a wide range of trauma experiences; post-traumatic symptoms; complex trauma responses, including functioning across behavioral, emotional, interpersonal, cognitive, and physiological domains; caregiver functioning; and a range of strengths within both the child and caregiving systems (Cook et al., 2005; D'Andrea, Stolbach, Ford, Spinazzola, & van der Kolk, 2012; Kisiel, Conradi, Fehrenbach, Torgersen, & Briggs, 2014). In addition to assessing the range of symptoms or functional difficulties, strengths and protective factors are equally important to identify. Strengths are essential to the service/treatment planning and service delivery process, yet they may not be captured consistently through routine assessment (Bell, 2001; Griffin, Martinovich, Gawron, & Lyons, 2009; Kisiel, Blaustein, Fogler, Ellis, & Saxe, 2009).

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The current authors have proposed guidelines for implementing a comprehensive trauma assessment approach (see Kisiel et al., 2014). In addition to assessing a range of key domains, other important aspects include gathering information from multiple perspectives or informants; utilizing a range of assessment techniques; assessing child and caregiver needs and strengths over time; and translating and integrating assessment findings for use in practice (see Kisiel et al., 2014). The use of a standardized, evidence-informed assessment approach to guide and support trauma-informed services and practice in the child welfare system still remains an important area of need (Kisiel et al., 2009, 2014).

The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose assessment tool that can be used in many capacities, depending on the needs of a particular child-serving system. The CANS addresses some of the existing challenges of assessment within child welfare through supporting clinical decision making, including level of care and placement decisions; linking the findings of the assessment directly to individualized service and treatment plans; engaging family members in the assessment process; and facilitating the planning and evaluation of service systems (Lyons, 2009). Several versions of the CANS have been developed or adapted for use within particular states or child-serving systems. The CANS-Trauma Comprehensive version (or CANS-Trauma), which will be highlighted here, was designed to be applicable in a range of service settings, with an emphasis on assessing the broad range of difficulties exhibited by traumatized children and their caregiving systems; assessing strengths or contextual factors and systems that can support a child's adaptation from trauma; and supporting and guiding trauma-informed and strengths-based treatment and service planning for children and adolescents with exposure to trauma (Kisiel et al., 2009). While several child welfare systems have adopted the CANS-Trauma (or another version of the CANS that includes trauma items, such as the CANS Comprehensive), other systems utilize a version of the CANS that contains a more limited number of trauma items. While different CANS versions are used across child welfare systems, this chapter focuses on the CANS-Trauma and its "ideal" use, given its relevance to trauma-informed, child welfare practice. That being said, while the CANS also represents an overarching assessment approach and framework, there are certain components that apply to all versions of the CANS. Therefore, in addition to highlighting specific features of the CANS-Trauma, there will also be some reference to the CANS more broadly.

This chapter also addresses the use of the CANS-Trauma in the context of trauma-informed, child welfare practice, overviewing how its use aligns with the key child welfare outcomes of safety, permanency, and well-being. For example, the use of the CANS fosters safety and stabilization by identifying and addressing prior and ongoing trauma exposure; permanency is supported by assessing the range of trauma-related needs and translating this information with caregivers and youth; and well-being is facilitated by reinforcing strengths and strengths-based planning with children and caregivers to enhance secure attachment with caregivers and through engagement with families and caregivers in the assessment process. These areas are elaborated further below.

Description of Intervention or Service

Population Served

Overall, the CANS tools (including the CANS-Trauma) are among the most widely used tools within child-serving systems across the country, including child welfare, mental health/behavioral health, juvenile justice, and early intervention programs. Within child welfare, the CANS is used in many capacities, including as a comprehensive assessment when children come into care; as a guide for service or treatment planning; to support decision making in intensive community-based services, treatment foster care, residential treatment, or outpatient treatment for youth in foster care; or to identify service (including trauma-related) needs early on in preventive or intact services (Anderson, Lyons, Giles, Price, & Estes, 2003; Lyons, 2009). The CANS tools, including the CANS-Trauma, are currently implemented at some level within all 50 states (with some applications in one or more child-serving settings) and specifically within child welfare in 24 states (with either statewide implementation or targeted applications). Specific versions of the CANS have been developed or adapted to meet the needs of special populations and various state systems. In addition to the adaptation for traumatized youth and families, these include CANS versions for juvenile sexual offenders, commercially and sexually exploited youth, complex medically ill youth, and early childhood populations (Cornett & Podrobinok, 2009; Hunter & Cruise, 2009; Huyse et al., 2009; Kisiel et al., 2009; Lyons, 2009).

Staff Qualifications

Training on the CANS tools is needed to build knowledge and skill in its effective and reliable use (Lyons, 2009). This is particularly essential given that the CANS requires a unique way of assessing individuals and families, and utilizing this information in practice is a key part of the process as described below. Further, since the CANS is a provider-report tool, training and certification (either in-person or online) is required in order to ensure an accurate understanding of the tool and its effective use. Certification on the CANS requires completing a test case vignette with a reliability of at least 0.70, in comparison to the "preferred scores" of CANS experts. Annual recertification on the CANS is also required (Lyons, 2004). These requirements are the same for the CANS-Trauma as well as any other version of the CANS that is utilized. Additional steps to support training and effective usage of the CANS include audit processes conducted by reviewing other sources of information on a given case to calculate reliability; and supporting meaningful usage of the tool at various levels of a system, involving monitoring and improving applications at the level of the individual child/family, the supervisor, and program management (Center for Child Trauma Assessment and Service Planning [CCTASP] & Family-Informed Trauma Treatment [FITT] Center, 2015; Kisiel & Fehrenbach, 2014; Lyons, 2009).

For the CANS-Trauma in particular, an online training course is available to offer initial training and certification (see www.canstraining.com). The online or in-person CANS-Trauma training provides a preliminary overview on the impact of childhood trauma and the effects of complex trauma; however, to ensure the most effective usage of the CANS-Trauma, it is also recommended that staff receive more extensive training or follow-up consultation on the impact of child trauma and strategies to support trauma-informed practice in child welfare settings. Implementation support and ongoing monitoring are also recommended as, much like other intervention approaches, CANS implementation is an ongoing process and, therefore, one-time training is insufficient (Kisiel & Fehrenbach, 2014; Lyons, 2009). For the CANS-Trauma, this process has included advanced trainings (also referred to as CANS-Trauma application trainings), monthly consultation calls, and collaborative meetings to support the use of the CANS-Trauma as part of the assessment process or in relation to service or treatment planning. This process of follow-up consultation and ongoing support has proven effective based on recent initiatives, including a national Breakthrough Series Collaborative (BSC) focused on the meaningful use of the CANS-Trauma and FANS-Trauma (Family Assessment of Needs and Strengths) tools in practice with youth and families (CCTASP & FITT Center, 2015; Kisiel & Fehrenbach, 2014).

As far as educational requirements, those with a bachelor's degree can learn to complete the CANS-Trauma reliably, as with other versions of the CANS. However, as noted above additional training and consultation/support on child trauma would be highly beneficial to enhance the effective use of the CANS-Trauma in practice. For instance, when rating and interpreting information on the more clinically focused domains or items of the CANS-Trauma (e.g., Traumatic Stress Symptoms), master's level education or training in clinical practice or supervisory support may be useful for bachelor's level child welfare staff, so they are better able to interpret these items for family members or use CANS information more effectively in practice (Hirsch, Elfman, & Oberleithner, 2009).

How Is the CANS Trauma-Informed?

The trauma version of the CANS was developed in conjunction with partners from the National Child Traumatic Stress Network (NCTSN), a congressionally established and federally funded initiative. It was developed to provide a comprehensive assessment that captures the range of potential trauma experiences to which children may be exposed, responses to these trauma experiences across several domains or areas of functioning, and relevant contextual factors for youth exposed to trauma. The initial trauma version of the CANS—originally called the CANS-Trauma Exposure and Adaptation version (CANS-TEA)—was developed over a decade ago for use within trauma-focused, clinical settings and was designed to address an existing gap in comprehensive, trauma-informed assessment. While several measures already existed to assess different aspects of trauma-related responses

(e.g., trauma exposure, PTSD symptoms, other mental health symptoms/needs, functional outcomes, strengths), there was not one measure to capture the broad range of trauma experiences, trauma-related needs and strengths for youth as well as caregivers. The CANS-TEA was developed in order to meet the need for a comprehensive trauma assessment tool that would capture all of this relevant information in one place and that was straightforward and easy to use for a range of providers (Kisiel et al., 2009). This trauma version has since been updated to the CANS-Trauma Comprehensive (Kisiel, Lyons, et al., 2013), based on feedback from child trauma experts and practitioners, to include additional content that more fully reflects the broad range of potential child trauma responses. The unique contribution of the CANS-Trauma is the inclusion of the Trauma Experiences and Traumatic Stress Symptoms domains in the context of a broader mental health assessment, as described more fully below.

There are also several areas of trauma-informed practice that the CANS-Trauma is designed to support. In brief, these include gathering information on the complex reactions of the child and caregiver to trauma; identifying strengths and protective factors within the child and caregiving context; organizing clinical and case information from multiple sources; guiding trauma-informed treatment and service goals; supporting youth/caregiver/family engagement and collaboration; assisting the clinical decision-making process; facilitating appropriate referrals to services; selecting and sequencing appropriate evidence-based, trauma-focused interventions; monitoring outcomes to inform changes to interventions if needed; and communicating about child/caregiver needs across multiple stakeholders and systems. These features are described in further detail below in relation to the "practice components" of the CANS (CCTASP & FITT Center, 2015).

Program Components

The CANS-Trauma is a tool that is designed to support trauma-informed practice and other practice efforts in a range of service settings. The CANS-Trauma includes 110 items and is comprised of eight primary domains: Potentially Traumatic/Adverse Childhood Experiences (or "Trauma Experiences"), Symptoms Resulting from Exposure to Trauma or Other Adverse Childhood Experiences Domain (or "Traumatic Stress Symptoms"), Child Strengths, Life Domain Functioning, Acculturation, Child Behavioral/Emotional Needs, Child Risk Behaviors, and Caregiver Needs and Strengths. In addition, there are two optional age-related domains: Ratings of Children Five Years and Younger (to assess developmentally specific needs), and Transition to Adulthood (for children over the age of 17, to assess for needs related to independent living). As noted above, the CANS-Trauma is designed to provide a structured assessment of these relevant domains, providing information that is immediately relevant for trauma-informed practice efforts. For most CANS domains, ratings reflect current needs (within the past 30 days). Two exceptions include the Trauma Experiences domain (based on lifetime experience)

and items in the Child Risk Behaviors domain (which account for either historical behaviors or actions and more recent actions, such as the past 7 days or past 24 h).

Items in the Trauma Experiences domain assess for lifetime exposure to a range of acute and chronic traumatic events. These items were developed to parallel the broad range of traumatic events recognized by the NCTSN. The Traumatic Stress Symptoms domain assesses PTSD reactions (e.g., avoidance, re-experiencing) as well as more complex trauma reactions (e.g., affect dysregulation, dissociation). The needs domains on the CANS (listed above) include childhood behavioral/emotional problems (e.g., attention, depression, anxiety, attachment); problems in day-to-day functioning (e.g., school, social, developmental); behaviors that put the child or others at risk of harm (e.g., suicide risk, self-harm, delinquency); culturally related needs (e.g., language, ritual); and developmentally specific needs for young children and adolescents (e.g., motor, communication, independent living skills). The CANS-Trauma was designed as a tool to address a broader range of responses to trauma across several domains, given that many traumatized children manifest mental health symptoms, risk behaviors, and functional difficulties, either in addition to or instead of typical PTSD symptoms. This range of complex responses need to be assessed more carefully as potential responses to trauma (Cook et al., 2005; van der Kolk, 2005). Therefore, it is important for providers using the CANS to understand that many items across the CANS needs domains may also be impacted by trauma.

Further, a unique feature of the CANS-Trauma is that it assesses the needs and abilities of the child's identified caregivers, as well as a comprehensive range of both child and caregiver strengths. The CANS-Trauma includes 11 child strength items (e.g., talents, spiritual, family) and several others for the caregiver (e.g., resources, knowledge), helping providers see the broad range of competencies in the child and caregiver that may contribute to a child or family's resiliency. This information can be readily utilized when developing strengths-based service or treatment plans. These domains and items are intended to be useful and meaningful to the child and family as they understand the types of services that are needed and how existing strengths can be used or built to support intervention processes, as well as a child and family's recovery from trauma. See Table 7.1 for a complete list of all CANS-Trauma domains and items.

The CANS-Trauma scoring system is easy to understand and designed to be directly relevant to practice. All items on the CANS-Trauma are scored on a four-point scoring system. (0–3 scale) according to two criteria: the degree of need (or strength), and the degree or urgency for intervention. Lower scores indicate better functioning; however, the meaning of the score differs slightly for strengths versus needs items. Scores of 0 on the strengths items indicate a strength that is well-developed, or a centerpiece strength; a score of 1 indicates a useful strength; a score of 2 indicates an area of potential strength; and a rating of 3 suggests no evidence of a strength. For needs items, a rating of 0 indicates no evidence of a difficulty or problem; a 1 indicates a mild degree difficulty or an area that may be emerging as a need (or an area where more evidence is needed); a 2 indicates a moderate degree of difficulty; and a 3 is severe difficulty or impairment in a given area. The CANS-Trauma, like all CANS tools, has a manual that provides a description and examples

Table 7.1 CANS-Trauma Comprehensive: Domains and items

Trauma experiences	**Life functioning**
Sexual abuse	Family
Physical abuse	Living situation
Emotional abuse	Social functioning
Neglect	Developmental/intellectual
Medical trauma	Recreational
Witness to family violence	Legal
Community violence	Medical
School violence	Physical
Natural or manmade disasters	Sleep
War affected	Sexual development
Terrorism affected	School behavior
Witness/victim to criminal activity	School achievement
Parental criminal behavior	School attendance
Disruptions in caregiving/attachment Losses	**Acculturation**
Traumatic stress symptoms	Language
Adjustment to trauma	Identity
Traumatic grief	Ritual
Reexperiencing	Culture stress
Hyperarousal	**Child behavioral/emotional needs**
Avoidance	Psychosis
Numbing	Attention/concentration
Dissociation	Impulsivity
Affective and/or physiological dysregulation	Depression
Child strengths	Anxiety
Family	Oppositional behavior
Interpersonal	Conduct
Educational setting	Substance abuse
Vocational	Attachment difficulties
Coping and savoring skills	Eating disturbances
Optimism	Behavioral regressions
Talent/interests	Somatization
Spiritual/religious	Anger control
Community life	
Relationship permanence	
Resilience	

Child risk behaviors	**Transition into adulthood**
Suicide risk	Independent living skills
Non-suicidal self-injury	Transportation
Other self-harm	Parenting roles
Danger to others	Intimate relationships
Sexual aggression	Medication compliance

(continued)

Table 7.1 (continued)

Runaway	Educational attainment
Delinquency	Victimization
Judgment	Job functioning
Fire setting	**Caregiver needs and strengths**
Intentional misbehavior	Physical health
Sexually reactive behaviors	Mental health
Ratings of children 5-years old and younger	Substance use
Motor	Developmental
Sensory	Supervision
Communication	Involvement with care
Failure to thrive	Knowledge
Feeding/elimination	Organization
Birth weight	Resources
Prenatal care	Residential stability
Substance exposure	Safety
Labor and delivery	Marital/partner violence
Parent of sibling problems	Caregiver Posttraumatic reactions
Availability of primary caregiver	
Curiosity	
Playfulness	
Temperament	
Day care preschool	

of behaviors or responses that would suggest different scoring levels for each item. The examples in the manual are not exhaustive, however, and for this reason the CANS scoring system also incorporates "actions levels" that help providers choose the most accurate score for each child and family (whether or not their presentation matches the example provided in the manual). For example, scores of 2 and 3 on need items are considered "actionable" which means these needs require some level of service or intervention to address and resolve the difficulty (e.g., with immediate or intensive action or intervention for a score of 3). These needs can be translated into a service or intervention plan or used to highlight an area that would need to be monitored or watched closely, despite not needing immediate intervention (e.g., this is referred to as "watchful waiting" and indicated in a score of 1). Scores can be considered separately for each area of need or strength when developing service or treatment plans, or scores may be summed to reflect cumulative difficulties in a particular area or domain (e.g., Trauma Experiences, Child Strengths); however, the CANS does not provide a total or overall score.

While in certain cases, the CANS-Trauma ratings are intended to capture the severity of needs or symptoms that may be associated with particular diagnoses, the CANS-Trauma is not a diagnostic tool. The CANS, however, is designed to be consistent with diagnostic language. For instance, examples of clinically significant symptoms or criteria from particular diagnoses are often included as part of the item

descriptors for items in the Behavioral/Emotional Needs domain (e.g., psychosis, oppositional behavior, depression, anxiety).

A unique feature of the CANS-Trauma (along with all other CANS tools) is that it is embedded within a framework referred to as Transformational Collaborative Outcomes Management (TCOM). Broadly, this framework expands traditional outcomes management to a multi-level (i.e., case, program, and system-wide) practice/systems management strategy (Lyons, 2009). The measurement approach of CANS-Trauma (and other CANS tools) is distinct from other psychometric tools in that it emphasizes assessment that has communication value and practical relevance in service delivery settings (e.g., decision support, resource management, and quality improvement). This framework is designed to unify and focus complex child-serving systems on the most essential shared vision—improving the lives of the children and families served. An overarching goal of TCOM is to facilitate the process of truly understanding the needs and strengths of the youth and families that are being served (McGill, 2015). For more information about the TCOM framework, and the communication theory behind the CANS, please see Lyons (2009).

In addition to these components described above, the CANS-Trauma and other CANS tools have demonstrated good measurement properties overall, including good reliability (internal consistency and inter-rater) and validity (Kisiel et al., 2009, 2016; Lyons, 2009). The CANS is also reliable at the item and domain level, which allows for continued adaptation of the tool while still maintaining its integrity (Lyons, 2009). Validity is also demonstrated with the CANS tools and their relationship to level-of-care decisions and other constructs that it is intended to assess (e.g., traumatic stress symptoms, mental health needs, risk behaviors) (Kisiel et al., 2016; Lyons, 2009). These properties of the CANS suggest that it can be used as a reliable and valid, and structured tool in the context of child welfare settings. It is also widely used and established across many child-serving systems.

The components and properties of the CANS outlined above serve as a foundation for the integration and use of the CANS more effectively in practice. In addition to the overarching framework, domains and measurement components of the CANS-Trauma, the *trauma-informed practice components* of the CANS are described below. Note that these practice components are described primarily in terms of the individual-level applications of the CANS (versus systems-level applications) in order to support child welfare providers' usage of the tool in a structured manner in direct practice.

CANS-Trauma Practice Components, Competencies, and Strategies

As noted above, the use or translation of assessment information into trauma-informed practice remains a largely unaddressed issue across child- and family-serving settings. To address this challenge, "meaningful use" of the CANS-Trauma can be considered a conceptual framework for outlining practice components and

competencies that are crucial for integrating the assessment process as a key part of child welfare practice. Recently, a national Breakthrough Series Collaborative (BSC) focusing on meaningful use of CANS-related tools with youth and families identified key skills or competencies for caseworkers and clinicians in relation to several areas of practice (CCTASP & FITT Center, 2015). These examples are highlighted below in relation to key CANS-Trauma practice components.

Use of the CANS-Trauma as a Comprehensive Assessment and Information Integration Strategy

As described above, the CANS-Trauma is considered a comprehensive assessment tool and strategy with the capacity to integrate information from multiple sources on a range of key domains related to needs and strengths. This addresses an important need in the field in terms of gathering an abundance of relevant information and integrating it for use in practice. This includes information on a range of complex reactions to trauma and caregiver-related needs that may impact a parent/caregiver's ability to support a child in his/her recovery from trauma. The CANS is also unique in identifying a range of strengths and protective factors within both the child and caregiving context, which other tools do not do in as comprehensive a manner.

Another distinctive feature of the CANS-Trauma is that it is designed as an information-integration tool. In other words, providers can synthesize, integrate, and consolidate information from several other sources when making CANS ratings (e.g., clinical interviews, other standardized measures, behavioral observations of child and family, collateral interviews, review of case files, and clinical judgment). This offers child welfare providers the ability to gather clinical and case information related to multiple domains and document it in a single measure for use in planning. While it is often recommended that varied techniques and tools are used to gather information for a comprehensive trauma assessment (Conradi, Wherry, & Kisiel, 2011; Kisiel et al., 2014), this can also create a burden for staff required to administer multiple tools which may not be readily applicable to clinical practice. The CANS-Trauma is intended to help reduce some of these burdens, as it is designed to incorporate and translate information from a range of sources with a scoring system that is easy to understand and translate. Therefore, it is designed to yield information that is directly relevant to practice.

Use of the CANS to Support Trauma-Informed Service and Treatment Planning

Once all of the relevant information on the child and family is gathered and integrated, using the CANS-Trauma to support the service or treatment planning process becomes the next critical step. As mentioned above, the CANS-Trauma includes a

straightforward rating scale for each item that readily translates into "action steps"; as such, each item on the CANS-Trauma suggests different pathways for treatment or service planning. The CANS-Trauma item-level scoring system also identifies the level of severity of symptoms or degree of strengths, which allows for ease of use by caseworkers when prioritizing specific needs and strengths as they formulate service plans.

The CANS-Trauma has been applied in the context of treatment or service planning in meaningful ways across different settings. For instance, scores on the CANS across different domains can help to drive and inform the service goals and recommendations. When using the CANS-Trauma in service planning, it is essential that all items scored as a 3 in any of the needs domains be included in the service plan. All items scored as 2 should also be incorporated into service goals and plans. However, when a large number of items that are scored at the level of 2 or 3 exist, it is beneficial for the caseworker to work together with the family to ascertain which needs can be grouped together when forming service goals and plans. Therefore, a useful strategy in creating trauma-informed service/treatment plans with families involves grouping together CANS-Trauma items in meaningful ways to create targeted goals and using a trauma framework to inform these goals. In this regard, guidelines have been developed to support these efforts of providers when developing trauma-informed plans with the CANS (see below under Strategies and Resources for further details). An additional step that may also be used when developing service goals involves identifying specific needs on the CANS-Trauma that may be connected to specific areas of strength; strengths that need to be built may also be identified in the context of the plan (Caliwan & Furrer, 2009). Family members will ideally be engaged throughout this process in the development of collaborative service or treatment plans as described below.

Finally, CANS-Trauma ratings also enable providers to measure child and family progress in conjunction with existing, as well as new areas of need that may emerge over time, helping maintain the service plan as an active process. For instance, some systems describe how the CANS-Trauma can serve as a "check and balance" system, considering the range of areas of need and strength that are rated "actionable" on the CANS and ensuring they are incorporated and addressed in the plan in some manner. This can be accomplished by working closely with both the family and other providers as needed (e.g., supervisor) prior to and during the service planning process. This also enables providers to establish goals and benchmarks based on CANS ratings that can be evaluated over time in conjunction with services that are offered (Hunter & Cruise, 2009) to ensure that needs are decreasing and strengths are increasing based on the goals outlined in the service or treatment plan.

One of the key steps in using the CANS-Trauma in trauma-informed service or treatment planning efforts is offering trauma-informed training and consultation in conjunction with CANS-Trauma training. This integration of trauma training with CANS training and certification can be used to help providers "connect the dots" between trauma experiences and the range of trauma reactions, help providers to identify potential triggers for these reactions, and support providers in developing trauma-informed service and treatment plans and intervening effectively with

families to potentially prevent more serious outcomes over time (Kisiel & Fehrenbach, 2014; Kisiel, Fehrenbach, Small, & Lyons, 2009). To competently use the CANS-Trauma in trauma-informed assessment and service/treatment planning efforts, caseworkers and other providers can build skills in the following areas:

- Training and certification on use of the CANS-Trauma tool
- Building basic (at minimum) knowledge in understanding trauma and its effects on children and families, and skills to address these needs through use of trauma-informed practices in the context of service delivery
- Gathering comprehensive assessment information on a range of trauma-related needs/strengths using multiple sources and types of information and perspectives
- Making sense of the information gathered by the CANS-Trauma to inform the case conceptualization process
- Documenting and utilizing information from the CANS-Trauma (including scores or summaries) to inform treatment/service goals and plans, and reviewing these plans in the context of supervision
- Recognizing and supporting caseworker's emotional reactions or secondary traumatic stress that may arise in the context of the assessment process

Use of the CANS-Trauma in Family Engagement

In recent years, an enhanced focus has been placed on strategies to engage youth, caregivers, and other family members through the assessment process (Kisiel et al., 2014). "Assessment translation" is a term that has been adopted to describe how assessment information can be used in meaningful ways in practice, with family members and other providers (Kisiel et al., 2014). Despite the value of this approach, however, sharing assessment information with youth and families may not be done on a consistent basis as part of the intervention process. The CANS-Trauma can lend itself to meaningful use with youth and caregivers in particular, given that it is generally well-regarded as easy to use and understand, offers information on contextual variables and child/family strengths, and provides a structure that is directly relevant for families (e.g., action levels with direct relevance to intervention planning). Furthermore, the CANS and TCOM approach is designed to help guide and support youth, caregiver, and family engagement and collaboration (CCTASP & FITT Center, 2015). Throughout the process of assessment and service/treatment planning, family members (both caregivers and youth, as appropriate) are ideally engaged as key partners in this process from the outset. Caseworkers can accomplish this by identifying and developing "collaborative" service or treatment goals and plans with family members; adjusting goals/plans as needed based on new information identified; and reviewing progress toward these goals with family members over the course of service delivery.

In order to effectively use the CANS-Trauma in the process of youth and family engagement, the following areas of skill or competency are recommended for caseworkers or other child welfare professionals:

- Facilitating initial and ongoing engagement by being transparent with family members from the beginning—explaining the purpose of the CANS-Trauma tool and how it will be used in the context of services and how it may inform decisions about services
- Offering trauma-informed psychoeducation through use of the CANS-Trauma—by developing a shared understanding about the effects of trauma with children and families through reviewing CANS-Trauma scores and summaries, and helping families make sense of child/caregiver needs across domains in relation to trauma experiences
- Sharing CANS-Trauma assessment feedback and results with families and engaging them as partners in collaborative service or treatment planning efforts
- Sharing progress toward goals and changes in needs and strengths over time with family members and making adjustments as needed in collaboration with families

Use of the CANS-Trauma in Provider- and Systems-Level Collaboration

The CANS-Trauma is also a helpful tool to support communication and trauma-focused planning across the various providers and service systems involved in a child and family's care. The CANS-Trauma is purposefully "simple" in design and in its scoring system in order to facilitate communication between providers across settings. For instance, different providers working with a given family are encouraged to collaborate in completing the CANS-Trauma as appropriate, as certain providers will have more in-depth knowledge in particular areas (e.g., if the child/youth is in mental health treatment, a therapist may have more knowledge regarding traumatic stress symptoms). Within a given system, the CANS-Trauma is also designed to support trauma-informed planning and communication about a particular child/family by sharing the progress made by a child/family as well as persisting areas of need through the easy-to-translate scores on the CANS. The CANS-Trauma can also support multidisciplinary team discussions and communication across systems that a child/family may be involved in by creating a common language in order to ensure everyone accurately understands the needs of the child and family. An important part of this process also involves using the CANS-Trauma as a communication strategy for educating family members and other systems (e.g., schools, juvenile justice settings) about the potential role of trauma in relation to the child's range of needs, as well as using the CANS to inform recommendations or referral to particular services, and to advocate for trauma-informed services that will address these needs.

To competently use the CANS-Trauma in systems-level collaboration, caseworkers and other providers may build skills in several areas:

- Joint completion of the CANS-Trauma or sharing CANS results across different providers and systems to support collaboration and transparency
- Agency provision of support and time for meaningful assessment, including use of supervision time to support the CANS-Trauma and its effective use
- Organizational support and training offered on use of the CANS-Trauma to support collaboration and trauma-informed practice with family members and other providers
- Organizational support, guidance, and consultation on strategies for using the CANS-Trauma to support trauma-informed interventions based on the needs/strengths of youth and families
- Using CANS-Trauma assessment results for monitoring improvements, informing supervision, and guiding systems planning, resource allocation, and effectively meeting the needs of youth and families

Strategies and Resources to Support Development of Competencies and "Meaningful Use"

Organizations across the country have utilized strategies to encourage staff and provider development of the practice components and competencies listed above. Many of these training strategies in particular derive from the national BSC on the meaningful use of the CANS and FANS-Trauma. These include incorporating "meaningful use" language and concepts into basic and advanced CANS-Trauma trainings, including topics such as youth/family engagement practices; understanding child trauma/complex trauma reactions; reflective supervision to address secondary traumatic stress; and using CANS-identified strengths more effectively in planning efforts. These organizations have developed innovative training efforts, including role play exercises (such as a family engagement role play that encourages multiple viewpoints on the trauma-informed assessment process in practice), as well as clinical/casework vignettes that illustrate specific aspects of meaningful use (such as use of the CANS-Trauma in supervision).

Several resources have been developed to support the use of the CANS in trauma-informed practice efforts, including use with providers and family members (see cctasi.northwestern.edu; CCTASP, 2015). These include guidelines for a step-by-step approach to using the CANS-Trauma in trauma-informed treatment/service planning; a tip sheet for use of the CANS in engaging youth and families; a resource on "creative applications" for use of the CANS across different provider roles; videos demonstrating family and youth engagement, and modeling trauma-focused psychoeducation with the CANS; and examples of "family friendly" CANS data reports. While these resources were designed for use with the CANS-Trauma version, they can also be usefully applied with other versions of the CANS that

incorporate trauma items or modules. The development of additional resources is also encouraged by agencies/programs to support meaningful use of the CANS-Trauma in practice. Some have found it helpful to supplement the CANS with visual representations of domains and/or scoring systems to make the assessment and assessment translation process more family- and youth-friendly. Others have found utility in creating a "family-friendly" brochure for introducing the CANS to families. Still others have also found utility in integrating the CANS with trauma-informed clinical interventions, by "mapping" CANS items/domains onto treatment components (e.g., Attachment, Self-Regulation, & Competency; ARC; Blaustein & Kinniburgh, 2010). Resources (e.g., scoring templates, visual scoring systems) have also been developed to facilitate this integration of the CANS-Trauma in practice in the above areas.

Additional CANS-Trauma Applications in Practice

Providers and agencies across the country effectively utilize CANS data (from the CAN-Trauma and other tools) for reporting purposes at an individual youth/family or aggregate level. For instance, a family-friendly "change report" of a youth's CANS strengths and needs may serve as an effective family engagement tool. For agencies or programs, reporting on aggregate and/or longitudinal CANS outcome data may be helpful for "making the case" and demonstrating an empirical basis for compliance reporting, other statewide reporting mandates, program evaluation, or seeking additional funding. Technological advancements in data management/warehousing can make this process more efficient and feasible.

An additional application of the CANS used across several states is the creation of provider peer groups to support the reliable, effective, and innovative use of the CANS in practice. For instance, CANS Super User groups (which are implemented across several states) often represent a cross-section of several different child welfare or behavioral health providers representing various roles and agencies. These groups typically meet on a regular basis to support CANS usage and implementation. Strategies and lessons learned for clinical, casework, supervisory, and administrative applications of the CANS are shared, and networking relationships across agencies are facilitated for ongoing support.

How Does the CANS-Trauma Advance Cultural Competency?

Assessment within the context of child welfare can be complex for numerous reasons, including the need to recognize and honor the variety of cultures and subcultures represented by the families that come into contact with the system. These include differences in class, race and ethnicity, sexual orientation, family composition, religion, and physical, emotional and developmental capacities. Assessment

approaches used within this context need to be sensitive to the diversity of needs and strengths of the population they serve.

The structure, administration, and content of the CANS-Trauma make it a useful tool within diverse settings. The simple scoring system paired with the action levels, for example, is an approach that can be easily explained and understood by those with little formal education, or those who may not speak English as their first language.

Experts have highlighted the need not only to respect differences in cultural beliefs and practices but also emphasize the benefits of conducting assessments in a family's native language when possible (Kisiel et al., 2014). As a result, the CANS-Trauma manual and scoring sheet have both been translated into Spanish. Likewise, providers who are more comfortable in Spanish can now receive online CANS-Trauma training in Spanish (available at www.canstraining.com).

The flexible administration approach inherent to the CANS-Trauma (along with other CANS tools) also lends to its cultural sensitivity. The tool is administered without the strict interview schedule used by many other comprehensive assessment tools. In fact, it is common for caseworkers or other providers to gather information to complete aspects of the CANS-Trauma during their standard clinical interview or through conversation with the family. By having the flexibility to begin with any domain on the CANS, there is the opportunity to build rapport with items that may be "easier" for a given child or family (e.g., the Strengths domain). This allows for a more natural "give and take," as the assessor can score the CANS as the family transitions the conversation from one subject to the next.

The CANS-Trauma Acculturation domain assesses child needs related to cultural identity and expression, assessing for opportunities the child may or may not have to engage in cultural practices. It also assesses how well a particular child welfare placement setting (e.g., foster home) may be supporting the child's specific cultural needs and strengths. When such culturally specific items are not included in an assessment, these important areas related to a child's overall well-being can be inadvertently overlooked. Likewise, using a tool like the CANS-Trauma may give providers an opportunity to open up necessary, but sensitive, conversations about difficult issues like race and ethnicity at the beginning of services, a practice that can ultimately break down barriers that might otherwise inhibit trust and rapport.

Challenges to CANS-Trauma Implementation

Like any assessment approach, there are issues to keep in mind when using the CANS-Trauma as part of a comprehensive assessment strategy. Depending on the training approach that is taken, some challenges may exist. Certain large-scale, statewide training efforts have focused primarily on staff training and certification on the CANS without a sufficient emphasis on follow-up implementation support.

Learning to reliably score the CANS is a necessary and important first step; yet, as previously noted, new CANS users benefit most when they are provided with ongoing training and support in the actual application of the measure in practice. Without this continued support, caseworkers and other providers across many systems may find less value in the tool. It is also possible that use of the tool without sufficient ongoing support and supervision could be less accurate or effective. For example, if staff do not receive adequate training and/or support on administering the more clinical or trauma-specific items on the CANS-Trauma (e.g., Traumatic Stress Symptoms), their own discomfort while discussing any of these items with children and families may reduce the validity of the information and decrease the opportunity for engagement, collaboration, and psychoeducation. Further, the CANS-Trauma is designed to incorporate and integrate information from multiple sources—caregivers, youth, teachers, case files, and other providers working with the youth. Therefore, completing the first CANS on a given youth may require a significant amount of time initially, with the idea that this initial time commitment will help to enhance collaboration and increase the possibility of the caseworker, family members, and other providers having a shared perspective of the case from the start, which leads to a more informed service plan; this allows for transparency with regard to the recommended services and other key decisions made in the life of a case. Thus, one implementation challenge of the CANS approach is the time required of providers from the outset, in order for the assessment process to have maximum benefit. Yet, gaining a broader understanding of the child and family, despite the time involvement, is intended to ultimately improve the quality of services for children and families.

Another potential implementation challenge is helping staff at all levels of a system understand the value of the CANS-Trauma, how it is different from other commonly used measures, and how it was designed to enhance real-world practice. The CANS tools are not designed as traditional psychometric tools and do not offer a total score or clinical cutoff score, such as tools designed for use in research, but rather serve as a communication strategy. Additionally, the CANS allows for a certain degree of "subjectivity" in its scoring. For instance, the person completing the CANS-Trauma may at times receive inconsistent or even contradictory information from various sources regarding a child's functioning in a particular area. These instances require the clinical judgment of the caseworker or clinician to determine the most accurate rating.

Finally, as is the case with any trauma-informed assessment approach that requires providers to discuss trauma experiences and reactions with families, it is possible that caseworkers themselves may experience secondary traumatic stress. Thus, when completing the CANS-Trauma with children and families, it is important for caseworkers to be trained and supported in attuning to their own potential secondary traumatic stress reactions and related self-care strategies to support them in their work.

Evidence for Success

One of the strongest pieces of evidence for the effectiveness of the CANS tools is that different versions of the CANS have been widely adopted across multiple child-serving systems and are used in various ways across every state in the U.S. While the CANS-Trauma is a relatively newer version of the CANS (with the updated version developed in 2013), research and evidence to support the success of the CANS-Trauma is still in its early stages. That being said, the CANS-Trauma has been shown to effectively guide service planning and placement decisions to support youth and families involved in child welfare as described above. Using the CANS-Trauma in practice can offer a structured and successful way for providers to engage youth and families in order to foster collaborative relationships and support the intervention process. Further, utilization of the CANS-Trauma can ultimately bolster the three pillars of child welfare: safety, permanency, and well-being, both at the individual and at systems levels.

The CANS-Trauma provides an effective way of engaging youth and families in the service delivery process. This upfront engagement enables collaboration between service providers and the family, which is an aspect of care that is desired by and beneficial to caregivers. Initial qualitative data collected from both birth and foster parents indicated a unanimous desire to be involved in the assessment process, but confirmed that oftentimes the CANS, like many other assessment instruments, are completed without the caregiver's knowledge or involvement. For instance, sharing the CANS manual and scores with the family, and offering to complete the tool together, can facilitate a more comprehensive understanding of the youth and caregiver's strengths and needs for both the family and provider. Additionally, this process demonstrates to families that their input is both needed and respected, but it is also being utilized to inform service recommendations. Further, qualitative feedback indicates that caregiver involvement in the CANS assessment process offers them increased insight into the needs and strengths of youth, so that they are better able to support their children in care (N. St. Jean & L. Davis, focus groups, March 17/April 9, 2015).

In the national BSC focused on the meaningful use of the CANS-Trauma and FANS-Trauma with youth and families, child welfare and mental health agencies sought to enhance their use of these tools with families. Data from participating teams demonstrated that family engagement strategies used during the assessment process (such as those described above) helped caregivers better understand the value of the assessment and its benefits to their child; it also resulted in caregivers' increased understanding of both the child and family's strengths and needs and enhanced the assessment process overall (Davis, Torgersen, & Kisiel, 2016).

Increased understanding of the youth and family's strengths and needs by the provider, caregiver, and youth, as a result of a collaborative assessment process, can also enable the development of more effective and meaningful treatment and service plans (Caliwan & Furrer, 2009). The identification and assessment of strengths, in addition to needs, facilitates service planning that is both strengths-based and

trauma-informed, which allows for services to focus on bolstering protective factors that may already exist within the individual or family system.

In addition to service planning, the CANS tools more broadly have also shown success in supporting safety and permanency by informing placement decisions for youth entering into the child welfare system. The CANS helps shift placement decisions away from what may be easiest or most cost effective for the agency, with a focus on strengths and needs of the child (Hirsch et al., 2009). Further, increasing awareness of trauma-related needs through the CANS-Trauma assessment process can help inform placement decisions and secure needed resources to ensure the youth's safety and involvement in trauma-informed care. The youth's strengths and needs can help guide the type of living arrangement that may be most beneficial for the youth, and facilitate placement in the least restrictive environment possible (Hirsch et al., 2009).

Developing decision support algorithms for the CANS tools has also proven effective for making more successful placement recommendations. Such decision algorithms have been used across several states, including Pennsylvania, Illinois, Tennessee, and Alaska (Epstein, Schlueter, Gracey, Chandrasekhar, & Cull, 2015; Lyons, 2004). The goal of the CANS, when used this way, is to identify the least restrictive level of care that will be adequate to meet the youth's current needs. Research indicates that youth placed in residential treatment at the recommendation of this algorithm showed more positive change in emotional and behavioral symptoms than youth assigned to residential placement against the advisement of the algorithm (Chor, McClelland, Weiner, Jordan, & Lyons, 2012). Decreases in symptoms have also been documented across placements at differing levels of restrictiveness when informed by both a multidisciplinary team and the CANS algorithm (Chor, McClelland, Weiner, Jordan, & Lyons, 2015). It has also been shown that youth placed in settings that are consistent with this algorithm have a decreased risk of disruption than peers placed in settings that are not informed by the algorithm (Epstein et al., 2015).

In addition to these benefits, the CANS tools overall have been successful in monitoring outcomes of youth in the child welfare system on a macro-level. Aggregate CANS data have shown to be beneficial for tracking agency outcomes through state-wide provider databases that collect CANS information; tracking agency outcomes identifies provider agencies that may be more successful at addressing particular needs as compared to other agencies (Hirsch et al., 2009). Systemic knowledge of these service achievements can inform service referrals based on individualized youth needs, in turn promoting safety and permanency.

At a federal level, the Administration on Children, Youth and Families (ACYF) has placed increased emphasis on measuring well-being as a way to better address child welfare outcomes (Samuels & Anderson, 2014). As the CANS-Trauma incorporates strengths into the evaluation of well-being, which many current assessments do not, it provides a unique opportunity for child welfare systems to track outcomes across the four recognized domains of well-being (cognitive functioning, physical health and development, behavioral/emotional functioning, and social functioning) (Administration for Children and Families [ACYF], 2012). Use of the CANS-Trauma

to measure well-being individually and in the aggregate is an emerging area of success that has promising implications, as data can be used to inform future practices and policies, especially those that may recommend enhancing strengths as one approach for supporting the well-being of youth in child welfare.

Summary and Conclusion

The CANS is one of the most widely used tools within child-serving systems across the United States, with several applications in child welfare settings. It is a well-established and structured tool that is multi-purpose in nature with demonstrated utility across various levels of a system. In particular, the CANS-Trauma is a trauma-informed assessment strategy that is designed to address some of the existing challenges in the field. It assesses a wide array of trauma experiences, trauma-related needs and strengths of the child and caregiving system; effectively identifying the range of complex needs of youth within child welfare settings is a critical first step in the assessment process. The CANS-Trauma also minimizes the potential burden of assessment on providers, by allowing them to incorporate several sources of information about the child and family and integrating this information in a centralized way into a single tool.

The CANS-Trauma lends itself to many trauma-informed practice components which are directly relevant to child welfare providers, including comprehensive assessment, support for service and treatment planning, family engagement, and collaboration and communication across providers. These practice components are supported by initial evidence and feedback from provider agencies along with several accompanying resources that highlight the benefits of this approach. As outlined in this chapter, "meaningful use" of assessment is a framework that can be used to support the building of competencies in effective use of assessment in trauma-informed child welfare practice; these competencies can be readily implemented in conjunction with the CANS-Trauma tool. When the CANS-Trauma is integrated in child welfare systems in a meaningful way, with support for the effective use of the tool in practice, this process can help caseworkers and other child welfare providers build competencies that will enhance safety, permanency, and well-being, and improve the overall quality of services provided to children and families served within child welfare systems across the country.

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Chapter 8
Partners in Child Protection: A Trauma-Informed Approach to Assessment in Child Welfare

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Introduction

Children in the child welfare system represent a group characterized by exposure to highly adverse circumstances including maltreatment-related trauma, significant secondary stresses, and loss. Research regarding the experiences of children in foster care estimates rates of trauma exposure at 80–93% and indicates that multiple or chronic exposures to traumatic events are common (Lipschitz, Winegar, Hartnick, Foote, & Southwick, 1999; Stein et al., 2001; U.S. Department of Health and Human Services, 2013) . Further, it has been estimated that childhood maltreatment experiences present a tenfold increase in lifetime risk for Posttraumatic Stress Disorder and other mental health disorders (Scott, Smith, & Ellis; 2010). The literature documenting the potential acute and long-term effects of untreated childhood trauma is significant and includes disruptions in emotional-behavioral, relational, academic, and physiological functioning (Cook et al., 2005; Felitti et al., 1998). Fortunately, numerous evidence-based interventions have been developed to promote trauma recovery for maltreated and other trauma-exposed youth, yet connecting children to necessary interventions and operating from a trauma-informed paradigm are not standard components of care in many child welfare systems.

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Trauma assessments can provide entry points for the integration of these evidence-based practices in child welfare.

Research supports the best practice recommendations that have been made regarding universal screening and assessment for traumatic stress and other mental health needs with maltreated children, as well as the development of trauma-informed child welfare systems (Chadwick TIS Project, 2013; Conradi, Wherry, & Kisiel, 2011; Ko et al., 2008; Sprang, Clark, Kaak, & Brenzel, 2004). Promoting trauma recovery for children in these systems requires not only timely intervention to address their mental health concerns, but also coordinated efforts to ensure their safety, protection, and permanency needs are met and secondary or systems-induced traumas are prevented. To achieve these goals, collaboration across systems including child protection, mental health, and the Courts is essential (Conners-Burrow et al., 2013; Darlington & Feeney, 2008; Ko et al., 2008). Because of the "silo-effect" that can occur with various systems and professional disciplines, coordinating efforts to promote the best interests of trauma-affected children and their families are complicated by challenges with accessing, sharing, and communicating information. Trauma-informed assessment protocols can provide a framework for understanding children's mental health needs and generate critical data to support decision-making from a child-focused perspective. Perhaps of equal importance, trauma-informed assessments can serve as important communication tools across systems and providers to increase shared knowledge about a child or family's experiences and promote continuity of care.

This chapter describes the *Partners in Child Protection* (PICP) project, a partnership between a university-based trauma center and public child welfare designed to utilize state-of-the-art assessment technologies to promote safety, well-being, and permanency for maltreated children and their families. The PICP project acts as an active implementation driver toward trauma-informed care integration in a complex, dynamic environment and is described as an example of how child welfare systems can partner with community agencies to achieve this goal. The following discussion provides an overview of the project, the assessment protocols utilized, and the implementation strategies applied to support and maintain the partnership. The PICP program is an innovation first conceptualized by child welfare leadership and its university partner almost two decades ago, and functions as a decision-making support system (a key organizational driver) that informs competency building in the area of training, coaching, and consultation. In times of transition or change, these strong implementation drivers put in place by PICP act in a compensatory manner to sustain the partnership and keep the quality of case planning and decision-making high. The chapter describes these protocols as well as evidence of successful implementation, implementation challenges, and strategies that can be replicated by child welfare agencies with local mental health partners in other contexts.

Goal and Purpose of Service

PICP includes comprehensive risk assessment and individual child trauma assessment protocols. Both of these protocols incorporate various methods of case-based consultation with individual child protection workers or service teams. Consultation services, at times, may also include associated courtroom testimony. The goal of the program is to collaborate with partners in the child welfare system to integrate the trauma perspective into decision-making at all levels in order to improve outcomes for maltreated children and their families.

PICP was developed in response to the need for improvements in the child welfare system following the enactment of the Adoption and Safe Families Act (ASFA) in 1997. This legislation marked a shift toward focusing on the needs of children with regard to safety and well-being, and securing permanency in a timely manner (Child Welfare Information Gateway, 2012; P.L. 96-272, 1980; P.L. 105-89, 1997) . Conditions that prompted the adoption of ASFA included children being returned to unsafe environments as well as the growing number of children languishing in foster care and suffering multiple placements without the stability necessary for healthy development or recovery from their experiences of maltreatment (Barth, Wulczyn, & Crea, 2004). While the goals of this legislation were widely supported, it resulted in tensions within an already overburdened system regarding how they would be achieved. It became evident that better methods of assessing risk and the effects of maltreatment-related trauma on children and families, as well as improved strategies to help them recover from trauma and repeated disruptions in attachment relationships, were critical. This occurred at a time when advancements in the understanding and treatment of child traumatic stress were progressing at a rapid pace. This context supported the development of community partnerships and cross-disciplinary collaborations to integrate new, evidence-based practice models.

Description of Service

PICP was developed as a collaboration between the flagship university and child protection system in a mostly rural and significantly under-resourced state (Sprang et al., 2004). This translational research and service program began with the development of the comprehensive risk assessment and consultation model that workers could use to support decision-making, but has since grown to include various other assessment-driven services. These services include individual trauma assessments, additional consultation models, evidence-based interventions for trauma-exposed children and adolescents, and trauma-informed interventions for foster-adoptive caregivers. In addition to these services, associated research, training, and educational services are provided to support the work of the partnership.

Population Served

The population served by PICP includes maltreated youth (ages 0–18) and their families, who are actively involved with the child welfare system. This particular program is designed to serve the entire state, and children are referred as needed by child protection workers who receive immediate consultation and "triage" services to identify the best course of action given the stage of development and specifications of the case. The initial consultation may lead to directing the case to one of the assessment protocols or to referral to a community partner for another more appropriate service.

While this program has a specific focus on serving children and promoting their best interests, child protection workers have always been viewed as intentional targets of service provision as well. This is an extension of the ecological, transactional approach utilized in this program to conceptualize child maltreatment and the recognition that child protection workers often serve as the connections between the structures in the child's microsystem as well as intervening agents within the exosystem. This layer includes the larger structures such as the legal and foster care systems, which have considerable potential to shape a child's developmental trajectory. Additionally, the program aims to support the workers not only intellectually but also in a more traditional sense. Previous research has shown that child welfare workers cite issues of secondary traumatic stress and burnout as significant barriers to their adoption of trauma-informed practices (Bride, Jones, & MacMaster, 2007; Regehr, Hemsworth, Leslie, Howe, & Chau, 2004; Sprang, Craig, & Clark, 2011), and PICP aims to provide supervision, training, and psychoeducation to support organizational change toward STS responsiveness.

Staff Qualifications

PICP has developed specific standards regarding clinical staff qualifications in order to achieve its goals that can be used to guide the selection of community partners by other programs. Since PICP aims to work interactively with child welfare professionals at all levels—frontline workers, supervisors, and members of agency management—no staff qualifications are specified for child welfare partners. Ideally, collaborating partners receive trauma-informed training to support this work. Perhaps the most comprehensive trauma-training program to date for child welfare, *The Child Welfare Trauma Training Toolkit* (NCTSN, 2008), is an example of an appropriate training curriculum, and is what PICP utilized to train child welfare professionals statewide to support its efforts. A few studies have evaluated the effectiveness of *The Child Welfare Trauma Training Toolkit* curriculum and found significant improvements in the use of trauma-informed practices in these systems (Conners-Burrow et al., 2013; Kramer, Sigel, Conners-Burrow, Savary, & Tempel, 2013).

The clinical services portion of this program utilizes a multidisciplinary team approach to assessment in an effort to reduce disciplinary specific bias. Clinical social workers, psychiatrists, psychologists, and psychiatric nurses at both masters and doctorate levels conduct the evaluations in conjunction with graduate-level students and residents from these disciplines since this is a university-based program. Clinicians are required to have some expertise in key areas and must possess certain qualities in order to conduct the assessments in an evidence-based manner and provide effective consultation. Domain-specific knowledge regarding trauma, attachment, child maltreatment, and developmental psychopathology is necessary to engage in these services. Skill-based knowledge in the areas of child, adult, and family assessment, and specifically the assessment of traumatic stress and evidence-based trauma interventions, is also instrumental.

Further, it is important that clinicians are capable of effectively communicating the outcomes of these assessments to other professionals and non-professional consumers. A capacity for relationship building and collaboration is critical to the success of the consultation service, and should be founded on practical knowledge and respect for the child welfare system itself. To promote understanding of the child welfare process, PICP has always maintained at least one staff member who is a clinician with some previous experience as a frontline child protection worker. This team member facilitates the initial triage process and provides child welfare-specific case consultation to other clinical team members to ensure relevant aspects of the child's legal and maltreatment history are properly understood and recommendations are tailored to meet the specifications of the child welfare system. In this way, the staff selection and training protocols become essential competency drivers that support implementation and sustainability of the project.

Another factor that has promoted the success of PICP has been the adoption of a scientist-practitioner model and purposefully recruiting and developing staff that adhere to this approach. In the ambiguous and often contradictory world of child protection work with families, the potentially harmful influences of bias, other social and psychological constraints, and practical limitations can interfere with evidence-based practice in numerous ways. In order to limit these harmful effects, the program maintains manageable caseloads, protects staff from legal reprisals, provides ongoing professional development, and creates specific structures for case conferencing and intellectual debate regarding the findings and interpretations of data gathered during the assessment (Sprang et al., 2004). Effectively engaging in the case conferencing process and properly administrating the evidence-based protocols requires development of specific core competencies by clinicians that include respecting protocol fidelity, integrating research into clinical decision-making, developing and testing hypotheses to inform clinical decision-making, and contributing to practice-based research (Shapiro, 2002). In order to promote this culture of work engagement, PICP orients staff to the scientist-practitioner model and provides education, supervision, and other structured activities on an ongoing basis.

Program Components

Understanding the complexity of child maltreatment and its effects demands a theoretical framework that allows for all aspects of a child's experience to be considered. A transactional/ecological framework (Lynch & Cicchetti, 1998) was chosen to guide the assessment protocol, which incorporates the complexity of both the etiology and impact of maltreatment while retaining the primary focus on a child's needs. This framework proposes that in order to fully assess the effects of maltreatment on an individual child, one must consider the context of his or her interactions with family, peers, school, neighborhood, community, and racial/ethnic and socioeconomic culture (Belsky, 1980; Bronfenbrenner, 1979), and understand that these interactions are reciprocal in nature (Lynch & Cicchetti, 1998). The transactional/ecological model makes several key assumptions that were instrumental in the development of the PICP program: (1) the pathways between individuals and systems are bi-directional in nature; (2) all factors are of equal importance and relevance; (3) both positive and negative influences between systems must be considered; (4) the age of the child at onset, the severity, duration, and the type of maltreatment are important; (5) repeated exposure and the accumulation of effects matters; and (6) the context within which the maltreatment occurs is of great importance (including familial, social, community, and cultural contexts) (Cicchetti & Lynch, 1993; Lynch & Cicchetti, 1998).

Within the transactional/ecological framework, trauma and attachment theories form the basis for understanding a child's responses and functioning, and the potential effects of maltreatment on developmental trajectories. Trauma theory presupposes that exposure to a traumatic event, such as sexual or physical abuse, neglect, or witnessing of domestic violence, can lead a child to experience intense emotional and physiological distress. Research has shown that childhood exposure to traumatic events, especially when exposure occurs repeatedly and at the hands of a primary caregiver, can have profound consequences for a child's emotional, relational, physiological, and cognitive functioning (Cook et al., 2005). Traumatic stress-related responses, such as intrusive thoughts, physiological arousal, avoidance of distressing stimuli, alterations in thinking and mood, and dissociation, are biological in nature and occur when a child's ability to cope with distressing events has been overwhelmed (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Children under the age of five are at particular risk for long-term neurobiological consequences of maltreatment due to this being a sensitive period of brain development (Corbin, 2007; Perry et al., 1995; Siegel, 1999). A secure attachment relationship, one that is characterized by the establishment of trust and emotional attunement between and a child and primary caregiver, facilitates emotional and social development and assists the child in learning how to modulate affective states (Ainsworth, 1969). The ability to form a trusting relationship with a primary caregiver is one of the most influential factors that can promote resiliency in a child and protect against the potential deleterious effects of trauma exposure.

Comprehensive Assessment Model

The goal of the comprehensive assessment process is to provide the referring child protection worker with recommendations for case planning regarding placement viability, permanency, and individual and relational interventions. Therefore, an assessment protocol was developed from the conceptual and theoretical framework to capture the complexity of child maltreatment and integrate information on the functioning of individuals as well as the family as a whole. Extensive reviews of the literature were conducted to determine the most relevant factors indicated by the model, as well as the best practice approaches to assessment in these areas. The domains of relevant factors dictated by the model include adult, child, relational, socioenvironmental, and maltreatment factors. Each of these factors is considered within its culturally relevant context, as well. Specifically, consideration is given to how cultural and environmental contexts influence what constitutes adequate parenting, socialization goals, developmental achievement, identity formation, parent-child relational patterns, assignment of caregiving responsibilities within family structures, use of social support, selection of coping strategies, and responses to interventions and service providers (Azar & Cote, 2002). The factors and associated assessment domains are summarized in Table 8.1.

The assessment protocol is designed to utilize triangulation of methods informed by varied epistemological assumptions to identify areas of convergence and divergence regarding family strengths and risks. Assessment methods are designed to capture a "snapshot" of individual and family functioning at the time of the evaluation, and provide some historical context for understanding their unique clinical picture. Standardized instruments, clinical interviews, structured observations, and content analysis of records from past and current providers are completed to achieve this end. The addition of historical data to the assessment of current functioning provides both a sense of the family members' functioning over time and indications of responses to past interventions.

The need for accuracy underscores the rigor of this assessment process. Both quantitative and qualitative methods of inquiry are utilized to assess each domain via multiple data sources in order to minimize error or bias. Upon completion of the data collection process, the multidisciplinary assessment team engages in a structured case conferencing process in order to examine the data with the goal of either confirming or disconfirming hypotheses through discussion and debate (Sprang, Silman, Whitt-Woosley, & Mau, 2015). This process allows for critical examination of the clinical conceptualizations generated by individual team members regarding their respective parts of the assessment process. Once the team reaches consensus regarding the conclusions and recommendations generated from the data, these are communicated to the referring child protection worker both verbally and in a user-friendly, written evaluation report. Ongoing consultation based on these reports is provided to child protection workers, service providers contracting with the child welfare system, and the family court system as needed.

Table 8.1 Factors and assessment domains

Child factors	Relational factors	Caregiver factors	Socioenvironmental factors	Maltreatment factors
Emotional/behavioral functioning Trauma history and trauma-related symptoms Level of depression Developmental and physiological functioning Academic functioning Cultural identity Child clinical and caregiving needs	Working model of child Parent-child attachment Parenting role, knowledge, level of skill in context Parenting stress Cumulative risks for caregiving difficulty	Psychological distress Trauma history/symptoms Psychosocial history Substance use Maltreatment history and child abuse potential, ego strength Aggression and expression of anger Criminal and DV history Conflict strategies Cultural identity Cognitive functioning Physiological functioning Work/financial stability Involvement/response to interventions	Home environment Social/physical environment Academic environment/support Systems interface (child welfare, criminal justice, mental health, etc.) Social capital	Nature, severity, frequency, and duration of maltreatment Caregiver insight into maltreatment and associated stage of change in mitigating contributing factors Child protection outcomes

Individual Trauma Assessment Model

The individual trauma assessment model was developed to support families, child protection workers, judges, and other professionals by assessing a child's traumatic stress-related reactions and providing recommendations for trauma treatment services. The model grew out of an identified need within the community for evidence-based, trauma-informed assessment and treatment services for children who have been trauma-exposed. There was a particular concern that children within the child welfare system were not able to receive timely assessment of their trauma-related mental health needs, thus delaying referral to available efficacious interventions.

The individual trauma assessment protocol was also developed from the theoretical framework and an extensive review of the research literature to identify the most relevant factors and best available assessment strategies. As with the comprehensive assessment model, the individual trauma assessment model is based on the triangulation of methods to allow for examination of convergence and divergence of data from various sources in order to reduce bias. Face-to-face interviews, standardized psychometric instruments, behavioral observations, and collateral contacts with community service providers are utilized to this end. The clinical interviews include developmental trauma screening that examines the nature, severity, type, and frequency of maltreatment or other types of trauma exposure and the gathering of psychosocial information including the child's functioning at home, school, and in other environs; relational functioning between the child and caregiver(s), peers and other significant adults (such as extended family and teachers); past and current mental health and physical health treatment; and levels of perceived social support by the child and caregivers. Psychometric instruments assess caregiver and child-reports of child functioning and symptomatology (including depression, anxiety, and other traumatic stress-related symptoms), parenting stress associated with caring for the child, and caregiver child abuse potential and ego strength. Psychometric instruments that examine sexualized behaviors for the child are also utilized when indicated. Collateral contacts with community providers can include child welfare workers, mental health therapists, psychiatrists, and primary care or other health specialists. The purpose of the collateral contacts is to gather a more detailed understanding of the child's current needs, past and current services provided, and the child and family's responses to intervention.

Upon completion of the assessment, the results are discussed within the treatment team with a focus on the critical appraisal of the convergence and diverge between data. A final trauma assessment report is then created that details the presenting problem, the history of trauma exposure for the child, past mental and physical health treatment received, psychometric results, a detailed case conceptualization, and recommendations for treatment. The conceptualization section of the report provides the opportunity for the assessing clinician to integrate and explain the data with an emphasis on understanding the child's current trauma-related symptoms and functioning within the context of their maltreatment history. The treatment recommendations then aim to identify available evidence-based interventions to best meet the child and family's needs.

Consultation Services

The assessment-driven consultation services with child protection workers are designed to be flexible enough to meet the requirements of each case yet consistently include the abovementioned core components. Consultation services may be provided individually to child protection workers, or at times may be delivered to service teams consisting of the frontline worker, child protection supervisor, or possibly members of agency management or legal teams if indicated. First, the consultation serves an educational function in that participating child protection staff are informed of what constitutes a trauma-informed approach and why it is necessary. This generally includes some discussion of how maltreatment experiences constitute traumatic events and the ways that children, caregivers, and families are potentially affected by maltreatment-related or other traumas.

Next, the process moves into conceptualizing the child and/or caregivers' identified problems within a trauma framework. The purpose of this process is to utilize the assessment information to assist the child protection worker with developing specific plans for service provision to meet the needs of children from their caseloads. Trauma-informed consultation in this respect is focused on explaining the specific mental health treatment plans to be shared with identified providers for the children and/or caregivers; making referrals to appropriate providers; discussing strategies for presenting service plans to children and families; problem-solving logistic challenges to obtaining necessary service provision (transportation, cost/billing issues, sequencing and prioritization of services, etc.); explaining the type of foster home or other placement indicated to provide the appropriate trauma recovery environment for the child; and consulting on psychiatric or medication management needs, academic challenges, and management of issues regarding physical and psychological safety during visitation.

If caregivers are evaluated as part of the assessment process, trauma-informed consultation is also provided regarding how the information gathered can inform risk assessment and decision-making. This often relates to considerations of goodness of fit between caregivers and children in context of where each individual is in terms of trauma recovery, interventions needed to reduce risk, and indications of prognosis for reducing risk and/or successful reunification within a reasonable timeframe.

Challenges to Implementation

Although there may be strategic reasons to form such partnerships, there remain significant challenges to successful and effective implementation of initiatives involving external agencies and public child welfare. Some barriers are substantive, involving budgetary, logistical, or systems issues. Other challenges fall into the category of inter-organizational cooperation and relate to the degree of trust, joint

problem-solving capacity, and/or the ability to resolve conflict. Successful cooperation is developmental, and in the case of PICP, a by-product of time and trial. Henry Ford once said that "Coming together is a beginning, staying together is progress, and working together is success." The sustainability of this university/public child welfare partnership has been directly related to its ability to overcome implementation challenges by developing, investing in, and maintaining the partnership. This should be a concerted focus of any collaborative programming.

Substantive Challenges

The public child welfare system operates within a system of "organized complexity" (Weaver, 1991). Expanding caseloads with complex needs, a disproportionate representation of children of color in out-of-home care (pointing to racism and discrimination), high staff turnover, difficulties recruiting foster parents, inadequate funding levels, community apathy, and bureaucratic turmoil are factors that complicate the organization's ability to operate effectively, protect children, and develop meaningful partnerships. Collaborations with organizations dealing with such issues must engage in incremental, adaptive planning and exosystem coordination to successfully navigate such complexity. PICP took such an approach to addressing some significant, substantive challenges to this partnership. For example, institutional knowledge regarding the role and functioning of the program within child welfare and the overall utility of the initiative have been occasionally threatened by staff and leadership turnover, and subsequent changes to standard operating protocols. To address these changes, PICP created an intensive and sustained practice of training and consultation to child welfare to onboard new personnel, and to provide ongoing assistance to seasoned workers who may have difficulties interfacing with the program. This required designated personnel to manage the consultation and interface functions of the partnership, and an integration of program staff into the cultural milieu of the child welfare system. This did not occur extemporaneously, rather through systematic, gradual assimilation of external staff into child welfare operations. These investments in competency development compensated for temporary loss of adaptive or technical leadership, essential ingredients of successful implementation. Simultaneously, the program worked with the family court system to institutionalize the use of PICP evaluations, to facilitate an expectation of quality, and set a standard for practice to guide key stakeholders and consumers. In this way, loss of institutional knowledge and/or appreciation of the program within child welfare were supplanted by external demand for the product. Over time intra-agency reliance on this partnership and the exosystem interest in the assessment model have led to integration of the program into the agency's performance improvement plan and accreditation metrics. The results for the children and families are significant, as reported previously, and the institutionalization of PICP outcomes has allowed the partnership to withstand budgetary and personnel challenges and changes.

*C*reating and sustaining effective relationships and communication among partners requires strategies for collaborative problem solving, conflict resolution, and consensus building. Successful implementation requires PICP members to develop these skills and to maintain them in a dynamic and sometimes chaotic environment. Healthy relationships become the context for these skills to develop and flourish but are vulnerable to disruption in times of turbulence or uncertainty. A trauma-informed, communicative action approach to developing and maintaining cooperation around case plan decision-making and targeted outcomes is utilized. This model of relationship building seeks to promote common understanding across partners through frequent and deliberate communication so that individuals with diverse roles and responsibilities can work together to achieve a common purpose. Partners seek to reach consensus about the problem, the remedy, and plans of action, and take interpersonal risks to coordinate their actions. The trauma-informed principles of trust, safety, choice, and empowerment are hallmark features of this type of interaction, and, when realized, make these risks tolerable. This approach stands in contrast to more individualized, strategic actions, which are designed to achieve personal goals (Habermas, 1984). The result is a form of social capital that the group cultivates, so that in times of conflict, change, or lack of consensus the good will created by investments in strategic communication and relationship building can sustain the partnership. This social capital is an organizational driver that supports implementation. This is especially important when working with publically funded systems of care (i.e., child welfare), which are led by political appointees whose tenure is tied to the election cycle. In fact, over the past two decades PICP has withstood many relationship disruptions, conflicts, and the system transformations that accompany them by using this type of communicative action approach. The principles of trauma-informed care-safety, collaboration, choice, trustworthiness, empowerment, and cultural competence (Harris & Fallot, 2001) guide interpersonal interactions between the external partners and public child welfare in a parallel process to service delivery, and become the organizational change framework to address implementation challenges.

Evidence for Success

Careful monitoring and evaluation of data generated by PICP has been prioritized since its inception. The focus of associated research efforts has been to examine the relationships between assessment domains and maltreatment risk and severity, rates of successful implementation, and the protocol's effectiveness in identifying the trauma recovery needs of maltreated children. Numerous research studies have been based on program-generated data that have not only supported program evaluation efforts but also contributed to the greater literature regarding maltreatment-related trauma and collaborations between child welfare and mental health systems.

An early study utilizing program data designed to determine the degree that primary assessment domains related to variation in the severity of child maltreatment

provided support for this trauma-informed, risk assessment approach. Sprang, Clark, and Bass (2005) found that trauma recovery, substance misuse, a child's externalizing behavior, family stress, and aspects of the parent-child relationship significantly contributed to the severity of child maltreatment. Another study by Craig and Sprang (2007) found that trauma exposure histories were predictive of child abuse potential scores in maltreating parents, thus confirming the importance of a trauma-informed assessment approach in child welfare service provision.

Program evaluation studies have also provided context for monitoring and adapting implementation efforts to support these protocols. Over the past 5 years (2010–2015), pre-assessment risk rating scores and post-assessment risk rating scores for families receiving recommended services have been analyzed. These scores are determined by the child protection system's standardized risk assessments, and they have demonstrated statistically significant declines each year. This program has traditionally served children and families with high-risk maltreatment histories, as evidenced by the annual, average pre-assessment risk rating scores placing them in the highest category (*extreme*). Average post-implementation scores have consistently decreased by two categories, resulting in families placing in the *moderate* category. This indicates the effectiveness of the case planning collaborations resulting from the assessments at reducing maltreatment risks, thereby improving outcomes for trauma-exposed youth. Additionally, these follow-up studies have also demonstrated a 96.6% adoption rate of the assessment recommendations by the child welfare system and an 80.6% rate of the recommendations being court-ordered by family court judges.

A 2008 article by Clark and Sprang entitled *Infant Mental Health, Child Maltreatment, and the Law: A Jurisprudent Therapy Analysis* outlines some other benefits of implementing this assessment approach with child welfare and associated family court systems. These include the therapeutic benefits of educating and training family court personnel on the implementation of trauma-informed approaches to using mental health data in court, and creating a state of therapeutic jurisprudence to benefit all parties involved in the process.

Application/Strategies

In order to create an effective service system, certain competencies in child welfare and mental health professionals should be developed, and intentional efforts should be made to mitigate secondary traumatic stress concerns for both parties, as these may interfere with successful implementation if unaddressed. A commitment to ensuring cultural competency and sensitivity is also a critical factor for any trauma-informed assessment program serving this population.

The competencies identified by the Council on Social Work Education (2012) in *Advanced Social Work Practice in Trauma* articulate what is necessary to practice in a trauma-informed manner that adequately meets the levels of complexity encountered in child welfare. Competency 2.1.6 states the obligation to "engage in research-

informed practice and practice-informed research," which is further explained in terms of trauma-informed practice as the need to "possess knowledge about the prevalence of trauma's base rates in populations they serve" and to be "aware of risk profiles and manifestations of trauma" (CSWE, 2012, p. 13). This knowledge is part of the competency related to scientific knowledge about trauma also put forth by the New Haven Competency Group (Cook & Newman, 2014). If child welfare workers have knowledge of how common trauma exposures are, associated risk factors, and the various manifestations of trauma in maltreated children and their families, then this will foster a commitment to the application of a trauma framework and help workers identify those in need of clinical assessment services. Mental health professionals can apply this same knowledge to understanding how interactions between social, psychological, and neurobiological factors may influence the ways children and families respond to maltreatment. Competency in this area should also translate to the development of more sophisticated case conceptualizations and decision-making as it will increase awareness of when and how trauma is affecting an individual or family, and ways to intervene that are respectful of those experiences and associated needs.

Competency 2.1.8 states the need to "engage in policy practice to advance social and economic well-being and to deliver effective social work services," which is further articulated as the need to "recognize that the deleterious effects of trauma across populations and stages of life are sufficiently pervasive to constitute a public health crisis" and to collaborate with others to develop "trauma-informed policies and prevention strategies" (CSWE, 2012, p. 14). This competency is particularly relevant for those in child welfare policy-making and management positions, and highlights the opportunity to recognize the public health and prevention opportunities assumed under the umbrella of trauma-informed screening and assessment. Implementation of best practice recommendations for universal trauma screening with children in child welfare systems would identify those in need of clinical services that can reduce risks for future mental health and related problems, and assist with the determination of child and caregiver needs for support and strategies to enhance psychological safety (Chadwick Trauma Informed Systems Project, 2013; Conners-Burrow et al., 2013; Conradi et al., 2011; Ko et al., 2008). This competency also underscores the need for collaboration with other systems to work effectively to implement trauma-informed policies and practices.

In order to develop a comprehensive understanding of a child and family's symptoms and functioning, mental health professionals must be able to respond to contexts that shape practice, including social, cultural, and historical contexts (Cook & Newman, 2014; CSWE, 2012). As discussed previously, the ecological/transactional approach underscores the importance of considering the bi-directional influences that society's laws, social norms, social and economic status, culture, extended family, neighborhood, and school may have on how an individual copes with adversity (Lynch & Cicchetti, 1998). This lens should be applied when interpreting assessment results and engaging in the consultative process with other providers.

Another important application consideration in these partnerships involves issues of secondary traumatic stress (STS) . STS refers to the emotional distress associated with hearing the accounts of another's traumatic experiences that can mimic the symptoms of posttraumatic stress (Figley, 1995). Previous research has found that child welfare workers are more at risk than other behavioral healthcare providers for STS, which affects not only their overall well-being but professional effectiveness (Collins, 2009; Conrad & Kellar-Guenther, 2006; Sprang et al., 2011). Previous research on the implementation of trauma-informed care in child serving systems has identified these issues as potential barriers. A study by Henry et al. (2011) found that child welfare workers were operating in "survival mode" due to STS, overwhelming caseloads and limited resources, and had little energy for learning new protocols or practices. Providing training upfront on STS and mitigation strategies were offered as ways to address this implementation barrier, as well as consultation on how to integrate trauma-informed care into existing practices in order to address concerns about time management. Worker discomfort with talking to children about their trauma experiences has been cited as another barrier to providing trauma-informed services such as trauma screening, and it has been suggested that providing child welfare workers with a forum for discussing and receiving consultation on instituting these protocols is beneficial (Chadwick Trauma-Informed Systems Project, 2013) . Mental health providers may also be hesitant to engage in trauma-focused service provision due to concerns about STS and burnout, and recommendations for addressing these concerns seemingly apply to both systems. Increased attention to supervision, provision of specialized trauma-training and other professional development, engaging in evidence-based practices, and an organizational culture that promotes self-care have been found to have protective effects against STS and burnout (Chadwick Trauma-Informed Systems Project, 2013; Craig & Sprang, 2010; Sprang, Clark, & Whitt-Woosley, 2007).

Finally, one of the most important application strategies when implementing trauma-informed assessment programs with child welfare populations is including adequate structures to promote cultural competency and validity. Six key principles of a trauma-informed approach have been identified as including provisions to ensure safety, trustworthiness, support, collaboration, empowerment, and cultural sensitivity (SAMSHA, 2014) . Attention to cultural, historical, and gender issues according these guidelines involves moving beyond traditional stereotypes, responding to differentially expressed cultural needs, recognizing the impact of historical trauma and marginalization, and using culturally indicated supports to promote healing and well-being. This is especially important given the overrepresentation of historically marginalized groups in child welfare systems, which research has demonstrated are often at greater risk for trauma exposure and its harmful effects related to the increased presence of other stressors and environmental risks (Breslau et al., 1998; Brewin, Andrews, & Valentine, 2000; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

PICP addresses the need for cultural sensitivity by placing a high value on the role of contextual factors, engagement, and attempting to understand the current and

historical issues affecting the cultural groups most represented in the population served. For example, many of the children and families served by PICP are connected to the Appalachian culture given that nearly half of the counties in the statewide service area are identified as comprising a significant portion of the Central Appalachian region (Appalachian Regional Commission, 2016). This is one of the nation's most severely impoverished and resource-deprived areas, where some of the poorest counties in the United States are located and the poverty rates often double the national average (Billings & Blee, 2000).

Related to the socioeconomic disparities, healthcare, economic, and educational resources are often severely limited and rates of disease and disability are high. According to the Centers for Disease Control and Prevention (1998, 2001, 2002), the Appalachian region has the highest rates of cancer, heart disease and diabetes, and there has been considerable speculation that social circumstances, environmentally hazardous industries, and related lifestyle choices are contributing factors. A study by Zhang, Infante, Meit, and English (2008) found that mental health diagnoses for Major Depressive Disorder and other forms of serious psychological distress and treatment for opiate addiction were proportionately higher in Appalachia than in the rest of the nation. The Surgeon General's report on Mental Health: Culture, Race and Ethnicity (2001) acknowledged the disparities between minority cultural groups' prognoses for recovering from mental health difficulties and that of the general population. It was noted that a greater "disability burden" results from the lack and insufficient quality of mental health resources for cultural minorities in America, which is an issue for Appalachia given that it has been deemed a Health and Mental Health Professional Shortage Area (Appalachian Regional Commission, 2016; Hendryx, 2008). Additionally, many barriers to seeking mental health or substance abuse treatment have been found to exist at higher rates including transportation problems, cultural differences (such as mistrust of outsiders, seeking help from non-traditional sources), and social stigma (Keefe, 1988; McInnis-Ditrich, 1997; Zhang et al., 2008).

PICP attempts to assess each individual and family in context of the kind of circumstances and history described with regard to Appalachian culture, and respect how these factors may be uniquely affecting the children and families served by the program and the manner in which they approach service provision. As examples, Appalachian clients may need extra time spent on engagement and the consent process in order to establish a sense of trust and the degree of open communication necessary to form an effective working relationship. Studies have also shown that Appalachians are more likely to somatically experience distress, and may have different experiences of domestic violence including increased severity prior to seeking intervention and substance abuse involving higher rates of prescription medication abuse (Clark et al., 2002; Roenker, 2003; Wagenfeld, 1990; Zhang et al., 2008). Assessments are conducted and service provision plans developed with these factors in mind. Additional planning with child welfare workers is offered to address resource limitations including provider shortages and transportation challenges.

Conclusion

Utilizing trauma assessment data as a framework for decision-making enhances conceptualizations of individual recovery needs and strategies for reducing maltreatment risks. Providing data-driven consultation to child welfare workers and the Courts provides necessary support to these overburdened systems. In addition, the provision of trauma-informed care promotes the best interests of children and their caregivers, thus reducing the false dichotomy between their interests that can derail the system and lead to poor outcomes for maltreated youth. The PICP model can guide the development of partnerships between child welfare and community agencies to promote safety, well-being, and permanency for maltreated children and their families.

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Chapter 9
Introducing Evidence-Based Trauma Treatment in Preventive Services: Child-Parent Psychotherapy

Julie A. Larrieu

Goal/Purpose of Intervention

Children who remain in the home and are recipients of child welfare services in order to prevent out-of-home placement are deemed to be physically safe but often benefit from trauma-informed intervention. Intervention with a child or adolescent often requires attention to the primary attachment relationship, particularly with young children, as well as to the behavioral, emotional, cognitive, and physical dysregulation caused by exposure to traumatic stress. Child-Parent Psychotherapy is an evidence-based practice for treating children ages birth through age 5 years who have experienced trauma and their caregivers (Lieberman, Ghosh Ippen, & Van Horn, 2015). The relationship between the child and caregiver is the target of the treatment and the mechanism for change. In several states throughout the country, Child-Parent Psychotherapy has been used successfully with families who are involved with Child Protective Services, both for prevention of placement of children outside of the home, and, when custody has been removed from the parents, with the goal of achieving safe parenting, such that reunification of families can occur (see childtrauma.ucsf.edu). This chapter focuses on the use of Child-Parent Psychotherapy (CPP) as it has been integrated into preventive services. The rationale for the treatment, the child welfare population best served by this intervention, who delivers the intervention, and challenges to the implementation of CPP within the constraints of preventive services are addressed. In New York City, there is an innovative family preservation program, Association to Benefit Children, All Children's House, that employs clinicians who are case workers for child welfare and who also are CPP therapists (http://www.a-b-c.org/familyprograms/family-preservation). The unique role of these clinicians is also highlighted in this chapter.

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Rationale for Treating Young Children and Their Caregivers: CPP as a Relationship-Based Intervention for Trauma

Young children learn about the world through their primary relationships and early caregiving experiences; they learn what to expect from others, to whom they can turn for comfort, and how to interpret safety and danger. When the caregiver is warm, nurturant, and sensitively responsive to the young child's needs, a secure attachment relationship is formed, which serves as the foundation for healthy development and well-being. The child learns to trust the caregiver, is able to turn to him or her to relieve stress, and internalizes a sense of efficacy and security; these qualities enable the child to explore and learn about the self and the world.

When the young child and caregiver experience trauma, the child's normative expectation for safety and protection is shattered. When maltreatment has occurred, the young child has an insolvable dilemma: the parent who is meant to protect and soothe the child is the source of threat or danger. This is particularly damaging for very young children, who are largely dependent upon their caregivers for protection. Maltreatment of infants and toddlers happens with alarming frequency. Very young children are the most vulnerable to abuse and neglect. In 2014, more than one-quarter (27.4%) of victims of abuse and neglect were younger than 3 years of age. The victimization rate was highest for children younger than 12 months. Very young maltreated children are more likely to die, sustain serious injury, and have long-term developmental sequelae from abuse and neglect as compared to older children and adolescents (U.S. Department of Health & Human Services, 2016). Because of its focus on young children and their caregivers, Child-Parent Psychotherapy is uniquely poised to treat trauma in the context of maltreatment with infants, preschoolers, and their parents.

One point of emphasis in CPP is the child's experience of contradictory feelings toward the parent, which is expectable when the parent has behaved in dangerous and painful ways. Love, anger, anxiety, and fear co-exist in the context of the relationship (Lieberman & Van Horn, 2005). When the child does not feel an internal sense of safety with the parent, all aspects of development can become derailed: physiological, cognitive, and social-emotional. The child's resultant distress and symptomatic behavior impair functioning and may further strain the parent's sense of efficacy and capacity to provide effective caregiving. The child welfare worker may note that the child appears to be afraid of the parent or consistently prefers to be with the worker rather than the parent. The child and/or the parent may be sad and withdrawn, or aggressive and angry, and if these behaviors are noted frequently and impair functioning, CPP may be indicated. At times, children may be overactive, inattentive, easily startled, and hypervigilant (e.g., looking for the next "bad thing" to happen). It is possible that these symptoms are coming from the trauma the child experienced and may be misunderstood as the child having Attention Deficit Hyperactivity Disorder. The parent and child may be triggering or reminding each

other of the trauma(s), which complicates the treatment and must be a primary focus of therapeutic attention. There are several symptoms that may indicate trauma, and it is always best for the child welfare worker to speak with a CPP therapist to determine if a referral is warranted, given the concerning behaviors displayed by the parent and/or the child. Young children often will let us know how they feel through their play; trauma-based play is repetitious, does not vary, is not enjoyable, and plays out themes related to the traumatic events. Even though they may not be literal recreations of the trauma, they often represent the trauma (e.g., a man falling off the roof of a house when the father had beaten the child and then was not seen again by his son). If these symptoms are noted, the parent and child should be referred. There are many ways the child welfare worker may become aware of a child or parent's distress, and discussing these behaviors and observations with a CPP therapist will help determine if the family would benefit from treatment.

CPP recognizes that for many families, difficulties in the relationship between the parent and the child are not only attributable to a lack of parenting knowledge and skills. Traumatic events from the parent's past may underlie the maltreatment of the child, and the degree to which they impede the parent's capacity to provide adequate care determines the emphasis they receive in the treatment. The parents may project onto the child their own unresolved traumatic experiences or losses, including their own experiences of insensitive or abusive caregiving by their parents. Thus, referral by the child welfare worker for parenting education alone is not sufficient to address the problems in the parent-child relationship. CPP focuses both on the child-parent interaction and each partner's perceptions, beliefs, and attitudes about the other. The child welfare worker may hear the parent speak very negatively about the child, saying he is "just like his father, always hitting, being mean and selfish." Such statements, if they happen often, may serve as red flags and thus warrant referral for CPP. The therapist assists the caregiver in developing adaptive responses to the child. Restoring safety and trust in the relationship, a central goal when maltreatment has occurred, is imperative to support the child in returning to a normative developmental trajectory. Adaptive coping and regaining pleasure in daily activities are facilitated. The therapist must focus on strengthening the parent's capacity to realistically evaluate danger and safety, and protect both herself and the child. The relationship formed with the therapist is a crucial aspect of the treatment and provides the safety and continuity to work through the trauma the dyad has experienced. Creating a trauma narrative allows for a new perspective on the traumatic experience and a resolution of the negative expectations of the self and the world, leading to positive growth and development. Establishing the parent as positive and protective sustains the unity in the family and is a principal objective of preventive services.

CPP incorporates all the aspects of *trauma-informed care* and follows the phase-oriented trauma treatment paradigm described in Chapters One and Two of this book: stabilization, with the immediate focus on establishing and maintaining safety within the therapeutic context while preserving safety within the

home; integration, in which the trauma is acknowledged, processed, and integrated to gain a new perspective and path toward positive functioning, such that permanency can be achieved; and consolidation of a healthy relationship moving forward, which allows for ongoing physical, emotional, and social well-being. In CPP, the therapist "speaks the unspeakable," namely talks about the maltreatment and the trauma, so that it can be dealt with. As the maltreatment and trauma are understood and there is real change (e.g., in parents' attitudes and behaviors toward the child), a healthier relationship develops. This stronger, more secure relationship is essential for permanency and well-being.

While CPP works to promote safety in that the parent and child learn adaptive coping strategies to manage difficult feelings and challenging behaviors such that stability and security can be achieved, safety planning also occurs, in that strategies for maintaining physical and psychological safety are acquired or strengthened. Assisting the parent and child in identifying their history of trauma, recognizing trauma triggers, and developing ways to cope when they arise, understanding bodily sensations, and normalizing traumatic responses are aspects of CPP that are safety planning interventions. The preventive services worker, with the requisite training, may provide CPP, as is the case with the ABC program, mentioned above; otherwise, the child welfare worker can encourage the family to accept a referral to an outside provider who has a contract with the Agency to provide CPP. Either way, the case worker is instrumental in facilitating safety promoting and safety planning interventions as foundations for processing trauma and repairing or building a secure parent-child relationship. Establishing such a relationship increases the probability of attaining the important goal of remaining with the parent permanently. The case worker's ongoing communication and coordination with the CPP therapist and with the family is one way that the family can feel safe, because the communications are open among all parties involved.

Description of Intervention: Population Served

CPP is indicated for infants and young children who have experienced at least one traumatic event, such as maltreatment, and/or are experiencing mental health, attachment, or behavioral problems, including posttraumatic stress disorder (PTSD). Caregivers are included in the treatment, which is focused on the dyad (Lieberman et al., 2015; Lieberman & Van Horn, 2005). The treatment has been used extensively with a range of diverse groups. Ethnic minorities include African American, Latino, Asian, Native American, and multiethnic, including families who have recently immigrated. Families have ranged from those who are at poverty level, middle-class, and above. Since the treatment includes both the parent and child, parents must be able to commit to the therapy and be consistently available for the sessions.

Indications and Contraindications for CPP

Child welfare workers can refer for CPP children up to age 6 years who have experienced trauma and/or are experiencing mental health, behavioral, attachment or other relationship problems, and their parents. Progress in the treatment is demonstrated by positive changes in children's and parents' attitudes, expectations, behaviors, and in their interactions with each other. A child may be seen approaching a parent and asking for help, or wishing to be held and comforted when upset. A parent may be seen offering to guide a child who is having a difficult time with a task or while playing, or praising a child for his or her efforts as well as successes. The parent and child show comfort and pleasure with each other, and have a sense of familiarity and mutual regard. If something distressing occurs, they can talk about it or manage it together without escalating into unsafe or harmful behavior. The parent can show warmth and also set appropriate limits, and the child can demonstrate age-appropriate behaviors. There is a sense of satisfaction and trust in the relationship. The parent and child do not speak in harsh and negative ways about each other, and the parent recognizes the child for who he or she really is, and not a "stand-in" for a person who has treated the parent badly in the parent's past. Symptoms that triggered the referral, including anxiety, sadness and withdrawal, sleep disturbances, and overactive, inattentive, hypervigilant behavior, have remitted or been greatly reduced. The parent and child are functioning adaptively and the child's development is back on track.

There are situations in which CPP may not be an appropriate choice of intervention. These include when the parent does not recognize the trauma or cannot acknowledge the negative impact it has on the child and his or her relationship with the child, even after the clinician has formed a trusting relationship with the caregiver. If the caregiver is the source of the trauma, he or she needs to be able to take responsibility for the trauma (e.g., maltreatment), apologize to the child, and make real behavior change. The case worker may be able to assist the parent in being open to CPP and encourage the parent to communicate to the CPP therapist the desire for a change in his or her parenting behaviors. This desire for change provides a foothold for the parent to accept responsibility and work toward what is in the child's best interest. The relationship the child welfare worker forms with the parent can pave the way for accepting a referral and accepting responsibility, such that the caregiver becomes open to therapeutic change. The caregiver must have the capacity to reflect on his or her behaviors and emotions, and be able to take the perspective of the child. If the parent does not have the intellectual, psychological, and emotional resources to develop or participate in reflective functioning, the effectiveness of CPP is likely to be extremely limited. Caregivers must be able to engage consistently in treatment, as establishing the safety and continuity of the treatment is an essential aspect in achieving success. Other contraindications include parents whose cognitive limitations, mental illness, substance abuse, and/or active involvement in violent relationships are debilitating. When case workers are providing preventive services, the determination has been made that the parent and child are safe together.

However, at times, discussion of trauma destabilizes the parent and/or child, so that issues of safety must continue to be monitored, especially if there is regression on the part of either person. If contraindicated conditions can be remediated to the point that it is safe to have the parent and child work together, and the parent has the mental and psychological capacity to engage in the work, then CPP can be considered as a viable option for trauma treatment. The case worker, through his or her ongoing relationship with the family, can continue to encourage the parent to be open to the treatment. Having the support and confidence of the case worker, and the assistance to ensure that all elements of the parent's case plan can be achieved, may inspire parents to do the difficult work that is necessary to overcome the conditions that caused the maltreatment and trauma for their child.

Staff Qualifications

CPP treatment is conducted by a licensed master's or doctoral-level mental health therapist (i.e., social work, psychology, psychiatry) who is receiving reflective supervision or consultation regularly. Knowledge of early child development and trauma is essential. There are a variety of mechanisms through which one may be trained in CPP; the most common is successful completion of an implementation-level course which is 18 months in duration. Clinicians trained to fidelity in CPP become rostered; case workers can determine if a therapist is rostered by accessing information through the website of the Development Team, Dr. Alicia Lieberman and Dr. Chandra Ghosh Ippen (see www.childtrauma.ucsf.edu) or through the CPP Facebook Page (www.facebook.com/ChildParentPsychotherapy).

Program Components

Children and caregivers are seen together in Child-Parent Psychotherapy. Because the caregiver and child are at different developmental stages and thus process trauma differently, caregivers may also have collateral (individual) sessions to address issues that impede their effective parenting but that are inappropriate to explore when the child is present (e.g., parents' past sexual abuse). The type of trauma experienced and the child's age and developmental stage determine the structure of the CPP sessions. With infants, the child is present for the joint sessions but treatment focuses on helping the parent to understand how the child's and parent's experience may affect the infant's functioning and development. Toddlers and preschoolers are more active participants in the treatment, which typically includes play as one vehicle for facilitating communication between the child and parent (Lieberman et al., 2015). The child welfare worker can assist the parents in understanding their importance to their child when explaining that the CPP sessions include both the parent and child, and that the parent may receive additional therapeutic intervention as needed. The child

welfare worker can also help agencies understand that there may be times that the parent needs to be seen without the child present, or that flexible configurations may be needed week by week. In the ABC program, the first goal is to stabilize families when they have come to the attention of the child welfare system and have been referred for preventive services. The initial task of the case workers/clinicians is ensuring a stable foundation for the family; the parents may need referral to substance abuse treatment or for domestic violence intervention. After this initial period in which the parent meaningfully engages in these services, typically within 2–3 months, stabilization occurs. Then a determination is made as to whether the family is ready to participate in CPP; if this is the case, CPP is initiated (E. Noguchi, August 24, 2016, personal communication).

In CPP, the main symptoms arising from the trauma are treated by establishing safety and consistency in the therapy, fostering accurate identification and perceptions of safety by the child and caregiver, highlighting the need for safe behavior, identifying factors that interfere with the caregiver's ability to provide for the child's well-being, and helping establish the caregiver as a protective, benevolent, legitimate authority in the child's life. The emotional health of the dyad is promoted by helping the child and caregiver explore new ways of relating that promote trust, reciprocity, and pleasure. Learning effective strategies for regulating emotions is paramount, as is fostering the caregiver's ability to soothe the child when he or she is upset. Helping the parent and child understand their bodily sensations and reactions, especially related to stress and body-based trauma reminders, and exchange of positive physical expressions of care are essential. A central component of CPP is the joint construction of a trauma narrative, with the goal of returning the child to a normative developmental trajectory (Lieberman & Van Horn, 2005).

There are six major intervention modalities used to support and strengthen the relationship between the child and caregiver as a vehicle for restoring the child's sense of safety (stabilization), improving the child's cognitive, behavioral, and social functioning by working through the traumatic events (setting the stage for permanency), and building a secure attachment relationship (achieving well-being). Within each modality, the affective experience of both the child and parent is recognized and legitimized to promote a sense of competence and to underscore that distressing feelings can be processed without resorting to harmful behavior, and that pleasure, mastery, and hope can be experienced.

1. Play, physical contact, and language are used to promote healthy development and build competence in the dyad. The therapist facilitates safe physical contact between the caregiver and child, developmentally appropriate play, and the use of language to explain reality, correct misperceptions, and identify and name feelings; these strategies facilitate the child's trust of the caregiver, and can help to build a secure attachment, the foundation for a healthy relationship, well-being, and permanence.
2. Unstructured developmental guidance provides the caregiver with information about children's age-appropriate behavior, needs, and feelings as they occur naturally in the treatment sessions. The therapist links the child's actions, needs, and

feelings to what is occurring in the family, and how these family circumstances may influence the child's experience. This approach is individually tailored to the dyad over the course of the treatment. The parent is assisted in understanding the child's view of the world. Parents often can then understand their own childhood experiences from a more empathic and compassionate stance. This modality of CPP addresses a key component of preventive services. The knowledge gained through unstructured developmental guidance is extremely beneficial for parents whose children are at risk for placement outside of the home. Developmental guidance supports the parent in understanding the child's abilities, areas that need to be strengthened, and the underlying meaning of behaviors as they are displayed during the intervention. Because the parent is learning about the child's behaviors and his or her own reactions as they are happening in the session, this information has more relevance and is usually learned more effectively than when presented in a didactic parenting class. When CPP is part of the parent's case plan, the child welfare worker can indicate that this intervention fulfills the requirement for parenting education, thus reducing another service needed by the parent since it is included as a component of CPP.

3. Modeling protective behavior is essential when a child may be engaging in potentially dangerous or harmful behaviors. If the therapist must step in to stop self-endangering behavior, a discussion about why he or she did so occurs with both the parent and child. The parent is asked to reflect upon what happened and to understand the potential danger and the protective action. This modality of CPP may include safety actions to assure physical safety and reduce immediate risk to the child, safety promoting interventions to de-escalate behaviors or feelings so that control is maintained, or safety planning interventions to prepare for potential triggers and facilitate emotional or behavioral stability.
4. Interpreting feelings and actions gives meaning to disorganized or disconnected emotions and perplexing behaviors. Interpretation often involves naming the unconscious or unspoken meaning of behavior in a way that allows the parent and child to have increased understanding of what may seem inexplicable. For example, the parent may see the child's normative defiance as willful disrespect and an attempt to undermine or even harm the parent, based on the parent's earlier experience of abuse by her own father. The parent's view of her child through this trauma lens impacts how she speaks to and acts with the child, and these negative attributions and actions are internalized by the child and are detrimental to his sense of self. The therapist can help make the parent aware of this misperception and free the dyad from these misplaced attributions.
5. Providing emotional support and empathy builds trust in the therapist and in the child-caregiver relationship. The therapist supports the parent emotionally and communicates empathically with the child. Building trust is the foundation for the parent and child to build a secure attachment, form a healthy relationship, and experience well-being and permanence.
6. Providing case management, concrete assistance, and crisis intervention allows families to avoid or manage crises and deal appropriately with stressful situations. Engaging in these activities also assists in forming and maintaining a

therapeutic alliance with the child and caregiver. Case workers providing preventive services often coordinate care among all the systems that support parents and young children (e.g., early intervention or childcare for the child, domestic violence, substance abuse, or psychiatric services for the parent). The case worker can communicate and work collaboratively with the CPP therapist to ensure these services are provided when needed. In the ABC program, the typical case management duties of the child welfare case worker are combined with the case management intervention that is an inherent part of CPP. Care coordination and service coordination occur in the context of the CPP intervention. Because of the number of case management demands in child welfare, ABC also employs case aides who collaborate with the CPP case worker/clinician to handle tasks such as searching for housing for families, assisting them in applying for entitlements, and assisting them in obtaining other basic services (E. Noguchi, August 24, 2016, personal communication).

How CPP Is Trauma-Informed

In order to restore safety in the relationship, a central focus of CPP is the parent's and child's experience of trauma. Assessment of each person's exposure to trauma and symptoms arising from trauma is integral to the conduct of CPP. The caregiver and child are educated about the impact of trauma, including common symptoms that arise from trauma, as well as the fact that with development, the way in which the child processes trauma may change. Helping caregivers understand that their own experiences of trauma may be affecting the ways in which they raise their children is a component of the treatment, so that negative cycles and intergenerational transmission of trauma can be broken. Time is spent on understanding trauma reminders and triggers so that they can be dealt with effectively. Discussions with the caregiver include how CPP processes trauma and how this may differ from the parent's cultural beliefs or her experiences of having been raised.

Components of CPP include helping the parent acknowledge that the child has witnessed and/or experienced trauma; helping the parent and child understand each other's reality and perceptions with regard to the trauma; providing developmental guidance acknowledging behavioral and emotional responses to trauma; making linkages between past traumatic experiences and current thoughts, feelings, and behaviors, including helping the parent understand associations between his or her own experiences and current feelings and parenting practices; highlighting the differences between past and present circumstances so that the dyad can see that new choices can be made; supporting the parent and child in creating a joint trauma narrative, making meaning of the traumatic experience, including discussion with the caregiver of including toys in the treatment that may help the child process the trauma, such as toy weapons, police cars, and ambulances; and facilitating behaviors that help the parent and child master the trauma and gain a new perspective. The dyad is assisted in acknowledging that, while the trauma happened to them, it does

not define them moving forward. The trauma is placed into perspective such that they can gain control over previously uncontrolled emotions evoked by memories of the trauma. The dyad can develop new ways to find meaning in life, and to experience hope and joy. Another important aspect of CPP is that attention is paid to vicarious trauma and how being a CPP clinician may expose a therapist to secondary traumatization. One component of CPP that is essential is reflective supervision/consultation, which assists clinicians in being able to hold the trauma stories they hear from their clients, but also process them with a reflective supervisor or consultant so that they do not negatively impact the clinicians' functioning. Child welfare workers are also at risk for secondary traumatization and are best supported by having access to reflective supervision and consultation as well.

Reflective supervision:

- Is a collaborative relationship between a service provider and supervisor
- Is based on reflection, collaboration, and regularity
- The provider's thoughts, feelings, and observations are explored within a safe relationship
- Facilitates knowledge of the self, engagement in the work, critical thinking, and effective clinical practice
- Purpose is to improve the provider's practice with children and families
  - Increases professional competence and awareness of the parallels between the parent and the provider as well as the parent and the child
  - Provider explores his or her own motivations, thoughts and behaviors, including anxieties and challenges
  - Facilitates exploring distressing feelings or thoughts in parents and children
  - Increases awareness and appreciation of others' perspectives and concerns (Shahmoon-Shanok, 2009)

Child welfare agencies that use relationship-based supervision have lower rates of turnover and greater success in obtaining permanent placements for children (Van Berckelaer, 2011).

Cultural Considerations

CPP is delivered in the context of the larger environment, including the family's culture. The child welfare worker holds an important role in educating the clinician about the family's cultural background and other aspects of family functioning that define their traditions, practices, and beliefs. CPP is based on responsivity to individual differences and encourages caregivers to engage in culturally consistent parenting practices that are appropriate given their context, as long as safety and protection are maintained. Discussions of intergenerational transmission of trauma, historical trauma, the family's faith-based and spiritual practices, traditional parenting practices, and cultural values are part of the therapy. While the basic principles and goals

of CPP apply across diverse groups, interventions are tailored to the specific family and their context, including their culture. The cultural context of the family informs engagement in treatment, assessment, and understanding of symptom expression. The family's cultural mores, beliefs, traditions, and child-rearing practices are discussed with the caregiver in order to understand that particular family's experiences, perspective, and expectations. There is an awareness that assumptions should not be made in a blanket or stereotyped manner, as there may be great variations within cultural groups with regard to parenting and child-rearing practices. The child welfare worker can monitor the families' assessments of the degree to which the CPP provider understands and appreciates their cultural practices.

Challenges to Implementation

Conducting CPP with families involved in the child welfare system creates both challenge and opportunity. Even in cases in which the child remains in the home with the biological parent, there may be regular Court hearings to assess progress toward case plan goals and to ensure that safety and protection are being maintained. In some cases, treatment may be mandated by the Court as one element of a parent's case plan. In this circumstance, the involuntary nature of the treatment immediately introduces a power differential between the parent and the CPP clinician. It is of utmost importance that the clinician be aware of the parent's perspective and history with individuals and systems who have had authority over them. Often there are difficult experiences in the parent's history that induce extreme distress, shame, guilt, anger, and suspicion (Lieberman & Van Horn, 2008). Chapter 12 in this volume addresses birth parent trauma in more detail. Trauma in the biological parent's history makes it particularly challenging for a parent to be open with the clinician about his or her experiences, beliefs, feelings, and expectations.

The clinician must be able to create a relationship of nurturance and trust at the same time that he or she is realistic about the changes that the parent must make to be able to safely and effectively parent the child. The CPP clinician can build trust through open discussion with parents about the possibility that the clinician is viewed as part of a system that controls decision-making about the custody of their children. The parent may have had experiences in which he or she felt disenfranchised, punitively controlled, or failed by large societal systems. Some parents involved with child welfare were involved in the Child Protective System themselves as children. It is imperative that this history be obtained from parents as they begin the CPP intervention, with a careful assessment of traumatic experiences of both the parent and the child, including intergenerational and historical trauma. Asking parents how it feels to be involved with the system again, and how it will be to engage with a therapist around these issues, is extremely important. An open, empathic stance by the child welfare case worker and the CPP clinician may provide an experience of being heard and supported in a manner that is new for the parent, such that the beginnings of trusting relationships can be formed. There are many

times that parents have expressed that the first time they were able to tell their stories of trauma and resilience occurred during the assessment process for CPP. Similarly, the child welfare case worker can also broach the subject of what it is like for the parent to be involved with the Child Welfare system, and openly discuss the parent's concerns, anger, and suspicions, if these are present. Demonstrating that there is concern for the parent and what he or she has been through in the past, as well as a wish for there to be open dialogue, can lay the foundation for a trusting relationship with the child welfare worker, and the opportunity to resolve difficult feelings or experiences that happened prior to the parent's current involvement with the system. Having honest and open conversations, being consistent and letting the parent know what the steps in the process are, and attending to those steps in a timely fashion, build trust and open the door for a better outcome for the parent and child. The child welfare worker can plan his or her visits to the parent's home on the same day and time, if possible, to help build the sense of predictability and safety.

In the ABC program, a challenge is in workforce development, to identify clinicians who wish to and have the skills to be both child welfare caseworkers and CPP clinicians (E. Noguchi, August 24, 2016, personal communication). These clinicians hold dual roles and must balance the determinations of safety and risk with the therapeutic stance of the CPP clinician. Every CPP clinician also is mandated to ensure safety and must report suspicions of maltreatment. Such reports could be made with the parent present, and, unless in extreme circumstances, certainly with the parent's knowledge, as maintaining trust is essential in the conduct of CPP. Nevertheless, if one is both the child welfare case worker and the CPP clinician, there must be the ability to move flexibly from role to role. This necessitates transparency and ongoing discussion with the family in CPP about the multiple demands and expectations of these dual roles. Another challenge in the ABC program is management of the workload, which involves not only the responsibilities related to the provision of CPP, but also the documentation requirements, quality assurance tracking, and other monitoring needed for child welfare case management (E. Noguchi, August 24, 2016, personal communication).

Also, as with all CPP clinicians, management of vicarious trauma is crucial. Families referred for preservation services often have experienced multiple traumatic events and may have ongoing trauma. It is essential to establish good boundaries, process the stress related to performing trauma work, and create safety in the workplace such that CPP clinicians can discuss the impact of providing CPP on their functioning. A core competency of CPP is reflective supervision/consultation, as there is an appreciation for how draining, demanding, and overwhelming it can be to do trauma work. Engaging in self-care consistently, cultivating ways to find joy in life, and relishing simple daily pleasures are necessary for the CPP clinician. There is the expectation that CPP clinicians work within agencies and institutions that support reflective practice, and cultivate environments that model appropriate and effective collaboration and self-care.

Ways in which the child welfare worker can support CPP:

- Be transparent about the nature and purpose of the intervention

- Introduce parent and child to the CPP clinician, if possible
- Discuss the limits of confidentiality
- Explore parents' questions, hesitancies, concerns, and hopes
- Maintain open communication with the CPP clinician and the parent
- Keep parent informed of the schedule and any necessary changes
- Check in with parent prior to and following any Court hearings
- Praise the hard work of parent and child in the intervention
- Monitor progress and facilitate modifications in plan, as needed

Clarification of the clinician's role with Child Protective Services and the child welfare system is crucial for all involved. Discussions about the limits of confidentiality, the fact that the clinician will need to share information the parent discloses with Child Protective Services and the Court, and the possibility that the clinician may be subpoenaed to testify in Court proceedings must occur prior to the initiation of CPP intervention. Obtaining signed informed consent needs to happen before CPP can begin. There may be times when the CPP clinician or the child welfare worker is subpoenaed to testify in Court about the parent and/or child's progress in the treatment or with their case plans. The child welfare worker may be asked about what he or she believes to be in the best interest of the child with regard to a plan for permanency. It is essential to have discussions with the parent prior to a Court hearing regarding what may happen, the types of questions that the clinician and/or case worker may be asked, including a clarification that legal discourse may sound very different than the types of discussions that occur outside the courtroom. An explanation can be provided that the clinician and case worker may be ordered to answer questions that pertain to material that has not yet been addressed in the treatment or in the case worker's conversations with the parent. Discussion of these possibilities ahead of time can build trust in the therapist and the case worker, and enhance their credibility with the parent, in spite of how difficult the discussions may be. Empathic discussions with the parent following Court hearings and any testimony provided can prove fruitful in building or furthering the parent's relationships with the clinician and the case worker. Building a trusting relationship is essential for facilitating the best outcomes in the intervention and with the family; when the clinician and the case worker are seen as trustworthy, parents are more likely to be forthcoming about their difficulties and less likely to withhold important information that is crucial to healing and promoting positive change.

This process mirrors respectful discussions with the parent that occur in CPP and with the child welfare worker about the necessity for the parent to change unsafe and self-destructive behavior. The CPP clinician and the case worker can balance an awareness of respect for the caregiver's vulnerabilities with the need to address lapses in safety, impaired judgment, and harmful behavior.

Working through the factors that underlie the child's maltreatment, such that the parent can be safe and psychologically available to the child, may necessitate a period of time in which the caregiver meets in individual sessions with his or her CPP clinician or with a different clinician to address impediments to safe parenting,

including psychiatric or psychological difficulties, substance abuse, intimate partner violence, and past history of their own abuse. Once the parent is able to accept his or her role in the trauma and is willing to consider the child's experience and perspective, CPP can provide the vehicle for restoration of safety, permanence, and well-being. Multiple challenges in the parents' history and/or current circumstances may need to be dealt with before safety can be established. If the parent is not able to acknowledge the child's experience of trauma, even after a parent's work in individual sessions, then CPP may be contraindicated.

Another issue that must be considered when working with cases referred by Child Protective Services is the timeframe of the treatment. CPP is a relatively long intervention; the average number of sessions ranges from 34 to 52 weeks. How much time does the clinician have to intervene? Is a Court order framing the length of the treatment? It is best if the child welfare worker can refer a young child and parent for CPP as soon as possible in the case planning process. In spite of the average length of the treatment, significant progress often can be seen within weeks of the initiation of the treatment. After an average of 22 sessions of CPP, one study had impressive results showing increased security of attachment being maintained for a year post-treatment at follow-up. It should be noted that the timeframe for the intervention was longer than 22 weeks because of missed and cancelled appointments (Stronach, Toth, Rogosch, & Cicchetti, 2013). The child welfare worker and CPP clinician should check in regularly to assess progress and next steps in the treatment.

Evidence for Success

Five randomized trials have been conducted on CPP. The five randomized trials involve over 500 young children; their families represent diverse ethnicities and income levels. The samples include maltreated infants, toddlers, and preschoolers whose families are involved with the child welfare system; some of the preschoolers studied were exposed to an average of five traumatic events. Across studies, the groups that participated in CPP had significantly better outcomes than the comparison groups post-treatment and at follow-ups occurring at various points thereafter. The outcome measures include security of attachment relationships, children's behavior problems and aggression, symptoms of posttraumatic stress disorder, depression and anxiety, cognitive performance, children's perceptions of their caregivers and themselves, and cortisol regulation. Caregivers demonstrated significantly better outcomes than comparison groups in avoidance, psychiatric symptoms, trauma symptoms, empathy, interaction with their children, and marital satisfaction (Cicchetti, Rogosch, & Toth, 2000, 2006; Cicchetti, Rogosch, Toth, & Sturge-Apple, 2011; Cicchetti, Toth, & Rogosch, 1999; Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011; Lieberman, Ghosh Ippen, & Van Horn, 2006; Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman, Weston, & Pawl, 1991; Peltz, Rogge,

Rogosch, Cicchetti, & Toth, 2015; Stronach et al., 2013; Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002). In the Toth et al. (2002) study, children involved in CPP through preventive intervention reduced their negative representations of themselves and their mothers, and had more positive expectations of the mother-child relationship. In the Cicchetti et al. (2006) study, the maltreated children who participated in this preventive intervention with their mothers demonstrated an increased rate of secure attachment relationships (from 3.1% pre-intervention to 60.7% post-intervention).

Stronach et al. (2013) conducted a follow-up of the sample of children and mothers involved in preventive intervention studied by Cicchetti et al. (2006). The Stronach et al. study demonstrated the effectiveness of CPP in promoting the maintenance of secure attachment relationships to their mothers in children 1 year after the conclusion of the CPP treatment. This larger sample (Cicchetti et al., 2006) was used to identify a subsample of mothers who neglected their infants; these dyads had been randomly assigned to either CPP, psychoeducational parenting intervention (PPI), or standard services typically available in the community when maltreatment had been identified (CS) (Toth, Sturge-Apple, Rogosch, & Cicchetti, 2015). Data were collected pre-intervention, post-intervention, and 1 year post-intervention. Saliva samples were taken from mothers to assess basal cortisol levels; self-reports of parenting stress were also obtained. Both CPP and PPI decreased perceived parenting stress, but only for mothers in CPP did this reduction in stress relate to child characteristics. The results suggest that mothers perceived their children in a more realistic and positive manner without being unduly influenced by their traumatic pasts. The mothers in the CPP group also demonstrated more adaptive regulation in basal cortisol; they showed more typical stress hormone regulation at 1 year post-intervention. The mothers participating in CPP benefitted both psychologically and physiologically, thus setting the stage for improved parent-child relationships.

With regard to stability of placement and permanency in the biological parents' home, in a follow-up of the randomized controlled trial (RCT) of CPP by Toth et al. (2002), preschool-aged children who were living with their mothers at enrollment were assessed at age 8 years, several years after the intervention had concluded. The RCT included two active interventions (Child-Parent Psychotherapy and a Preschool Psychoeducational Intervention) and two comparison groups. By age 8 years, 21% of the children in the Community Standard Comparison group had been placed in out-of-home care (either foster or kinship care). Within the intervention groups, only 2% of the children in the CPP group and 10% of the children in the Preschool Psychoeducational Intervention group were living outside of their mother's care. None of the nonmaltreated comparison children were living outside of the home. These real-world outcomes underscore the duration of effects of CPP and success in improving family outcomes for maltreated children (Manly, Toth, & Cicchetti, 2016). In 2011, CPP received accreditation as evidence-based by the Substance Abuse Mental Health Services Administration National Registry of Evidence-Based Programs and Promising Practices (http://nrepp.samhsa.gov).

Specific Competencies that Social Workers/Clinicians Need to Implement the Intervention

There are several core competencies identified as necessary to implement CPP with fidelity. Having many of these competencies also enables child welfare staff to identify families who would profit from referral for CPP, for communicating with the Court and other child-serving systems about the treatment, and for their own work with the families in facilitating successful completion of all the elements in the families' case plans. These competencies include (1) having familiarity with relevant bodies of knowledge, including infant and early childhood development; adult development and becoming a parent; developmental psychopathology and diagnostic frameworks for infants, children, adolescents, and adults, especially regarding symptoms that frequently arise following trauma, and trauma theory; (2) understanding sociological and cultural influences on individual and family functioning; (3) ability to observe behavior, including both caregiver's and child's behavior and how their interactions impact one another; (4) capacity to act as a conduit between the parent's and child's experience, including translating each partner's behavior and its underlying meaning; (5) co-constructing a trauma narrative; (6) capacity to engage in collaboration with multiple service systems; and (7) capacity for self-reflection, including having the time and space to engage in ongoing reflective practice (Lieberman & Van Horn, 2005). While understanding the intricacies and nuances of psychopathology and diagnosis, translating behaviors and their underlying meaning, and co-constructing a trauma narrative may be outside the scope of the Child Welfare Workers' training and skills, understanding that these are elements of the CPP intervention would aid them in their support of families' involvement in CPP.

Delivery Methods

CPP may be conducted in an agency, clinic, or in the home, and thus is flexible and can be adapted to the needs and circumstances of the family. When CPP is conducted in an agency or clinic, one advantage is that there is continuity in the setting; there also is freedom from the distractions that may occur in the home setting. Another advantage is that the clinician can assess how well the parent can manage the types of tasks that are imperative to care for the child effectively, such as maintaining appointments and arriving timely. Because the child will have medical and other appointments as well as be expected to attend school or other programs, this aspect of attending sessions outside the home can be of benefit in establishing the type of routine that will be expected in daily life once treatment and services with the Child Protective Services Agency have ended. Conducting CPP in the home also has distinct advantages. Going to the parent's home demonstrates an openness to learning about the family's daily life and environs, and conveys appreciation for

the stress of having to attend outside appointments, particularly for families who may not have reliable transportation or support systems. A disadvantage to the home setting is that the clinician must be mindful of appropriate structure and boundaries, as well as skilled in dealing with unexpected intrusions by others into the therapeutic space. Maintaining the clinical focus on the intervention is of paramount importance. In addition, the clinician must feel safe in the neighborhood and home; ensuring safety is a core feature of the treatment. In some circumstances, the CPP clinician may provide the intervention in a domestic violence or homeless shelter if the parent and child are residing there while more stable housing is being sought.

In all these instances, awareness of and attention to a safe and supportive work environment are protective against the stress of working with families who have experienced trauma and also assist the CPP clinician in maintaining a sense of internal equilibrium. Such a stance can engender hope in the child and caregiver who are engaged in the challenging and transformative work of Child-Parent Psychotherapy.

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Chapter 10
Working with Resource Parents for Trauma-Informed Foster Care

George S. Ake III and Kelly M. Sullivan

Goal/Purpose of Intervention of Service

In 2010, The National Child Traumatic Stress Network (NCTSN) launched a product called *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents* (Grillo et al., 2010; a.k.a. Resource Parent Curriculum or RPC) to assist child welfare and mental health professionals to train resource parents (e.g., foster, adoptive, kinship, therapeutic foster parents) on trauma-informed parenting. Specifically, the curriculum consists of psychoeducational material designed to inform resource parents about the impact of trauma on children and illustrate strategies to minimize the effects of trauma and promote resiliency for those children in their care. On the surface, the content of this curriculum seems similar to materials often found in child welfare pre-service trainings for resource parents, but in reality, it fills a tremendous gap in training resources available to foster a better understanding of how trauma impacts child behaviors and how parents and caregivers might effectively advocate for trauma-informed services.

The need for this curriculum is significant given children who have experienced traumatic events in their caregiving environment from a young age are at risk not only for emotional and behavioral disorders (Burns et al., 2004), but also for impairments across multiple domains of development (Cook et al., 2005). The children with the most significant trauma exposure and subsequent trauma reactivity require caregivers who understand the emotional and psychological context of problematic child behaviors. These behaviors and lack of resource parent training to support higher needs of children have been both cited as reasons for placement breakdown

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(Brown & Bednar, 2006; Chamberlain et al., 2006). In addition, it is difficult to engage foster parents as almost half of those completing pre-service training drop out prior to completing an application to foster within the first 6 months of training (Rhodes, Orme, Cox, & Buehler, 2003). Even worse, in some cases, foster parents are exiting this role at rates as high as 62% and in some states exit quicker than children do from care (Gibbs & Wildfire, 2007). When resource parents lack a trauma-informed perspective and see child problems as willful or as a consequence of their inadequacy, they are more likely to request a placement change (Barth et al., 2007). The combined weight of the high needs of children in care who have been exposed to traumatic events, early foster parent exits from the child welfare workforce, and lack of trauma-informed training is tremendous, and this curriculum provides a much-needed approach to address the growing needs of resource parents to equip them with strategies to support children in their care.

As outlined in earlier chapters, phase or stage-oriented trauma treatment models are becoming more prominent and widely accepted. Most focus on establishing stability, integrating traumatic memories among children in care to reduce the impact of the trauma, consolidating personal and interpersonal growth to return to a normal developmental trajectory, and forming more secure attachment relationships. Conceptually, RPC is a workshop that maps best onto the integration phase of trauma treatments supporting the permanency goals within the child welfare umbrella of services. RPC teaches parents what they need to know about how adverse childhood experiences impact a child's perception of adults and the world. Parents also learn about how to shift their own thinking to better understand challenging child behaviors and look at these behaviors through a "trauma lens." Parents who participate in RPC groups learn about and practice key skills to attend to children, minimize their reactivity to issues common in children who have experienced trauma, and support the overall goal to maximize placement stability in the home. For parents with children in their home who are ready to receive an evidence-based treatment to address symptoms secondary to trauma, RPC can provide them with skills and supports to help advocate for comprehensive trauma-focused assessments, selection of treatments that will best address the concerns identified in the assessment, and for regular involvement of the caregiver in the treatment to monitor and maintain progress once connected to a provider.

Description of Intervention or Service

RPC was developed through an NCTSN Subcommittee within the NCTSN Child Welfare Committee along with staff from the National Center for Child Traumatic Stress (NCCTS). The developers worked for approximately 2 years to write, pilot, and refine the curriculum before putting it into the public domain. The RPC curriculum materials include facilitator and participant manuals, as well as supporting workshop materials such as PowerPoint slide decks and training guidelines offered through the NCTSN Learning Center (Grillo et al., 2010).

Population Served

The RPC curriculum targets educating resource parents who currently have foster, kinship, or adoptive children in their home who are obtaining hours toward maintaining their license as a foster parent or to receive continuing education to support their learning. Many states have identified a training curriculum that they use consistently for pre-service training including resources such as Model Approach to Partnerships in Parenting (MAPP; Pasztor, 1987); Parent Resources for Information, Development, and Education (PRIDE; Deluca & Spring, 1993); and Parents as Tender Healers: A Curriculum for Foster, Adoptive, and Kinship Care Parents (PATH; Jackson & Wasserman, 1997); however, there are no current nationally utilized in-service trainings to help resource parents understand the impact of trauma on children in their care (Sullivan, Murray, & Ake, 2015). The RPC is meant to be designed to offer to all kinship, foster, therapeutic foster, and adoptive parents and many NCTSN members are translating the materials into other languages, adapting the materials to be more culturally specific, and developing additional case studies to make the curriculum more widely accepted and applicable. Currently, there are efforts to use and learn about the delivery of RPC materials translated into Spanish and there are military-informed mental health training projects focused on development and use of military-specific cases to assist with the increasing need for resources for military families. The military cases seem most appropriate for use with kinship families with a family member who recently was deployed where extra support is needed to understand how to support the children during deployment.

Staff Qualifications

According to the NCTSN Resource Parenting Curriculum Training Guidelines (NCTSN, 2012), there are three different roles that family partners and professionals may play in providing RPC including co-facilitators, staff facilitators, and master trainers. First, an RPC co-facilitator is either a resource parent or adult with childhood experiences in the child welfare system. Typically, co-facilitators have participated in a full course of RPC at least once and have been identified as a good candidate to help facilitate content from the curriculum as well as facilitate meaningful discussions in smaller groups during the delivery of the curriculum. Co-facilitators have varied numbers of years of experience as parents and can come from various cultural backgrounds. Co-facilitators are often compensated for their time and dedicate time outside of the groups to plan, debrief, and review the evaluations for RPC groups.

Staff facilitators are typically professionals in the human services field (e.g., child trauma mental health therapist or child welfare staff) who have the primary responsibility of coordinating all aspects of the workshop and who have received specialized training from an RPC master trainer. The average staff facilitator has a Master's degree in the human services field and has several years of experience with

most facilitators also holding a license in their prospective fields. It is very common for staff facilitators to serve as trainers of other curricula within their agencies and to have worked with foster and adoptive parents in the past (e.g., providing pre-service trainings). Successful staff facilitators are able to: (1) hold the perspective that those with lived experience (e.g., co-facilitators) are vital and equal partners; (2) hold a trauma-informed perspective and understand how traumatic stress symptoms can present in children; (3) share examples of traumatic events involving children in a way that participants can receive and learn from; (4) balance skills in delivering training content on trauma-informed parenting with managing a group pulling for varying levels of emotional responses from parents to the content; and (5) understand the fundamental concepts of cognitive-behavioral therapy, behavior management, and the child welfare system (Sullivan, 2015).

Finally, Master Trainers are members of or close collaborators of the NCTSN who are qualified to train other facilitators. Master Trainers usually have facilitated a significant number of RPC groups and have extensive experience working with resource parents including the use of a co-facilitator in groups. These trainers often have supplemental experience in training evidence-based treatments to mental health clinicians and are skilled in developing training for facilitators and co-facilitators that will adequately prepare them to deliver the group with fidelity to RPC. There are several Master Trainers throughout the NCTSN listed on the NCTSN Learning Center for Child and Adolescent Trauma.

Program Components

The program components of the curriculum are organized into eight essential elements (see Table 10.1), and all of the content is provided to parents in a Parent Handbook (Grillo et al., 2010).

What Makes It Trauma-Informed?

There has been a recent surge of interest in the topic of what makes an intervention, training, agency, or system trauma-informed within the mental health and child welfare systems. Using the definition of a trauma-informed child and family service system from the NCTSN (NCTSN, 2016), the RPC definitely fits within this definition as it supports parents as they learn to "recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers." RPC gives parents a comprehensive look at how trauma impacts children and families while also offering concrete strategies for their response that at a minimum that can impact the life of a child and at the most could impact the way a local system responds to a child's recovery from trauma.

RPC provides the foundation for resource parents to know how to interpret children's behavior in a trauma-informed way and to thereby assist with their emotional expression and regulation. This type of response is often core for

Table 10.1 Essential elements of trauma-informed parenting

1. Recognize the impact trauma has had on your child.
2. Help your child to feel safe.
3. Help your child to understand and manage overwhelming emotions.
4. Help your child to understand and modify problem behaviors.
5. Respect and support positive, stable, and enduring relationships in the life of your child.
6. Help your child to develop a strength-based understanding of his or her life story.
7. Be an advocate for your child.
8. Promote and support trauma-focused assessment and treatment for your child.
9. Take care of yourself.

parents to understand and practice with children who are involved in evidence-based mental health treatments targeting symptoms secondary to traumatic events. In some cases, experienced resource parents who have completed RPC could leverage their experience and knowledge to help expedite the delivery of treatment, as they already have some of the skills needed to support children in treatment. At the very least, trained resource parents would be less likely to hinder or disrupt treatment if they appreciate the importance of caregiver involvement and understand the skills generally required to support children receiving mental health services.

One commonly asked question from child welfare workers learning to screen for child trauma exposure among children in foster care is "what happens if we ask them about their experiences and they endorse something?" They want to know about the resources available to families to best address the traumatic events. While RPC is not an evidence-based treatment, it can be part of the standard response to child trauma in child welfare by equipping resource parents with tools they will need to adequately navigate trauma-informed parenting. It will help families where the child does not have ready access to a trauma-informed therapist as the resource parent will be able to identify and advocate for needed services in the community and trauma-informed strategies in various systems (e.g., schools) to help meet the needs of the child.

Parents involved in RPC training learn significantly more than just trauma-concepts as the training encourages active application of skills. They have the opportunity to assess their initial attributions of the behaviors presented by the children in their home and work to reconcile their self-assessment with what they know of most children who have been exposed to trauma. Through the workshop, caregivers have ample time and a process to operationalize how trauma might challenge the way children approach new relationships and to identify solutions for enhancing connections with biological caregivers. Parents learn about their role in shifting their child's developmental trajectory and what type of support children need to

make this journey. The curriculum also teaches parents how to maintain a psychologically safe home atmosphere and transform what they know about serving as an emotional container (Grillo et al., 2010) into concrete and testable strategies for approaching difficult situations for children who may need parents to anticipate and deescalate situations when children lose control.

In addition to the military supplemental materials that were developed to work with the increasing number of military involved families with children in care, RPC incorporates an inherent cultural lens through the delivery of the model to families. By working with existing families in a community to identify, select, and co-train with a resource parent, staff facilitators of the curriculum are empowered to really think about how to include a parent voice in a way that extends beyond parents hearing from parents. For programs that identify several resource parents to partner with in the delivery of the curriculum, staff facilitators can hold miniature focus groups to assess the cultural sensitivity and relevance of the evaluation measures, the language, and the delivery of the activities with the parents.

Advancing Cultural Competence

Based on feedback from NCTSN members implementing RPC, it is clear that facilitators of this workshop would benefit from considering the context of RPC delivery throughout the planning and execution of groups. Resource parents attending RPC workshops delivered in highly urban settings as part of the initial pilot reported identifying with case studies with a different set of experiences and trauma exposure than those from rural settings. Parents who were part of a resource parent association who participated in workshops often reported the content was something that they had ongoing conversations about and continued to apply to their everyday parenting practice as opposed to parents who may not share as much of a connection with one another (e.g., adoptive parents).

One major advantage and opportunity provided by doing RPC groups with regard to advancing cultural competence of mental health and child welfare agencies is the delivery of RPC in partnership with resource parents or foster care alumni as co-facilitators. Facilitators of the curriculum are typically mental health or child welfare professionals and may or may not represent the group receiving the workshop. If RPC is established as a best practice within child welfare agencies, there are an endless number of advances that can be made by selection of co-facilitators who connect with the culture of resource parents. Benefits may include: (1) co-facilitators may relate to the group of parents and be able to communicate the material in a more culturally specific manner; (2) enhanced debriefing conversations between facilitators and co-facilitators to test assumptions facilitators might have about the group of parents and how they may or may not be responding to the material; (3) with a strong working relationship, co-facilitators can be empowered up front to hold facilitators accountable to cultural norms and assumptions; and (4) agency leaders may be able to generalize lessons learned

about how to meet the needs of parents better by considering how other child welfare or mental health practices might be adapted or tailored to be delivered in a more culturally specific manner.

Challenges to Implementation

Implementation science research suggests that evidence-based practices take approximately 17 years from initial development until most frontline practitioners can access them (Westfall, Mold, & Fagnan, 2007). Additionally, the field's traditional methods of training adult learners only yield 5–20% of trainees who change their practice without ongoing support and attention to implementation (Joyce & Showers, 2002). The EPIS framework (Aarons, Hurlburt, & Horwitz, 2011) is a widely accepted implementation framework and for the rest of this section, the phases of this framework will be used to discuss the facilitators and challenges to implementation. The EPIS framework consists of the exploration phase, preparation phase, implementation phase, and sustainment phase.

The first phase of the EPIS framework is the *Exploration Phase* in which child welfare and mental health agencies working with resource parents should examine the needs of their training programs and determine if RPC would be a good fit to address training needs. During this phase, key stakeholders examine all of the available curricula for resource parents and determine what awareness, knowledge, and skills need to be addressed through training. In the case of RPC, it is one of the very few options for human service workers looking for a trauma-informed approach for experienced resource parents. In general, agencies are learning that RPC is a good fit for them if they have a relatively stable training workforce and mechanism for recruiting parents from existing working relationships. These are typically medium- to large-sized child welfare or mental health agencies with experienced trainers with some of their time dedicated to training resource parents. These agencies also have access to support resources (e.g., childcare from a local church and snacks donated from a local store) and space either owned by the agency or in the community to cut down on costs. Agencies are less of a good fit if they have a very high turnover rate, are in very small agencies with staff who are not dedicated to train, and from agencies with "initiative overload" who get excited about new projects but have a history of having problems with follow through.

When thinking about the *Preparation Phase of implementation*, agency leaders need to be thinking about the best selection of workers to facilitate and co-facilitate the workshops to prevent waste of resources and time on professionals that would not have proper support to run groups. To assess the goodness-of-fit to RPC, one approach would be to consider examination of multiple domains of practice commonly found in staff facilitators.

Referencing Fig. 10.1, there are several different domains of trauma-informed facilitation skills needed in staff facilitators including trauma knowledge, orientation to child welfare practices, promotion of psychological safety, time management, and partnership practice with parent co-facilitators.

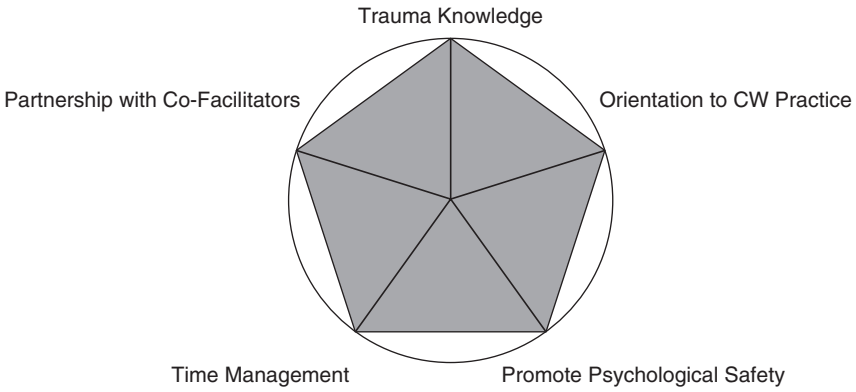

Fig. 10.1 Domains of trauma-informed facilitation

Depending on which of these areas are relative strengths or weaknesses, facilitators may require different types of coaching to address implementation barriers. For example, facilitators who are especially knowledgeable about child trauma knowledge and are well oriented to the policies and procedures often found in child welfare agencies will take to the material quickly and will have an easier time tailoring the content to meet the needs of the parents in an RPC workshop. If facilitators are particularly strong in their ability to manage time and maintain psychological safety in the group, their participants may be more likely to build trust in the facilitator to cover the material appropriately while also managing emotionally charged discussions in a way that prioritizes the needs of all members of the workshop. When facilitators are particularly weak in any of these areas, there are varying levels of risk including poor engagement of the parents, difficulties addressing questions parents have about how to address issues at home through a trauma lens, and levels of management needed to ensure that all of the content is delivered effectively. Of all these skills, having solid knowledge about trauma, traumatic stress, and the impact of trauma on children is particularly important to best meet the needs of the group. In addition, facilitators who partner well with adults who have lived experience as foster parents or foster care alumni can enrich the discussion significantly. Participants consistently appreciate hearing directly from co-facilitators and value consistency between the facilitator and co-facilitator's delivery of information.

During the *Implementation Phase* of RPC training, agency leaders, facilitators, and co-facilitators need to work together to address practical barriers to offering the group as well as monitoring implementation throughout the group. Practical barriers often needing attention include preparing for make-up sessions for parents, providing food and childcare to minimize the burden on parents to attend, and documenting participation to provide continuing education certificates to parents upon completion of the group. Factors that help with monitoring of implementation include setting aside time for facilitators and co-facilitators to debrief each session, including review of weekly evaluations; tracking of attendance and participation to examine patterns over time regarding delivery of specific modules; and collection

and use of evaluation data to examine changes in beliefs or attitudes of parents to understand the impact of the group and to assist with quality improvement efforts for future groups.

During the *Sustainment Phase* of RPC training, facilitators and agency senior leaders should work to address any longer term barriers by first determining if the group produced adequate outcomes and if it is feasible to continue running groups based on effort, budget, impact, and overall satisfaction with the group delivery. Facilitators and co-facilitators should also consider longer term plans for growing capacity to deliver the group, and senior leaders should consider changes to budget, policies, and training to ensure the maintenance of the groups if this meets their needs. This includes making strategic plans to continue involvement of resource parent co-facilitators including securing funding to pay for their time to plan and deliver groups with staff facilitators. In general, it is beneficial for agencies wanting to sustain RPC to: (1) think about budgeting at a minimum for co-facilitator time and expenses such as printed materials for parents for ongoing groups; (2) study the frequency of groups to determine how many groups and how many parents are feasible each year; and (3) think about how to build the 16-hour curriculum into requirements for continuing education for parents. Some of the barriers to sustain RPC include difficulty securing budget to maintain the groups, utilization of co-facilitators without proper compensation leading to burnout of volunteer resource parents, and poor planning to anticipate the number of RPC facilitators needed to account for growth of resource parents or attrition of workers.

Evidence for Success

Research on RPC is limited. Recently, the NCTSN initiated an evaluation project, referred to as the Child Welfare Practice Laboratory, in which RPC was evaluated. More than ten sites across the US participated, but the findings have not yet been published. Currently, there is one published empirical study evaluating RPC (Sullivan et al., 2015). Data were analyzed from 159 resource parents who participated in RPC workshops in 19 counties in North Carolina from 2012 to 2014. All parents included in analyses completed 10 or more hours of training, had experience as a resource parent, and completed the pre- and post-measures.

Of the 159 participants included for analyses, 58.7% were White/Caucasian, 37.4% were African American, 1.3% were Asian, 1.3% were Latino, 1.3% were multiracial, and 2.6% chose not to report race/ethnicity, females (69%) who were spread across all groups of resource parent types including foster parents (67.1%), therapeutic foster parents (12.0%), adoptive parents (47.5%), and kinship caregivers (12.0%), with many having more than one role. Participant age ranged from 24 to 77, with a mean of 48 years. Participants' years of experience as a resource parent ranged from less than 1 to 35 years ($M = 5.7$ years, SD = 6.5).

Participation in the workshop and the study was voluntary. RPC workshops were typically facilitated in 2-h sessions across 8 weeks, one module per session, with only rare modifications. Facilitators were mental health professionals

(e.g., psychologists and social workers), and co-facilitators were adults with either lived experience as a resource parent and/or as a child in the child welfare system.

Parents completed a number of self-report measures. The Resource Parent Knowledge and Beliefs survey has three subscales, all of which have information on their psychometric properties (see Sullivan et al., 2015). The Trauma-Informed Parenting (TIP) subscale was developed for RPC because no other scale existed to measure parents' knowledge about how trauma affects children and beliefs and attitudes about parenting a child who has experienced trauma. The Tolerance of Misbehavior (TOM) subscale includes four items adapted from the Casey Foster Applicant Inventory—Applicant Version (Orme, Cuddeback, Buehler, Cox, & Le Prohn, 2007) that assess a parent's ability to care for a child with difficult misbehaviors that commonly occur in traumatized children (inappropriate sexual behavior, lying, rejecting parent, and cursing/verbally aggressive behavior). Parenting efficacy (EFF) was measured using a version of the Parenting Self-Agency Measure (Dumka, Stoerzinger, Jackson, & Roosa, 1996) in which "parent" was changed to "resource parent" and "child" was changed to "child who has experienced trauma." Parents rated their agreement to statements from "strongly disagree" (rating = 1) to "strongly agree" (rating = 5).

The Post Workshop Satisfaction Survey (PWSS) is a project-developed parent self-report questionnaire completed at the end of the workshop with satisfaction items (e.g., "I would recommend this training to other resource parents.") and usefulness of six RPC teaching strategies/activities rated from "very unhelpful" (rating = 1) to "very helpful" (rating = 5). Also, project-developed evaluations for each module were used. They assessed interest, balance of teaching methods, previous knowledge of the material, if presenters were clear and effective, if the family partner co-facilitator provided insight and understanding, and feeling of preparedness to achieve the goal of that specific. All items on the Module Evaluations could be rated from "strongly disagree" (rating = 1) to "strongly agree" (rating = 5).

Repeated-measures mixed ANOVAs and post hoc repeated-measures GLM were used to measure changes on the Knowledge and Beliefs scale, while data from the module evaluations and satisfaction measures were summarized. It appears the RPC workshop is effective in improving multiple domains of trauma-informed parenting knowledge and beliefs and is satisfactory to resource parents. Specifically, after attending RPC, foster, adoptive, and kinship caregivers reported a significant improvement in their knowledge about the essential elements of trauma-informed parenting, with the foster and/or adoptive parents having more improvement than kinship caregivers. All caregivers reported feeling significantly more efficacious in their ability to care for traumatized children. Foster and/or adoptive caregivers also reported a significant improvement in their ability to care for children with several specific behavior problems, while kinship caregivers generally reported higher levels of tolerance of misbehavior before participating in RPC and their levels did not increase.

Participants reported high levels of satisfaction with the workshop, including the training materials, and that they would recommend the workshop to other resource parents. Participants also reported that they would be less likely to request a future placement change and that they are better able to meet their child's needs because of the workshop. Participants also rated the workshop's teaching strategies favorably, with the highest rating for family partner co-facilitator inclusion. These favorable ratings were reported on the weekly module evaluations as well, with participants reporting the workshop to be interesting and engaging and that its teaching methods were balanced. The weekly module evaluations also indicated participants viewed their facilitators and co-facilitators highly. Participant responses were variable on the item assessing if they already knew the material presented.

The positive findings on RPC are important because research suggests that parent cognitions and attributions impact behavior, which, in turn, impacts child outcomes (e.g., Sabatelli & Waldron, 1995). Specifically, parents' confidence relates to positive parenting behaviors (Coleman & Karraker, 1997), and parents more willing to tolerate misbehavior are more likely to keep children in their homes (Hartnett, Falconnier, Leathers, & Testa, 1999). However, the few resource parent training programs demonstrating improved child outcomes are more intensive and include elements of individualized support and coaching to facilitate skill acquisition (Dorsey et al., 2008). Therefore, it is important to examine whether RPC alone is sufficient to improve observable parenting behaviors, child outcomes, placement stability, and foster parent retention or whether additional support would be needed.

This study was limited because it did not examine changes in participant behavior or system-level results such as placement stability. Future research should include other methodology such as behavioral observations and information from other reporters. Another limitation of the current study is the lack of a control group and randomization, which prohibits the inference of causality. Additionally, even though numerous quality controls were put in place for the delivery of the workshops in this study, fidelity of implementation was not examined. Future directions for research should include a scaled-up study of national implementation of RPC, including the effects of facilitator skill and fidelity on participant outcomes to ensure that the findings from the current study are generalizable to a wider population of participants and facilitators. Future research should also examine if RPC is effective when implemented in different formats, including longer but fewer sessions, since format for implementation has become quite variable in practice without evidence as to which parameters for implementation retain RPC's effectiveness. Finally, an additional future direction for practice and research is to examine the impact of RPC in combination with other strategies for facilitating system-level change. Although resource parents are key stakeholders in providing trauma-informed care within the child welfare system, it is likely that true trauma-informed care in child welfare would be best achieved by augmenting the RPC workshop with other strategies, such as trauma-informed training for child welfare staff and mental health service providers.

Application Strategies

There are a number of considerations for mental health and child welfare agencies to keep in mind when preparing to host RPC workshops. The main considerations have to do with what it takes for their agency to apply RPC to the target population with the intended outcomes. The application strategies for these agencies to consider include: (1) selection of facilitators and co-facilitators to deliver the workshops; (2) identification and recruitment of participants; (3) proper setting including decisions about including observers; (4) maximizing of protective factors and minimizing of risk factors for participants, co-facilitators, and facilitators.

As mentioned earlier in this chapter, there are a number of characteristics of facilitators and co-facilitators as well as domains of their facilitation skills to assess before selecting staff to run these workshops. In addition to examining facilitator characteristics, it is important for agencies to assess the level of experience, interest, time, and investment staff needs to provide a successful workshop as well as identify needs to sustain them. For agency leaders who identify staff with all of the preferred characteristics of facilitators and co-facilitators, but who don't consider how these workshops fit into their workload, work flow, and professional goals of the staff member, there are risks in running a very short RPC program with limited reach and impact. For agency leaders who engage in discussions early and throughout implementation of RPC with their staff to assess fit and problem solve areas of need, their staff will likely remain engaged and feel supported.

When newly trained RPC facilitators go back to their home agencies and start developing materials and opportunities to support recruitment for groups, they are often surprised with how much effort it can take to successfully identify and engage parents about this curriculum. For mental health facilitators, they often do not experience "if you build it they will come" situation where they develop an engaging flyer, they send it to their clinic for any other clinicians who work with resource parents, they send it to their community partners who have resource parents as a part of their service array, and they find that very few people register. Child welfare partners have access to resource parents; they are able to identify plenty of parents who would benefit from the workshop, but once they put their materials out they find difficulty answering questions about how this might differ from other trainings or have some difficulty answering more clinically based questions that parents might want to ask, leading to some feelings of nervousness and uncertainty about offering groups after the first one. The recipe for successful recruitment of RPC participants includes ingredients such as one solid, trauma-informed brochure to describe the workshop and how it will meet the needs of the parents who have children in their homes today as well as one strong connection to a referral base of resource parents who need continuing education and who are likely to respond if they know the trainer. Child welfare and mental health agencies need to partner to maximize the chances for successful recruitment for the first two groups. After two groups, the parents really are the best referral sources as they often are connected to the resource parent community and can make recommendations for the workshop to their friends and colleagues.

Another really important application factor is the training setting and determining who else can be in the room in addition to facilitators, co-facilitators, and participants. Parents will do best in a setting that they are familiar with and that they have already built positive experiences with training. If this exists, then it is ideal to leverage those physical spaces to give parents one less thing they have to get acquainted with. It is important to consider the relationship of the parents to the agency organizing to also help determine the best space. For example, parents who regularly attend trainings with child welfare and are accustomed to the space and style of how trainings are organized might love attending RPC in that space. However, if most of the parents have strained relationships with their workers and are worried they are going to be "graded" by workers, then it might be worth looking into another venue.

Aside from the physical space, the setting is also made up of those who attend the workshop. Inevitably, agencies will want to send other staff or have outside staff or interns observe these workshops to see how they are structured and learn about trauma-informed parenting. This is a sign of a flourishing RPC program and is something to definitely consider. It is, however, important to consider the number of observers to keep the ratio small in comparison to the participant number. It is also important to consider any dual roles observers might play in the lives of the participants. For example, it might not be the best match for a foster parent who is in the initial stages of adopting a child to have the worker who will make recommendations about their adoption in the room unless they have a strong positive relationship. It might also be difficult for the adoptive parent to have their therapist observe the group when it would be just as easy for the therapist to observe the next group offered.

The last consideration for those planning on running RPC workshops is to think of how to maximize protective factors as well as minimizing any risk factors for participants, co-facilitators, and facilitators. This curriculum has some inherent elements that really help promote protective factors including an entire module on self-care, activities and discussion points meant to help normalize beliefs and experiences of resource parents, and each of the modules focuses on sharing some of the more difficult consequences of trauma while also maintaining a balance of hope for children with these traumatic experiences. The concept of the emotional container (Grillo et al., 2010) is one that facilitators and co-facilitators can use to help contain emotions that come up in the groups among participants as well as a frame for their time debriefing groups, which is a powerful concept to reflect on regularly. There are basic tools included in the curriculum such as the feelings thermometer to post on a wall and refer parents to each group as well as refer to when there seems to be an especially emotionally valiant discussion going on in the group. The delivery of the group is also designed to allow parents to process the information and their thoughts and feelings about the material over time versus a one-time information dump that could cause some parents to feel overwhelmed or overloaded. Staff using RPC should really think proactively about how to incorporate these elements into the training to help support parents who may struggle to reconcile their previous approaches to dealing with moods and behaviors of their foster,

kinship, and adoptive children. Staff using RPC should also think about how to minimize the risk factors that come with providing psychoeducation to parents on definitions of trauma, impact on the child and family, and advocating for trauma-informed care given the likelihood of some staff having personal experience with trauma. Agencies can also minimize risk by having regular check-ins with staff to identify times where extra support is needed.

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Chapter 11
Addressing Birth Parent Trauma: Pathway to Reunification

Elizabeth A. Thompson

Goal/Purpose of Intervention

Successful engagement of the birth parent by child welfare is critical to the healing process for the parent-child relationship and for the amelioration of the trauma experienced by the child. An empathic approach that recognizes the parent as an individual, with their own difficulties, and resiliencies, will result often in stronger parental engagement. Acknowledgment of the parent's own history of exposure to trauma, often with enduring effects, is an important aspect of the approach to engagement. If the parent is engaged, the child will benefit.

A variety of factors has been found to be related to the success or failure of reunification, and a broad review of the literature indicates that the majority of these fit into the following domains: child, birth parent, family, casework, and systemic. Birth parent factors include attitudes toward reunification, the level of engagement with the reunification process, as well as mental health and substance abuse issues (Akin, 2011; American Humane Association, 2012; Brook & McDonald, 2010; Cheng, 2010; Child Welfare Information Gateway, 2011; DeGarmo, Reid, Fetrow, Fisher, & Antoine, 2013; Dougherty, 2004).

There is increasing recognition that birth parent factors may have their roots in unresolved traumatic stress. Untreated trauma that occurred earlier in life (e.g., during childhood) and present-day trauma can impact birth parents in terms of their coping, parenting skills, and their ability to engage effectively with the child welfare system. The intervention discussed in this chapter—Addressing Birth Parent Trauma—can positively impact the child welfare system goals of safety, permanency, and well-being. This chapter (1) provides a brief review of the impact of trauma on birth parents in the areas of individual coping, parenting capacity, and

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interactions with the child welfare system; (2) describes an approach to casework called Addressing Birth Parent Trauma that workers can engage in that allows their interactions to be more trauma-informed and facilitates birth parent recovery from their own trauma histories that may interfere with their ability to effectively parent and interact with service providers; and lastly, (3) explores implementation challenges, evidence for success, and application strategies for the approach.

Statement of the Problem

A wealth of empirical and clinical evidence over the past few decades has firmly established that traumatic stress can have profound negative impacts on an individual's emotional well-being and psychological functioning. Known effects include psychiatric symptoms that meet formal diagnostic criteria (e.g., PTSD, Anxiety, Major Depression) as well as sub-threshold symptoms that have negative impacts, but do not meet full diagnostic criteria (American Psychiatric Association, 2013). Deficits can also occur in areas of psychological functioning such as regulating behaviors and emotions, accessing cognitive capacities, negotiating interpersonal interactions/relationships, and coping strategy utilization (Briere & Spinazzola, 2005; Cinamon, Muller, & Rosenkranz, 2014; Maschi, Baer, Morrissey, & Moreno, 2013). Depending on a host of internal and external factors, we also know that effects of an individual's trauma can be short, medium, and/or long term, and can include the intergenerational transmission of trauma. Adequate conceptualizations of adult trauma must take into account exposures that happened in the past (e.g., childhood physical abuse) that might be still unresolved as well as those that are more current (e.g., domestic violence).

While the lack of screening in many jurisdictions prevents adequate empirical documentation regarding the number of birth parents with trauma histories, practice-based (clinical) evidence suggests that a high proportion have either experienced trauma in the past or the exposure is ongoing. Available data support this claim. Chemtob, Griffing, Tullberg, Roberts, and Ellis (2011) screened 127 mothers who were enrolled in a child welfare prevention program in New York City and found that 9.6% had experienced at least one traumatic event; 61.7% met probable criteria for depression; 54.3% for PTSD; and 48.8% met criteria for co-morbid condition of the two. The authors reported that most were not receiving any mental health treatment at all for their symptoms at the time of screening. According to several studies, caregiver functioning is a predictor of child functioning (e.g., Lieberman, Van Horn, & Ozer, 2005). Results from the *Survey of State Child Welfare Initiatives for Maltreated Infants and Toddlers* found that fewer than half of the 46 states that responded had specific policies in place that required birth parents to be provided with the opportunity to receive treatment for their own domestic violence, trauma, and substance abuse issues (Zero To Three, 2013). Untreated trauma in birth parents has negative impacts on individual functioning, parenting capacity, and interactions with child welfare system. Each of these areas is discussed below.

Impact of Trauma on Individual Coping

In addition to the psychiatric symptomatology mentioned above, individuals with unresolved trauma histories may have trouble managing the normal tasks of day-to-day living. The presence of traditional PTSD symptoms (avoidance, numbing, hyperarousal) can be confounded by "trauma triggers," that is, a stimulus (stimuli) in the environment (such as a sound, smell, sight, touch, etc.) that reminds the person of a past traumatizing event, so much so, that the individual is in a sense transported back and has an emotional and or behavioral reaction similar to that which occurred at the time of the original trauma. Physical symptoms (e.g., pain, sleep difficulties) may also be present, as well as impairment in managing emotions such as anger. A trauma history can increase vulnerability to additional life stressors, such as lack of employment, economic instability (which includes food and housing challenges), as well as increase in the likelihood of additional traumatic exposure.

The experience of complex trauma—a term used to describe both exposure to multiple traumatic events early in life, often of an invasive, interpersonal nature, as well as the wide-ranging, long-term impact of this exposure—may be particularly problematic for birth parents. If left untreated, this type of exposure can result in long-term difficulties with forming and maintaining secure and trusting relationships. This can be problematic for adult partnering, parenting, and engaging successfully with personnel in the child welfare system. Forming and maintaining healthy intimate adult relationships, having the capacity for attachment needed for secure parenting, and possessing the belief that an assigned worker really has their best interest in mind during the case management process are examples of qualities that facilitate healthy birth parent-worker relationships.

Substance abuse- and trauma exposure-related disorder often occur co-morbidly (Blakey & Bowers, 2014; Boughner & Frewen, 2016; Coffey et al., 2016; Otero & Archer, 2013). One hypothesis suggests that substance abuse can be viewed as a maladaptive coping mechanism which functions as a way to "self-medicate" and dull emotional distress (Boughner & Frewen, 2016). Many who seek treatment for substance abuse also have high rates of trauma exposure (Otero & Archer, 2013). In this scenario, substance abuse can be understood as a symptom of unresolved trauma. Prevalence data vary due to differences in methodology, definitions, type of substance demographics, etc., but parental (especially maternal) substance abuse is well documented as a reason for foster care entry, with one-third to two-thirds of children entering out of home care related to caregiver substance misuse (Smith & Testa, 2002; Wingfield, Klempner, & Pizzigati, 2000; Wulczyn, Chen, & Courtney, 2011). Lloyd and Akin (2014) reviewed 5 years of foster care data from a single state in the Midwest and found children stayed 49–156 days longer if they were removed due to drug abuse. Parental substance abuse decreases the likelihood of successful reunification (Green, Rockhill, & Furrer, 2007; Gregoire & Schultz, 2001; Rosenberg & Robinson, 2004). In a Child Welfare briefing, the importance of continued substance abuse treatment once reunification has occurred was noted (American Humane Association, 2012),

Clinical evidence indicates that many women with abuse and/or domestic violence exposures during childhood unwittingly find themselves in abusive relationships with intimate partners as adults. This suggests that unresolved traumatic stress may underlie victimization. Domestic violence exposure is a risk factor for perpetrating child maltreatment (Kernic et al., 2003; Kohl, Barth, Hazen, & Landsverk, 2005), which can then lead to child protective services involvement. Marsh, Ryan, Choi, and Testa (2006) found that successful reunification was 53% less likely to occur in families when there was a lack of progress on domestic violence issues.

The Child Welfare Information Gateway's brief on *Domestic Violence and the Child Welfare System* (2014) noted the rate of co-occurrence of domestic violence and child maltreatment and the high number of families involved in both systems, and advocated that intervention efforts be aligned and collaborative in nature in order to be of maximum benefit to families. Several states (e.g., Oregon, Virginia) have established guidelines for child welfare practice with families experiencing domestic violence.

Impact of Trauma on Parenting Capacity

Unresolved trauma can negatively impact many of the skills needed for successful parenting. It is widely accepted that security of attachment in the context of a primary caregiving relationship is a developmental cornerstone for children. When parents are unable to maintain secure attachments with their children due to their own unresolved trauma histories, several domains of the child's functioning can be negatively impacted. Another key aspect of parenting is the ability to provide a safe physical environment for the child. Previous traumatic exposures may impair a parent's ability to make appropriate judgments about their child's safety when evaluating risk, resulting in either over protection or under protection (Gewirtz, 2016). Parents are a child's first "teacher" and if there is a compromised ability to regulate, the parent may have difficulty normalizing and helping their children express emotions effectively. The fact sheet entitled *Birth Parents with Trauma Histories in the Child Welfare System: A Guide for Child Welfare Staff* developed by the Birth Parent Subcommittee of the National Center for Child Traumatic Stress Network (NCTSN) (2011) notes several additional parenting capacities that can become negatively impacted due to unresolved trauma: A compromised capacity to meet their children's needs may extend to challenges supporting the child in counseling; difficulty negotiating interpersonal relationships making it difficult to develop, maintain, and access supportive relationships; being "triggered" by a child's behavior which can result in personalizing the child's actions or responding impulsively. Discipline strategies can become overly harsh (even abusive) at one end of the continuum or nonexistent at the other (Gewirtz, 2016). In a review of the literature on sexually abused mothers, Riser (2009) reported higher rates of permissive parenting, parental stress, and the use of physical discipline and physical abuse of children in abused

mothers versus those who had not been sexually abused. Additional studies cited in Riser (2009) indicate a history of child abuse, predicted use of physical and verbal abuse for mothers, and higher rates of poor parenting in parents of both sexes. Newcomb and Locke (2001) found that sexual abuse was related to rejecting parenting practices in fathers, but aggressive parenting practices in mothers. Banyard, Williams, and Siegel (2003) found rates of trauma exposure related to increased reports of child neglect and protective services reports, use of physical punishment, and decreased reports of parenting satisfaction.

It is important to note that parents may not be aware of and understand how previous/current trauma exposures are impacting their present-day parenting capacities. This does not excuse parents from being responsible for any actions (or inactions) that may have led to the removal of their children, but this knowledge is an important step for both parents and workers in understanding the factors that need to be addressed to achieve successful reunification.

Impact of Trauma on Birth Parent Interaction with the Child Welfare System

Success in the child welfare system for birth parents depends upon many of the skills that may be compromised due to unresolved trauma histories. These include the underlying cognitive, emotional, and behavioral capacities necessary for working effectively with child welfare staff and other personnel, such as attorneys, child advocates, judges, foster parents, mental health professionals, as well as meeting the reunification requirements. Parents with unresolved trauma histories have difficulties engaging with and trusting those designated to help them (Kemp, Marcenko, Hoagwood, & Vesneski, 2009). In a presentation at the 7th Annual International Conference on Child and Family Maltreatment, Otero and Archer (2013) reported that failure to directly address trauma in adults whose children are in the child welfare system may result in lack of engagement in services, withdrawal from relationships with those providing services, increase in trauma symptoms/re-traumatization, and minimal success when interventions are implemented. The system itself may re-traumatize parents given that a child's removal and placement in foster or kinship care results in a loss of power and control, which is a hallmark feature of traumatic stress. The NCTSN fact sheet (2011) highlights the impacts of trauma in birth parents. When "*triggered*," parents can exhibit emotions such as anger and fear, which may get interpreted as being directed at the child welfare worker or others in the system when they are in reality emotional reactions to their own histories. *Avoidance* may manifest itself in missed scheduled visitation or family planning meetings**.** Engaging with the child's caseworker(s) and foster parent(s) as well as other service providers can be difficult given the challenges in developing and maintaining interpersonal relationships. *Disengagement and numbing*, both maladaptive coping strategies for dealing with trauma reminders may be incorrectly interpreted as

resistance, lack of co-operation, and/or an unwillingness to do what is mandated for reunification. *Planning for the future* may be challenging if parents have impaired decision-making ability, a secondary symptom of traumatic stress. Negative reactions to birth parents' behaviors that result from unresolved trauma histories may lead to judgmental/blaming attitudes and/or punitive responses that serve to further alienate them as well and decrease the likelihood that they will engage with the system in ways that have the best chance of leading to safety, permanency, and well-being of their children. Although parents are often required to attend generic parenting; anger management; and/or substance abuse interventions as part of their reunification efforts, studies indicate the importance of referral to interventions that directly address parental trauma (Chemtob et al., 2011).

Description of the Approach

The approach discussed in this chapter, Addressing Birth Parent Trauma, in order to increase the likelihood that the goals of safety, permanency, and well-being will be achieved for children in the child welfare system can be implemented: (1) by thorough screening and assessment of traumatic stress; (2) through the general practices of trauma-informed care and the acquisition of knowledge, skills, and attitudes that consider the birth parent's needs and history; and (3) through utilization of trauma-specific interventions. These steps are described in detail below.

Step One: Screening and Assessment for Traumatic Stress

A first step might be to ensure that *all* parents who receive child welfare prevention, post-removal, and/or pre-reunification services are screened for exposure to traumatic stress, with positive screening leading to a full assessment and intervention planning [see section below for discussion of specific trauma-informed interventions]. One challenge that may occur is the birth parent's reluctance to endorse trauma symptoms out of fear of negative consequences (e.g., child removal, delayed reunification). The most liberal view held by many mental health professionals is that any untreated/unresolved trauma in birth parents should be addressed clinically. A more conservative approach suggests treatment is warranted if PTSD symptoms and related difficulties, such as anger, fear, anxiety, depression, confusion, etc., persist for long periods of time, are overwhelming, and are distressing to the individual. Concern or worry expressed by others may also be an indicator. If symptoms are severe enough to interfere with carrying out normal daily activities in home, school, or work settings, it may also be time to seek help. Other indicators include use of alcohol, drugs, and/or sex as coping mechanism, as well as the presence of physical symptoms that includes tenseness, agitation, and hypersensitivity that interfere with interpersonal interactions/relationships.

Step Two: Using Trauma-Informed Principles, Knowledge, Attitudes, and Skills to Guide Practice

All workers should be trauma-informed and commit to developing the knowledge, skills, and attitudes that will allow them to take birth parent trauma histories into account when engaged in the range of child welfare activities (e.g., visitation, case planning/management, court hearings, family conferences, investigation/removal, reunification, etc.). The Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) has delineated six principles that should be adopted and sustained in efforts to ensure a trauma-informed approach to service delivery: (1) Safety; (2) Trustworthiness and Transparency; (3) Peer Support; (4) Collaboration and Mutuality; (5) Empowerment, Voice, and Choice; and (6) Cultural, Historical, and Gender Issues. Best thought of as "universal precautions" applying these principles is an approach that can be used with all birth parents. However, for some, this may not be enough, and it may be necessary for the caseworker to refer birth parents to a specific evidence-supported trauma intervention [see the above section for when to refer for treatment]. Such interventions have demonstrated positive outcomes in addressing trauma symptoms, maladaptive coping, and promoting recovery. With rare exception, they can only be delivered by a licensed mental health clinician (i.e., social worker, psychologist, professional counselor) with the requisite training and supervision. It is important to note that even though they might not have the credentials to implement specific intervention, all workers should have knowledge about what these interventions are and what they have in common and be able to help birth parents evaluate potential therapists with regard to the needed trauma expertise as well as assess progress once treatment has begun.

The NCTSN fact sheet (2011) mentioned above lists several approaches to encourage staff at all levels to engage in their work through a trauma lens. Grouped by the author of this chapter for convenience into knowledge, skills, and attitudes, these are listed in Table 11.1. The two accompanying vignettes give readers the opportunity to be thoughtful about how they might view the scenarios through a trauma lens.

Step Three: Trauma-Specific Interventions for Birth Parents with Trauma Histories

The knowledge, skills, and attitudes described above form the basis for clinical decision-making that links the screening and assessment process to the delivery of evidence-based practices. A review of the National Registry of Evidence-Based Programs and Practices (NREPP) and/or the California Evidence-Based Clearing House for Child Welfare (CEBC) found 17 interventions that *specifically address adult trauma and associated traumatic stress symptoms.* These appear in Table 11.2. Inclusion does not constitute an endorsement by the author of this chapter. Trauma-specific interventions that include substance abuse and domestic violence as targeted issues do appear in the table. Interventions/programs listed in these two

Table 11.1 Knowledge, skills, and attitudes necessary to work with birth parents who have experienced trauma

Knowledge	Be aware that negative emotions (e.g., avoidance, anger, etc.) though sometimes directed at caseworkers may in fact stem from reactions to traumatic stress events from the past While it is important to hold birth parents accountable for negative behaviors that led to their involvement in the child welfare system, it is equally important to help them understand the relationship between past traumatic experiences and these current behaviors When developing service plans, workers should have general knowledge about trauma-informed services that are available including knowing when to refer to specific evidence-supported interventions. Referring clients to services that fail to adequately address underlying trauma issues are unlikely to result in positive outcomes	Mary's 1-year-old daughter, Jessica, was put into foster care, after a pot of boiling water fell off the stove and burned her legs. Jessica's two older siblings are being raised by their paternal grandparents. The CPS investigation revealed that Mary was high on alcohol and drugs at the time. Two other adults were in the home partying when the incident occurred and no one realized Jessica had gotten out of her bed and gone into the kitchen. Mary took a cab to the emergency room. Jessica is recovering nicely and after 3 months in care, she is becoming attached to her foster mother. Mary felt bad about the incident and follows up with the caseworker on a regular basis to hear how Jessica is doing. However, her attendance in a court-ordered drug treatment program has been sporadic and she has missed more than half of scheduled appointments. She complains that she hates the group, no one really understands her, and especially not the group leader, who according to Mary, does not seem to know what she is doing. The worker has stated to her supervisor that she does not understand the noncompliance since it is a condition of reunification, and she knows how badly Mary wants to get her daughter back. In her first supervised visit with Jessica, Mary shows up with red eyes, and smelling like alcohol. The worker informs her that she cannot see her daughter and they will have to reschedule for another day. Mary screams at the worker and tells her that she is out to get her like everyone else in her life and storms out of the building.

Skills	Workers should have the necessary skills to be able to assess a parent's history to gain an understanding of how parenting and functioning in everyday life have been impacted by traumatic experience Be familiar with how trauma reactions can manifest in child welfare activities that birth parents engage in (e.g., visits, case conferences, court hearings) Help parents develop strategies for becoming aware of and how to respond adaptively to triggers Learn how to advocate for the utilization of trauma-informed service delivery and for the development/expansion of such services if none exist, or there is limited availability	Carol has a history of childhood sexual abuse (mother's boyfriend) and has experienced domestic violence in her on-again, off-again relationship with James, her boyfriend of five years and father of her daughter, Lilly. Carol and Lilly are very attached to each other and Carol has always wanted to be the kind of mother that she never had. Unemployed, Carol moved to a shelter after James broke the daughter's arm when he tried to force her to sit in a chair. James is out on bail, and Carol is considering moving back in with him because she believes he is really sorry this time and is worried she cannot make it on her own. Lilly was placed in kinship care with Carol's maternal aunt because the only shelter in her town would not take children over the age of 5. When Carol comes over to her aunt's house to visit, she notices that Lilly seems angry with her and the aunt reports it is hard for her to settle down when Carol leaves. The aunt petitioned to become Lilly's legal guardian, when Carol acknowledged her desire to move back in with James. At the hearing, the worker noticed that Carol looked like she was in a daze the whole time and mostly mumbled responses when the judge asked her questions
Attitudes	Judgmental, blaming, and punitive attitudes toward birth parents are likely to be counterproductive in efforts to motivate and empower Assume a strength-based stance and try to build on parent's desire to keep their children safe and parent effectively	The worker noticed she was feeling frustrated with Carol for her decision-making and her inability to advocate for herself. She reminded herself that Carol's response could be related to her trauma experiences, and these reactions could be interfering with her ability to take action. She checks her attitude toward Carol and decides to ask for a trauma assessment to determine if a traumatic stress condition could be an issue

Table 11.2 Interventions with evidence of effectiveness or efficacy for birth parents who have traumatic stress conditions

Name of intervention	Site	Type	Degree of evidence	Intervention targets
Trauma recovery and empowerment model	NREPP CEBC	Adult group	Promising 3, medium	Trauma symptoms, depression, anxiety, alcohol/substance abuse
Boston consortium model: Trauma-informed substance abuse treatment for women	NREPP	Integrated collection of substance abuse and trauma-informed mental health services to low income minority women in Boston	Legacy review	Substance abuse, mental health symptoms, PTSD
Child parent psychotherapy	NREPP CEBC	Child/parent dyad	Legacy review 2, high	Attachment, child PTSD/ behavior, maternal PTSD/mental health, domestic/intimate partner violence
Cognitive processing therapy for posttraumatic stress disorder	NREPP CEBC	Adult individual or group	Legacy review 1, medium	PTSD, depression, anxiety
EMDR	NREPP CEBC	Adult	Legacy review 1, medium	PTSD, anxiety, depression
Combined parent child cognitive Behavioral therapy: Empowering families who are at risk for physical abuse	NREPP CEBC	Child/parent, individual or group	Legacy review 3, high	Child PTSD, positive parenting skills, parent/ child relationship, parental trauma history
Healing our women	NREPP	Adult HIV+ women with a history of child sexual abuse, individual	Legacy review	PTSD, HIV risk, HIV behavior treatment adherence
Living in the face of trauma: An intervention for coping with HIV and trauma	NREPP	Adult HIV+ women with a history of child sexual abuse, group	Legacy review	Traumatic stress symptoms, child sexual abuse, HIV risk behaviors
Prolonged exposure therapy for posttraumatic stress disorder	NREPP CEBC	Adult men and women, individual	Legacy review 1, medium	PTSD, depression, anxiety

(continued)

Table 11.2 (continued)

Name of intervention	Site	Type	Degree of evidence	Intervention targets
Seeking safety	NREPP CEBC	Adult men and women, group or individual	Legacy review 2, medium	PTSD, substance abuse, psychological distress
Trauma affect regulation: Guide for education and therapy	NREPP CEBC	Adult men and women, group or individual	Legacy review 3, medium	Survivors of physical, sexual, and emotional trauma
Traumatic incident reduction	NREPP	Adult men and women, individual	Legacy review	PTSD, anxiety, depression
Accelerated resolution therapy	NREPP	Adult men and women, individual	Effective	Trauma symptoms, depression, personal resilience/self-concept
Narrative exposure therapy	CEBC	Adult men and women, individual	1, low	PTSD, substance abuse, anxiety, depression
Skills training in affective and interpersonal regulation plus modified prolonged exposure	CEBC	Adult survivors of childhood or chronic interpersonal trauma, individual	3, medium	Attachment, emotion regulation, interpersonal functioning
Brief eclectic psychotherapy for PTSD	CEBC	Adult, individual	3, medium	PTSD symptoms, social problems related to PTSD
Helping women recover/beyond trauma	CEBC	Adult women, group	2, medium	Decrease in substance use/stabilize recovery, decrease depression, decrease trauma symptoms, increase self-efficacy

databases that address substance abuse and domestic violence are not included if attending to parental trauma is not a clear focus based on the description. NREPP contains both "legacy programs," which are those that made the list prior to 2014 under old criteria, and those under the new rating system which includes four categories related to outcomes (effective, promising, ineffective, and inconclusive). Interventions listed on the CEBC have two ratings: A number that corresponds to the quality of the research—1–5, NR. A rating of 1 indicates the intervention is "well supported by research evidence." The second rating of high, medium, or low denotes the intervention's relevance to the child welfare system. The list below only includes intervention with at least a rating of 3 ("promising research evidence") on quality of research. Only, the 11 interventions that are rated medium or high in terms of relevance to Child Welfare in addition to a research rating of 1, 2, or 3 by the CEBC are discussed further below.

Both Child Parent Psychotherapy (CPP) and Combined Parent Child Cognitive Behavioral Therapy (CPC-CBT) focus on the parent-child relationship. Common elements are safety, enhancing the parent-child relationship, affect regulation, trauma work—which includes creating a joint trauma narrative and mastery over traumatic events—and fostering enhanced functioning in day-to-day living. Both can be effectively implemented in home or clinic settings. CPP is conducted weekly for 12–18 months in parent/child dyadic sessions, while CPC-CBT is shorter and designed to be completed in 16–20 sessions which can be either individual/dyadic family (90 min) or a multifamily group (2 h). CPP was specifically developed for children under the age of 6 and their parents, and is the only intervention listed that notes domestic violence/intimate partner violence as a targeted exposure. CPC-CBT was designed for parents at risk for physically abusing their children due to maladaptive parenting practices as well as those with substantiated cases of physical abuse.

Four of the trauma-specific interventions listed were developed to alleviate adult PTSD symptoms: Cognitive Processing Therapy for Post-Traumatic Stress Disorder (CPT), Eye Movement Desensitization Reprocessing (EMDR), Brief Eclectic Psychotherapy for Posttraumatic Stress Disorder (BEPP), and Prolonged Exposure Therapy (PE) for Posttraumatic Stress Disorder. Common elements include trauma psychoeducation, skill-building, and working through the specific traumatic experience(s). CPT addresses cognitive distortions, and primary skills learned are those aimed at managing beliefs and thoughts. Similarly, BEPP is focused on getting rid of the painful memories, thoughts, and feelings associated with the traumatic event and includes a letter writing technique. PE uses in vivo and imaginal exposure to reduce avoidance behavior, and a breathing technique which is designed to help the client remain calm when working through the trauma. All of these interventions were designed to be implemented in agency settings and are relatively short in duration—ranging from 8 to16 weeks of weekly (or twice weekly) protocols. Also, highly effective in alleviating PTSD symptoms, but still considered nontraditional by many, EMDR is rooted in brain physiology and alters the way the brain processes thoughts, feelings, smells, images, sounds, etc. connected to the traumatic event. Like PE and CPT, EMDR was designed to be implemented in agency, and improvement has been noted in as few as three sessions. There is no homework involved in EMDR.

Three of the 11 interventions—Seeking Safety, Trauma Recovery and Empowerment Model (TREM), and Helping Women Recover/Beyond Trauma (HRW/BT) target both substance abuse and trauma. A men's version of HRW/BT has also been developed. Each entails a specific number of topics that needs to be covered: 25, 29, and 28, respectively. A set of topics in HWR/BT helps to identify relapse triggers. Seeking Safety and HRW/BT include handouts, activities, and homework for each topic; TREM does not. Seeking Safety is nongender specific and was designed for individual and group formats, while HRW/BT and TREM are both gender-specific and implemented only in group settings. The Trauma Recovery and Empowerment Model (TREM) is gender-specific (women) and is conducted in group format only.

Common elements of the final two trauma-specific interventions highlighted in this section, Trauma Affect Regulation: Guide for Education and Therapy (TARGET) and

Skills Training in Affective and Interpersonal Regulation plus Modified Prolonged Exposure (STAIR/MPE), include affect regulation and reduction of PTSD symptoms. STAIR/MPE has a focus on improving interpersonal functioning and addresses current traumatic stress versus traumatic memories from the past. TARGET is the only intervention on this list with an indication that it can be provided by BA level workers, case managers, or child advocates with supervision from a licensed clinician in the description on the CEBC website. Target can be implemented in home or clinic settings and ranges from 3 to 10 sessions depending on group or individual format. STAIR/MPE is a clinic-based intervention designed to be completed in 17–24 sessions.

Parenting Interventions

It is noted that there are several interventions (e.g., Parent-Child Interaction Therapy, Chicago Parent Program), with solid clinical and research evidence in enhancing skills necessary for effective parenting for adults with children in the welfare system. However, they do *not* specifically address parental trauma, the intervention that is the focus of this chapter, and as such, are not described in any detail here. Trauma-informed parenting, a recommended set of skills versus a specific intervention, is child focused. According to the NCTSN Resource Parent Curriculum (2010), the goal of trauma-informed parenting is for the parent to adopt a specific set of skills designed to help the child deal with his/her trauma [see previous chapter for a more detailed discussion of trauma-informed parenting]. It may be that these trauma-informed parenting strategies increase parental capacity post reunification. Resolution of parental trauma likely helps with the attunement necessary to help children deal with their traumatic stress. Gewirtz (2016) has reported on successful efforts with a trauma-informed adaptation of the *Oregon Model of Parent Management Training.* Listed on both NREPP and CEBC, the 3rd edition of *The Nurturing Program for Families in Substance Abuse Treatment and Recovery* provides a trauma-informed parenting curriculum that specifically addresses parental mental health, substance abuse, and trauma, and includes specific session geared toward fathers.

How Does This Approach Achieve Cultural Competency?

There are dozens of definitions of cultural competency that appear in the literature. A review of those compiled from different authors into a single list by Tawara Goode at the National Center for Cultural Competence at Georgetown (Goode, 1995) reveals concepts that seem relevant to a discussion of how working with birth parents through a trauma lens might lean in the direction of achieving cultural competency. Two definitions specifically mention the culture of institutions which suggests the importance of understanding how the culture of the child welfare system may be at odds with birth parents with unresolved trauma issues. Another mentions tailoring service delivery to meet individual needs, which would compel workers to

take into account individual histories of the parents they work with. Other definitions include the idea of honoring and respecting the behaviors, interpersonal styles, attitudes, etc., of those receiving services, which goes against the negative attitudes that birth parents face in the system by many. A final definition refers to the importance of humility and checking power imbalances in client care, which was mentioned earlier as a tenant of trauma-informed care.

Disproportionality and disparity exist in the child welfare system, which underscores the importance of attending to cultural competency when addressing birth parent trauma in terms of general trauma-informed care as well as when implementing a trauma-specific mental health intervention. The trauma of racism should be considered in addition to the types of psychological traumas more typically assessed (e.g., abuse, violence exposure). Classic trauma responses are associated with the experience of racism (Bryant-Davis & Ocampo, 2005; Butts, 2002; Carter, 2007; Comas-Diaz & Jacobsen, 2001; Helms, Nicolas, & Green, 2010). These studies showed that experience of racism at the personal level results in responses of cognitive impairment, physiological arousal, detachment, restricted affect, hypervigilance, inability to recall certain aspects of the experience, somatic symptoms, self-blame, shame, guilt, depression, and increased susceptibility to Posttraumatic Stress Disorder following a (nonracist) terrible event. All workers should have a general awareness of their own thoughts/feelings around institutional/structural racism, implicit bias, particularly as it relates to policies, practices, and procedures in the child welfare system, as well as the impact of these issues on interpersonal interactions birth parents as they navigate the child protection process. It is expected that all licensed mental health professionals implementing evidence-supported trauma-specific interventions are versed in culturally responsive clinical service delivery as a basic competency.

Challenges to Implementation

Challenges to addressing birth parent trauma in the child welfare system either through general trauma-informed approaches or trauma-specific interventions can be categorized in three groups of factors: parent, worker, and system. Birth parents may be reluctant to acknowledge traumatic histories out of fear it may negatively impact decisions about their children. They may lack awareness of the impact of untreated trauma on parenting and current functioning. When made aware, they may find it difficult to engage in treatment given its reliance on interpersonal interaction. Parents from minority groups may be motivated to avoid a system that is perceived by many to engage in discriminatory practices and/or institutional racism. Many children come into the system as a result of parental dysfunction and because of this; birth parents often get vilified by the system and are viewed as “bad.” In these situations, it may be difficult for workers to empathize and put themselves in the parent’s shoes, which will negatively impact engagement. Making the cultural shift to one in which parents are viewed through a trauma lens can be challenging

for individual workers and the system at large. There may be a tendency to treat parents as willfully noncompliant, avoidant, and resistant when goals are not met. These negative worker attitudes are likely to exacerbate already existing trust and engagement issues being held by the parent. Holding parents accountable, yet viewing maladaptive behaviors as coping strategies that are no longer useful even though they once were, is likely to yield better results.

Efforts to become trauma-informed require a significant organizational investment and places demands on resources: staff time to attend trainings and take part in learning opportunities; time/personnel to review existing policies and procedures to identify needed areas of improvement; and financing improvement efforts. Once it has been determined that a parent needs trauma-specific intervention, there may be issues of availability of desired treatment and/or mental health providers with trauma treatment expertise. Affordability, childcare, and transportation are additional access issues for many parents which can impact attendance. Failure to recognize the impact of historical trauma and present-day racism (e.g. institutional racism) in a system overrepresented by African Americans will pose challenges when trying to operationalize many of the principles of trauma-informed care (e.g., empowerment, voice, mutuality, and trustworthiness). Secondary traumatic stress, which is the experience of significant emotional distress including psychological symptoms that can result from hearing about another individual's first-hand experience with trauma, is a potential challenge for workers. Casework is a demanding job with a variety of associated stressors. Expectations that child welfare personnel help navigate traumatic histories may have negative consequences to worker well-being if not properly acknowledged and addressed at both the individual and organizational levels.

Evidence for Success

A review of the literature did not yield any studies that evaluated outcomes specifically related to the approach which is the focus of this chapter—Addressing Birth Parent Trauma— in an effort to positively impact the broad Child Welfare goals of permanency, safety, and well-being. However, there is emerging evidence to suggest success with trauma-informed efforts made at the system level, more generally speaking. In an effort to establish a framework for evaluation efforts and to set the stage for comparing studies in addition to the 6 principles mentioned earlier, SAMHSA (2014) also provided a working definition of exactly what it means to implement trauma-informed care by specifying 10 "implementation domains." These domains are: (1) governance and leadership; (2) policy; (3) physical environment; (4) engagement and involvement; (5) cross-sector collaboration; (6) screening, assessment, and treatment; (7) training and workforce development; (8) progress monitoring and quality assurance; (9) financing; and (10) evaluation.

Utilizing self-report measures, Lang and Connell (2016) evaluated four statewide strategies in Connecticut (screening children for trauma symptoms, access to evi-

dence-supported treatment, workforce development, and changes to policy). Systems-level improvements were noted in ratings of knowledge, attitudes, and practice in most of the areas evaluated including knowledge about birth families. Of note, the measure used in this study was the Trauma System Readiness Tool, and one of the subscales is labeled "Birth Family Trauma Support" which includes nine items.

Application Strategies

Applying the principles of a trauma-informed approach is considered best practice when working with all birth parents regardless of whether or not a specific history of traumatic stress has formally been identified. In recent years, it has become increasingly acknowledged that all child welfare workers and the system in general can enhance desired outcomes of permanency, safety, and well-being by engaging in trauma-informed practices, policies, and procedures. The effort must be intentional and involves a culture shift that is not expected to happen overnight. Additionally, workers are expected to have the knowledge to refer birth parents to a mental health professional with trauma expertise if either psychiatric or secondary symptoms significantly interferes with day-to-day functioning and/or fulfilling roles/responsibilities (e.g., parenting). Eleven trauma-specific interventions listed on NREPP and/or CEBC are highlighted earlier in this chapter and were selected based on relevance to the child welfare population and scientific ratings. While more than half of the eleven focus on primary and/or secondary PTSD/trauma symptoms, two are indicated when focus of treatment is deemed to be the parent-child relationship and three are appropriate when substance abuse is a co-occurring concern. With the exception of TARGET, all of the specific interventions require implementation by a trained graduate-level mental health professional with specific training in the actual evidence-supported intervention.

Trauma-informed engagement is a necessary skill when working with birth parents and is more likely to occur in settings that incorporate SAMHSA's six principles of trauma-informed care. The Family-Informed Trauma Treatment Center, a Category II site, in the NCTSN developed questions related to the trauma-informed principles that child welfare staff can ask themselves in their efforts to apply trauma-informed practices at the agency level (Gardner, 2015). For example, in the area of trustworthiness and transparency, some questions child welfare staff may ask themselves include: Does staff do what they say they are going to do? Is the complaint process clearly noted and does follow through happen when a complaint is made in quick and efficient manner? How is it handled when service providers make errors? Similarly, to achieve the goals of collaboration, child welfare staff should consider whether providers work with birth parents on shared goals, and are all opinions valued and respected on the treatment team regardless of the role? To ensure the empowerment of birth parents, child welfare workers should take care to ensure birth parents have a say in what they do and do not want in their care, and have an awareness of procedures for filing complaints or speaking to agency administrators if needed.

The Social Work and Psychology disciplines have proposed a competency-based approach to trauma-informed practice which can be viewed as foundational and necessary irrespective of the specific evidence-based interventions such as those mentioned earlier in this chapter. The Council on Social Work Education (CSWE) (2012) expanded the 10 previously approved 2008 Educational and Policy and Accreditation Standards to identify the advanced knowledge and behaviors needed for trauma-informed social work practice. The New Haven Competencies, geared to psychologists are comprised of eight skill-based functional competencies and five broad foundational competencies that provide a basis for trauma-informed mental health practice (Cook & Newman, 2014). The reader is referred to the original sources for a detailed discussion of the development and description of these conceptual models. Both highlight the importance of an awareness of the potential for secondary traumatic stress as well as staying attuned to self-care, discussed above, as an implementation challenge.

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Chapter 12
A Trauma-Informed Model for Supporting Pre-adoptive Placements

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An Innovative Model for Supporting Pre-adoptive Placements: Screening, Cross-System Collaboration, and Trauma-Informed Parent Management Training

Goal and Purpose of Intervention

This chapter provides an example of the manner in which child welfare agencies can partner with other community stakeholders and services to prepare pre-adoptive parents for adoption of traumatized children and adolescents who are on the road to well-being as they transition to a permanent home. Although there are great strengths and resiliency exhibited by many young people involved in the foster care and pre-adoptive system, a significant portion also struggle with placement stability, well-being, and behavioral challenges related to the trauma of maltreatment. Children who experience multiple moves in care are at greater risk for emotional and behavioral problems, as well as disruption of both foster and adoptive placements (Clark, Lee, Prange, & McDonald, 1996; Chamberlain, Moreland, & Reid, 1992; Fisher, Burraston, & Pears, 2005). Trauma-informed supports and interventions for pre-adoptive parents may be a crucial element for post-permanency continuity, trauma consolidation, and child and family well-being.

Child behavioral problems (Rosenthal, 1993; Berry & Barth, 1990; Festinger, 1986; Rosenthal, Schmidt, & Conner, 1988) are risk factors associated with adoption disruption and post-permanency discontinuity. Further, the research indicates strong connections between externalizing behaviors and placement disruption (Aarons et al., 2010). It is approximated that between 40% and 50% of all children

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in foster and pre-adoptive care present with some form of externalizing behaviors, putting them at-risk for placement disruption and thus perpetuating the cycle of instability (NSCAW Group, 2003; Chamberlain et al., 2006).

Providers and caregivers within the child serving system of care are often inadequately educated, trained, or supported. Randall (2009) suggests that there are clear needs among pre-adoptive and adoptive parents related to managing difficult behaviors and attachment problems, pointing to the importance of integrating trauma-informed assessment, trauma-responsive caregiver training, and trauma-specific family treatments into the service array for pre-adoptive families with children who have experienced complex and developmental trauma.

As Chamberlain and colleagues (2008) demonstrate, placement disruption can be linked to the number of problem behaviors foster and kin parents face each day and their levels of competency and self-efficacy regarding their ability to manage the behaviors. One study found that foster parents receiving parent-training interventions saw a decrease in child behavior problems, a decrease in placement disruptions, and as a result the system experienced less attrition of foster parents from the public child welfare systems (Price et al., 2008). Specialized training in trauma and behavior management strategies equips foster and pre-adoptive parents with the knowledge and skills necessary to understand, respond to and manage the externalized behaviors presented by children/youth in their care (Chamberlain et al., 2006; Dorsey, Farmer, Barth, Greene, & Reid, 2008). As stated earlier in Chap. 2, "*…, it is important that the pre-adoptive parents are familiar with the impact of trauma, have the necessary skills to reinforce coping behaviors, and have worked on the development of their relationship with the child as a safe, secure emotional base*."

Yet, as important as it is for resource parents to receive trauma-informed training to properly care for children with trauma-related needs placed in their homes, it is just as critical that child welfare caseworkers be trained on the use of screening tools to identify strengths and trauma-related needs *early*, so that "rapid and relevant" referrals for trauma-specific treatment and services can be made (p. 40, Strand, 2018). Additionally, mental health clinicians within the same system of care must be trained and available to provide evidence-based and trauma-specific therapeutic interventions instead of generalist or eclectic approaches that lack the family-centered, trauma lens critical for trauma consolidation (Child Welfare Committee, 2008). Finally, pre-adoptive and adoptive parents must play a central part in the case planning and treatment delivery. Chamberlain et al. (1992) found that foster and pre-adoptive parents were more satisfied when treated as experts in the care of their child, for instance on a trauma treatment planning and delivery team.

In sum, there is a need for interdisciplinary system intervention models that support the child and family by providing trauma-informed and trauma-responsive training, coaching, and related services to (a) foster and pre-adoptive caregivers, (b) the child welfare workforce, and (c) the mental health workforce. This chapter describes an initiative being implemented in one state to improve the likelihood for trauma consolidation and well-being and increase the prospects for healthy adjustment and stable, successful adoption.

Description of an Interdisciplinary Systems Model

The Vermont Placement Stability Project (PSP) focuses on providing supports and training to foster, kin, and pre-adoptive parents, as well as the child welfare, mental health, and post-permanency service providers who support these same families. The goal is to improve placement stability and permanence by enhancing the social and emotional well-being and restoring developmentally appropriate functioning, of children and youth who are pre- and post-permanence through the implementation of family-engaged, adoption-competent, trauma-informed training to four populations: (a) foster, kin, pre-adoptive and adoptive parents, and guardians, (b) the child welfare workforce, (c) the community mental health, and (d) other system of care professionals.

Figure 12.1 depicts the system-level support aimed at preparing a trauma-informed system of care by enhancing interagency collaboration, professional development on trauma and behavior, and strengthening pre-adoptive parent understanding of, and response to, trauma and related challenges.

While Fig. 12.2 depicts the child-level interventions focused on early identification of trauma-related needs, trauma-responsive referrals, trauma-specific treatments, and trauma-informed training and supports for caregivers.

The child-level intervention is initiated when a child welfare staff partners with caregivers to complete a standardized screening where each child's strengths and needs around social-emotional development, functioning in major life domains, and trauma exposure are identified (see examples below). Once a child's strengths and needs in these areas are identified, child welfare staff continue to partner with caregivers, clinicians, and other team members in a collaborative team meeting to ensure appropriate referrals are made for family-engaged,

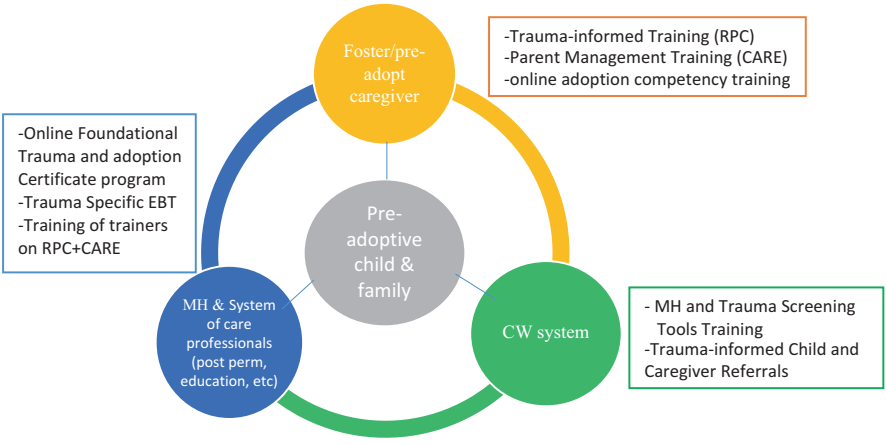

Fig. 12.1 System level preparation

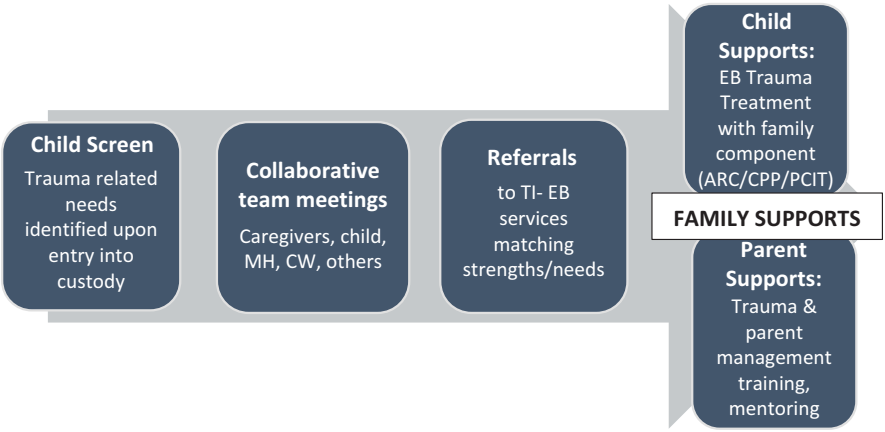

Fig. 12.2 Child level intervention

trauma-informed, and adoption-competent treatments and services. Using the same screening tools to monitor a child's progress over time, the child's team is able to adjust supports as the child's strengths and needs change. In this way, all those responsible for the child's well-being are working with common awareness, language, and data to efficiently and effectively target limited resources to best support the child. At the same time as the child with identified trauma and behavioral health needs is referred to a trauma-trained mental health clinician, the pre-adoptive parents are included as a part of the family component of the trauma treatment intervention. Lastly, during the duration of trauma treatment, the caseworker makes appropriate referrals for the pre-adoptive parent and connects the pre-adoptive parent to trauma-informed training (RPC+ will be described below), support groups, and mentoring.

System-Level Preparation

The child-level intervention aims to have a systematic process by which pre-adoptive children and families have the supports available within the system of care to maintain adoption and move toward trauma consolidation. In order for the child-level intervention to be implemented effectively, there must be a skilled and well-prepared workforce to support the strengths and needs as they arise. We defined "skilled and well prepared" using the essential elements and competencies of Trauma-Informed Child Welfare Practice developed by the National Child Traumatic Stress Network's. *Child Welfare Trauma Training Toolkit: Trainer's guide* (2nd ed.). The system-level preparation focuses on workforce development and caregiver development through training and coaching on key knowledge and skills related to trauma, behavior, and permanency.

Child Welfare Workforce

Child welfare caseworkers are trained in the validated screening tools and are responsible for engaging families in a child trauma and mental health screening process upon entrance into custody. The screenings include the following tools: Ages & Stages Questionnaire—Social/Emotional (ASQ-SE), Strengths & Difficulties Questionnaire (SDQ), and Child PTSD Symptom Scale (CPSS). In addition, caseworkers are trained and coached in collaborative case planning, trauma-informed referrals, and progress monitoring in order to track areas of success and challenge that may lead to adoption continuity and ultimately trauma consolidation.

Once child welfare workers complete a mental health and trauma screen which indicates a need for further trauma-specific services and supports, they will work with family and other providers to create a case plan that includes referral to RPC+ and a provider that is knowledgeable in trauma-specific treatments and services. It is important to note that additional training on secondary traumatic stress is also provided to the workforce, although is not described in detail in this chapter.

Mental Health and System of Care Professionals

The second system-level workforce development component of PSP focuses on preparing mental health clinicians and other system of care professionals in foundational trauma theory and skills as well as more advanced clinical treatment interventions that are evidence-informed and trauma-specific. Training on trauma-informed and evidence-based therapeutic interventions, such as Attachment, Self-Regulation and Competency (ARC), or Parent Child Interaction Therapy (PCIT), is often cost prohibitive to community mental health clinics. Even when training is made available through specific initiatives, such as PSP, staff turnover makes it increasingly difficult for consistent offering of trauma treatment in the community mental health setting. In fact, turnover has a significant negative impact on the successful implementation of evidence-based practices (Woltmann et al., 2008). Further, a considerable percentage of mental health practitioners enter the workforce with limited clinical training and even less training in the area of evidence-based practice about core concepts of trauma that would allow them to more effectively utilize trauma-specific treatments with children and families (Placement Stability Project, 2014).

Thus, in addition to supporting the ongoing training of evidence-informed trauma treatments (ARC, CPP, PCIT), PSP has addressed the ongoing need for basic trauma knowledge through the development of an online training program. This program, entitled *Foundations Certificate in Trauma-Informed Practice with Children and Families*, and its more advanced in-person training called, the *Academy for Trauma-Informed Practice with Child Welfare, Mental Health and School,* provide a more in-depth grounding in trauma theory and foundational knowledge that is relevant to professionals across disciplines and caregivers working with children, youth, and families impacted by trauma and adoption. Agencies, programs, and professionals

will have the opportunity to integrate the online foundations certificate training material into their in-house new staff orientation or may freely access web-based learning for other staff development. Additionally, caregivers have access to training content. This may serve two purposes for caregivers: (a) supplement their own foundational knowledge and training related to the children in their care and (b) aid in their understanding of content professionals use to guide their practice.

Program Components

Eleven modules are available within the Foundations Certificate in Trauma-Informed Practice. The content areas covered in the online modules are as follows depicted in Table 12.1.

The Academy for Trauma-Informed Practice in Child Welfare, Mental Health and Schools is available to individuals who have completed the *Foundations Certificate Trauma-Informed Practice* online. The Academy provides nine in-person full days of training building on the online modules available through the Foundations Certificate in Trauma-Informed Practice online modules. The training, offered once a month for 9 months, is provided by local, regional, and national experts. The Academy for Trauma-Informed Practice brings together multi-disciplinary professionals including educators, mental health agency clinicians, child welfare caseworkers, pre-adoptive parents, and students at the University. This allows for cross-system conversation, interdisciplinary work that increases the trauma and adoption competence within the system, and a better understanding of one another's distinct professional roles within the greater child serving system of care. Clinicians and graduate students attending the Academy receive training on evidence-based interventions including Attachment Regulation and Competency (ARC), Child Adult Relationship Enhancement (CARE), and Parent Child Interaction Therapy (PCIT).

Table 12.1 Foundations certificate in trauma-informed practice

Module	Title
1	Family systems
2	Attachment
3	Lifespan development and the brain
4	Developmental trauma
5	Assessment, formulation, and treatment planning
6	Core competencies of trauma-informed practice
7	Secondary traumatic stress
8	Adoption competency
9	Motivational interviewing for family engagement
10	Cultural responsiveness in trauma-informed practice
11	Trauma-informed reflective supervision

Foster, Kin, and Pre-adoptive Parents

The final and anchor component of the system-level supports targets evidence and trauma-informed caregiver training and supports specifically for caregivers. Specifically, Vermont's training and supports with pre-adoptive caregivers has four focus areas: (a) trauma-informed caregiver foundations training, (b) RPC+, (c) caregiver supports, and (d) enhanced Respite (see Fig. 12.3).

Foundations Trauma-Informed Training for Foster, Kin, and Pre-adoptive Parents

Vermont's foundations training, required for all foster, kin, and pre-adoptive parents within the first year of licensure, provides new foster parents with a solid trauma-informed curriculum.

Resource Parent Curriculum+

The Resource Parent Curriculum Plus (RPC+) is designed to provide pre-adoptive and other resource parents with the knowledge and skills needed to effectively care for children and youth who have experienced trauma focusing on the following goals:

- To educate resource parents about the impact on the development, emotions, attachment and behavior of the children in their care
- To provide resource parents with the knowledge and skills needed to effectively care for a child who has experienced complex trauma

Vermont's implementation of RPC+ innovatively pairs the National Child Traumatic Stress Network (NCTSN)'s *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents, also known as the Resource Parent Curriculum (RPC)*, with Child and Adult Relationship Enhancement (CARE). The RPC was previously covered in an earlier chapter. CARE is a trauma-informed caregiver-focused

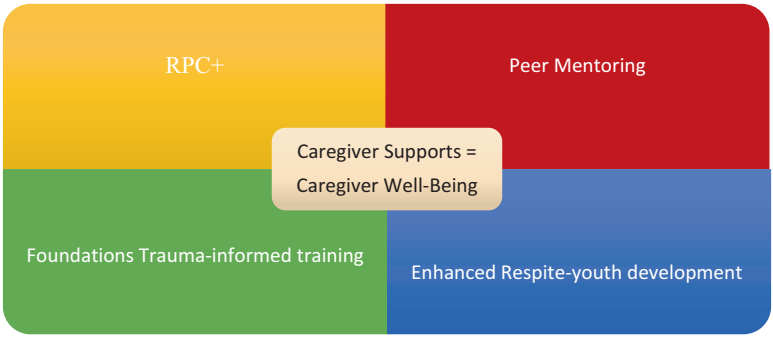

Fig. 12.3 Pre-adoptive parent supports

intervention, which was developed out of PCIT trained clinicians' desire to help adults outside of a clinical setting to use a set of skills to improve the relationship and interactions with a child or children, similar to that gained through PCIT (Gurwitch et al., 2016). Its focus is on providing concrete skills for enhancing relationships and minimizing real and perceived challenges related to child behaviors.

The RPC+ teaches pre-adoptive parents and other resource caregivers to respond appropriately to the behavioral and emotional challenges in a manner that maximizes the development of healthy attachments. Skills obtained through participation in the intensive skills workshop allow caregivers to work with their child, develop their strengths, and increase appropriate coping strategies (NCTSN, 2010). CARE training serves an important role by enhancing relationships and increasing effective communication. This improves caregivers' child and adolescent behavior management skills and sense of success.

It is important to note that although CARE is derived from the basic tenets of therapeutic interventions (e.g., PCIT) , CARE is not therapy. CARE consists of specific skills and strategies for relationship enhancement and interaction with a child and is NOT a therapeutic intervention (Gurwitch et al., 2016).

Although Vermont's focus of CARE training currently is on caregivers, including foster, adoptive, kin, and biological, a wide variety of populations have been trained nationally. In addition to caregivers, the following groups have been trained in CARE: child care providers, child protection case workers, foster care caseworkers, and mental health clinicians (NCTSN, 2008).

Participants in the RPC+ learn how trauma-informed parenting can support children's safety, permanency, and well-being and hopefully lead to trauma consolidation. Caregivers engage in skill-building exercises through CARE training that help them apply this knowledge to the children in their care. The content covered in the RPC+ includes the following:

- Trauma 101
- Understanding Trauma's Effects
- Building a Safe Place
- Dealing With Feelings and Behavior
- Connections and Healing
- Becoming an Advocate
- Taking Care of Yourself
- Three Ps (Praise, Paraphrase, and Point-out-Behavior)
- Strategic Ignoring
- Giving Good Commands

The 10-week intensive skills workshop spans 25 h and uses a co-facilitator model, with a mental health clinician as the lead instructor and a pre-adoptive or adoptive parent as the assistant instructor (NCTSN, 2010). RPC+ is offered in both child welfare offices and in community partner offices. Several strategies are used to support participant involvement: (a) child care/groups are offered by qualified and licensed mental health clinicians which could assure foster and pre-adoptive

parents of adequate care for the child/ren, (b) credit for ongoing training hours required is provided for participants, and (c) meals are provided for both the pre-adoptive parent and children's group as appropriate.

Enhanced Respite for Pre-adoptive Parents

RPC+ includes a trauma-informed group curriculum for the children and youth in the care of the adult participants. The group aims to encourage resiliency and healthy development of children through increasing affect regulation and coping skills. When addressing resiliency of children and youth in out-of-home care, it is critical to address the child's ability to develop healthy relationships and supportive connections (Leve, Fisher, & Chamberlain, 2009). Each group differs depending on the age of the participants, and the content focus changes week to week (e.g., affect regulation, connection, healthy coping skills, calming techniques). The group is offered simultaneously while pre-adoptive parents are in RPC+ training. It is critical to ensure that caregivers receive opportunity to actively participate in training. In the Vermont implementation, the purpose of providing the children's group is not solely supporting children and youth development, it offers a needed enhanced respite for the caregiver. Studies have found that foster and pre-adoptive parents provided with additional support and attention through increased trainings and/or respite increase their sense of well-being and support retention (Chamberlain et al., 1992).

Peer Mentoring for Pre-adoptive Parents and Other Resource Families

As a continuum of support, additional efforts have been implemented in Vermont as part of Placement Stability Project to support the overall well-being of caregivers including the development of a formalized mentoring program. Mentors provide pre-adoptive families with an opportunity to continue connection and support. Seasoned and skilled foster and pre-adoptive parents, including those who have completed the RPC+ training, receive training to become a mentor and then are linked with a mentee. With the mentor having significant knowledge of and experience with the child welfare system, he/she is better able to prepare newer pre-adoptive caregivers while acting as an important addition to the formal training required. The mentoring program was created to strengthen the caregiver's natural supports while decreasing reliance on an overburdened child welfare system.

Advancing Cultural Competency

When providing evidence-based and trauma-informed interventions within the child welfare and mental health systems, it is important to ensure that the ethnic and cultural diversity is taken into account in their delivery. The National Center for Cultural Competence (NCCC) and the NCTSN provide guidance and leadership in advancement

of cultural competence within organizations and systems (Culture and Trauma Brief V2 n2 2007 NCTSN). This cross-system collaborative approach, using both organizations' guidance, embraces the belief that cultural competence is not something reached or achieved, but an ongoing process that evolves. This is true not only for the individual professionals and caregivers trained, but it is also the case with the agencies, and systems participating and involved within all facets of the intervention.

NASW defines the word "culture" as "implying the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group" (NASW, 2000, p.61). When applying a trauma-informed lens, the very core beliefs, thoughts, and values of an individual and system can be challenged. NASW goes on to state, "cultural competence in social work practice implies a heightened consciousness of how clients experience their uniqueness and deal with their differences and similarities within a larger social content" (NASW Cultural Competence 2001 p 8). It is through the evaluation of beliefs and values, self-assessment, and increase in trauma knowledge that the very culture (of an individual, a home, an office, and larger systems) begins the evolution process toward cultural competence. In addition to the broader expansion of cultural competence through application of the trauma-informed lens, specific steps were taken within each of the implementation prongs to be culturally aware, responsive, and competent.

The NCTSN is very interested in and looking at cultural issues and evidence of appropriateness of interventions in relation to culture. The case vignettes used within RPC are culturally inclusive and representative of children placed in out of home care. Our perspective is that cultural awareness, sensitivity, and understanding need to be infused throughout the operations of every level of an organization to be most effective.

PSP is culturally responsive in the strengths-based screening measures it utilizes as well as the RPC+ curriculum focusing on participant-centered experiences, and culturally relevant case vignettes. A safe environment is an essential component of the RPC+ in order for foster and pre-adoptive parents to be vulnerable and learn from each other. The creation of a safe environment allows caregivers from a variety of cultural and ethnic backgrounds to share their own experiences as pre-adoptive parents. Specifically, PSP creates a culturally responsive environment through the availability of interpreters, awareness of literacy issues, focus on language used, a lens of cultural curiosity, and a variety of case vignettes.

Challenges to Implementation

During the installation and early implementation phases of PSP, four main challenges manifested: (a) workforce overload, (b) cross-system collaborations are challenged, (c) data-driven IT systems, and (d) evaluation and financial resource. One important lesson learned early on in implementation was how critical it is for the intervention to be integrated into the day-to-day work and not experienced as an additional task.

Workforce Capacity and Overload

Child welfare Overall, the implementation of screening tool training of child welfare workers is time intensive. Time is required in making the initial regional connections. Developing cohesive cross-agency leadership teams to move the initiative forward required much attention and coaching. The development of and delivery of the screening tools training was time intensive as well. Ongoing coaching of child welfare workers on use of screening tools, case collaboration, and referrals was imperative.

Mental Health Research shows that community mental health turnover presents a challenge when training clinicians in evidence-informed treatment interventions (Woltmann et al., 2008). Although turnover of community mental health clinicians does pose a challenge to the implementation of trauma- and evidence-informed training, the implementation design attempts to address this with offering free online modules to community mental health clinicians to be accessible at any point in time for any new community mental health agency clinicians. In addition to the readily accessible online modules, the Academy for Trauma-informed Practice in child welfare, mental health, and schools is offered annually allowing a cohort of both graduate school students soon to join the workforce and newer clinicians in the field to access in-depth training. The number of clinicians that can participate in the in-person trauma- and evidence-informed training is limited to a small cohort each year which poses a challenge.

The time required for community mental health clinics and the clinicians to dedicate for preparation for the RPC+ group/class, set-up, actual time required for in person facilitating, and wrapping-up each group was a significant investment. The group facilitation took away time and energy from the clinician's ongoing caseload, distracted focus from other responsibilities, and notably took away from possible billable time. The dedication required of community mental health agencies to support a clinician in the implementation RPC+ is great, when considering the billable time lost, which is critical in under-resourced community mental health agencies.

Cross-System Collaboration

Another challenge experienced in implementation was the historical tension and relationships between child welfare and mental health agencies. This tension presented some challenges to successful implementation of the child welfare worker screening tool trainings. The relationship between child welfare and mental health agencies varied based on location and had impact both negative and positive on the follow-up and progress monitoring following screening and referrals made to services. The screening tool completion itself wasn't negatively impacted but the case planning, coordination, and treatment planning were at times impacted if the relationships were not addressed through the course of the implementation.

The success of referral for services and case collaboration is often dependent on the relationship between the local child welfare agency and mental health agency. The working relationships between child welfare offices and mental health agencies varied within our implementation. Some regions experienced the positive relationship among the agencies as integral in successful implementation where other regions experienced friction and some challenges during the implementation of screening tool training.

Initially, the roll-out of the child welfare worker screening tool training was initially child protection system focused. The training approach quickly shifted to be both a child protection system and mental health-focused approach. Caregivers and mental health clinicians needed to be included in the screening tool training of child welfare caseworkers.

Depending on the historical relationship between the community mental health clinics and child welfare/protection offices, it set the tone for the implementation ease. Individual and personal relationships seemed to assist greatly in the implementation movement and success, not organizational driven.

Data-Driven Systems

Tracking of screening completion created a challenge during the initial stage of implementation. In order to track children coming into care, those that need screenings, those that have had screenings completed required significant time and follow through. A database was developed to assist in addressing this barrier. The database allows for tracking children coming into care, screenings completed, referrals, and follow-up.

Caregiver Supports and Training

Evaluation data collection posed some limitation due to absences among participants at key times in data collection, errors in completion of evaluation tools, and changes in child(ren) residing in their home during the course of the class. Due to limited use of technology, email, and internet access among some pre-adoptive caregivers, completion of pre-implementation surveys was challenging and time intensive.

Although the therapeutic children's group has the possibility of being a billable service, as a means to supplemented support for the implementation, it also presented challenges. The community mental health agencies experienced hitting their Medicaid billable cap faster than usual, which was contrary to the intended creation of additional funding to support the concurrent children's group. Separate funding streams exist that cover children under six, yet children over the age of six participated in the group, which also presented billing complications.

Preliminary Evidence for Success

An initial evaluation of round 1 of PSP was conducted in three sites across Vermont and used a pre- and post-test design to assess changes in knowledge and skills among child welfare and mental health professionals as well as pre-adoptive and other resource parents after engaging in PSP-related training. Preliminary results show some positive trends in improving several areas including workforce improvements as well as improvements in the knowledge, skills, and self-efficacy of pre-adoptive parents. Specific examples include:

- From year 2 to year 3, approximately 30% more child welfare workers report conducting screenings through case consultation with caregivers and other care providers using standardized screening tools (41–70%).
- Understanding of child well-being and trauma among the child welfare workforce increased by approximately 10% from pre- to post-training, while there was a 20% increase in their perceived ability to develop an action plan for families based on the screening data.
- Before training on strength-based screening, child welfare caseworkers reported an average rating of 3.5 on a 5-point scale related to their ability to promote placement stability through behavior management. After the training, their average scores increased to approximately 4.0.
- Pre-adoptive parents and other resource caregivers participating in the RPC+ reported significant increases from pre- to post-training in the following areas:
  - Self-efficacy
  - Advocacy (assessing for trauma-informed services for participant's family)
  - Commitment to self-care
  - Parenting skills
  - Commitment to helping child feel cared for
  - Trauma-informed listening skills
  - Decrease in parent report of negative child behaviors from pre- to post-intervention.

The implementation of the PSP model continues to be implemented and evaluated across Vermont. Thus, further data will become available as implementation rounds move forward; however, this preliminary evidence points to real shifts toward the creation of a trauma-informed system that supports pre-adoptive parents and adoption continuity through family-level interventions and system-wide collaboration. It is through a trauma-informed continuum that adopted children who have experienced trauma will be able to achieve permanency, trauma consolidation, and long-term well-being.

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Part III
Creating Trauma-Informed Agency Culture

Chapter 13
Using Implementation Science Principles to Sustain Trauma-Informed Innovations in Program Development

Virginia C. Strand and Cambria Rose Walsh

Introduction

Organizational interventions with staff, like evidence-based practices used with clients, demand fidelity to the implementation process. Just as with empirically supported treatment that identify specific components in a specific sequence, there now exists widely agreed-upon stages of implementation that, if sequenced in a particular order, are more likely to result in sustainable outcomes. This chapter introduces an empirically supported implementation process, highlighting the need to adhere to stages of implementation as well as the need for a conceptual framework or theory of change to drive the implementation of new trauma-informed practices within organizations. It also highlights the need for an evaluation of the success or failure of any new practice.

The outcome of any trauma-focused implementation strategy is highly dependent upon the ability of an agency or organization to infuse principles guiding the implementation into the culture of the organization at all levels (Harris & Fallot, 2001). Organizational culture has been defined as the expressed mission and goals, the values that guide decision-making, and the focus and management style of leadership (Schein, 1990). The policies, practices, and organizing structure of a unit or system may be as important to adopting and sustaining any trauma-informed evidence-based practice as any content knowledge or skill acquired by the worker.

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While a considerable literature has developed that describes the essential elements of a trauma-responsive system, published examples of how these principles are applied in child welfare settings are limited.

The concept of implementation science has been defined as "the scientific study of methods to promote the systematic uptake of clinical research findings and other evidence-based practices into routine practice ..." (Eccles & Mittman, 2006). There are thus two issues critical to reaching positive outcomes and sustainability of new practices – the degree of empirical support for the specific practice or intervention, and fidelity to an implementation process. Attention has turned only in the last decade to the latter.

Success in implementation of evidence-based practices in child welfare has emerged, as well as indications of factors associated with limited or failed implementation. Aarons, Hurlburt, and Horwitz (2011) identify a number of factors contributing to the *lack* of progress in implementing EBPs in child welfare that are related to both the child welfare agency context and the implementation process itself. Among the factors related to the organizational context, the authors noted specifically that the hierarchical structures of public child welfare tend to focus on procedure and high documentation demands, making innovations, and lateral decision-making processes – which are helpful in implementation – difficult. Ogden and Fixsen (2014) note that decentralized decision-making, diverse professionals with specialized knowledge, lack of formality, good internal communication, and technical support for change are all essential for successful implementation. These elements do not typically characterize the child welfare bureaucracy (Aarons et al., 2011). Mildon and Shonsky (2011) argue that other larger contextual issues, like the high sensitivity to negative media attention, often need to be addressed as part of the implementation process. This latter analysis is consistent with the need to use a trauma lens for organizational stabilization as articulated in earlier chapters.

In general, those studying implementation science and models for successful implementation suggest that organizational culture may have the largest influence on the acceptance of evidence-based practices. Organizational culture has been defined as "shared behaviors and norms" (Williams & Glisson, 2014 p 757), while climate refers to the worker's perception of how the organization impacts their job function and well-being (Williams & Glisson, 2014). Crea and Crampton (2011) found in a study of staff attitudes toward the implementation of a comprehensive casework practice model that organizational indicators were the most significant and positive predictors of program implementation. Organizational indicators under consideration were organizational context (measured by attitudes toward culture, climate, job satisfaction, and commitment to the organization) program fidelity measurement, and the degree to which data was perceived as being used to inform practice and organizational learning. It is for these reasons that we emphasize the importance of attending to agency climate and culture through the establishment of organizational safety and stabilization.

Lessons from Implementation of EBP in Child Welfare

Aarons, Sommerfeld, Hecht, Silovsky, and Chaffin (2009) found that the implementation of an evidence-based practice in state-run preventive services predicted higher staff retention rates accompanied by lower staff turnover. Job autonomy, a factor thought to be perceived by many staff as reduced with the implementation of an evidence-based practice, was perceived as stable. Lower levels of emotional exhaustion were also associated with the implementation of an evidence-based practice as opposed to practice as usual (Aarons, Fettes, Flores, & Somerfeld, 2009).

Other findings from the implementation of EBPs in child-serving systems have highlighted the importance of a number of implementation issues, including the importance of organizational leadership committed to the innovation, system readiness for innovation, the capacity of the organization to absorb the new practice, and a receptive context for change (Greenhalgh et al., 2004). Prerequisites for organizational readiness include leadership involvement with interorganizational networks and collaboration that are engaged in the implementation of new practices also seems to support adoption. Attributes of practices that accelerate uptake are: (1) Good fit, (2) Feasibility, (3) Fidelity, (4) Cost covered, (5) Penetration, and (6) Sustainability (Proctor et al., 2011). Goodness of fit refers to the manner in which a specific practice is consistent with the goals, mission, programs, and clientele of an agency. Feasibility refers to the degree to which the organization is ready to commit staff time to training and data system capacity development. Fidelity refers to the degree of adherence to the model by which a particular program is implemented. The cost of ongoing training to account for staff turnover, maintenance of support systems, ongoing fidelity monitoring, and other practices (e.g., specific kinds of client assessment) are ongoing items for which there needs to be funding. Penetration refers to the extent to which the practice is implemented in all relevant programs and services, and sustainability is of course, the manner in which the practice is integrated and becomes "practice as usual."

Some of the literature on sustainability suggests that the support of community stakeholders – usually organized around a mutually defined goal – may enhance support for an innovation (Brown, Feinberg, & Greenberg, 2010; Fagan, Hanson, Hawkins, & Arthur, 2008). This is particularly relevant for public child welfare agencies, which often feel isolated and viewed negatively by the public and other community stakeholders. In a study of the implementation of a workforce initiative to build trauma-informed services, Fraser et al. (2014) found that bringing child welfare workers, mental health providers, and consumers together helped sustain efforts to implement, maintain, and spread trauma-informed practices.

In a review of the literature on sustainability factors, Cooper, Bumburger, and Moore (2015) found that it was important for the new innovations or evidence-based practice to be aligned with the organization's goal and mission – defined by some as the implementation-organizational-fit (Aaron et al., 2009). The degree of organizational readiness and support, including strong administrative leadership

and a positive working environment, is associated with successful implementation of EBPs (Cooper et al., 2015).

Description of the Implementation Process

Meyers, Durlak, and Wandersman (2012) analyzed 25 implementation frameworks to ascertain the presence of common stages and components across the frameworks. Findings revealed common approaches to stage-based implementation with fairly consistent agreement across the stages in regard to important components, which were called different things by different authors, but basically ascribed to four Implementation Phases. Meyer et al. (2012) labelled these four as (1) Initial Considerations Regarding the Host Setting, (2) Creating a Structure for Implementation, (3) Ongoing Structure Once Implementation Begins, and (4) Improving Future Applications. Steps critical in Stage 1 include assessment strategies (often including an organizational readiness to adopt an evidence-based practice) and decisions about which EBP to adopt. This process often involves analysis of the goodness of fit between the new practice and the organization's mission, structure, and population served.

A third emphasis in Phase 1 is focused on capacity-building strategies. Fixsen, Blasé, Naoom, and Wallace (2009) have developed a conceptualization of components in addition to implementation stages that are needed for implementation. These components are identified as leadership, organizational, and competency "drivers." Organizational drivers are especially critical for Stage 1 implementation, in particular the development of decision-support data systems. This capacity will be important not only in measuring fidelity to the implementation of an individual evidence-based practice, but also in measuring client outcomes and fidelity to the implementation process itself.

The second implementation phase is characterized by steps necessary to create a structure for implementation. The establishment of an implementation team is critical here, and it is important that this team is not only involved in carrying out the implementation plan, but has ownership for the process. Other tasks associated with Phase 2 include attention to acquiring resources, which often involves assessing the external environment for potential support; Stage 2 tasks additionally involve preparing the organizational infrastructure and beginning to think about how the agency administration will facilitate implementation challenges.

Phase 3 involves initial implementation. Steps important here include specific attention to the competency driver, as outlined by Fixsen et al. (2009). This includes careful attention to selection of staff who will implement the new practice: Will there be qualifications for selection? Are all staff appropriate? How will these decisions be made? Likewise, the agency will need to develop or devote resource not only to training, but also to coaching, technical assistance, and ongoing supervision in the new practice. This is also the stage for evaluation of the process to be initiated and the development of supportive feedback mechanisms completed. Fidelity to the

implementation process is a priority in the initial implementation stage. Overlapping sometimes with process evaluation, this is where, not surprisingly, the decision-support data systems become important – feedback from fidelity monitoring is needed at both the individual worker level and the organizational or program level. Fidelity includes not only adherence to the model, but also the nature of delivery, the quality of the delivery (practitioner skill), and client responsiveness (Carroll et al., 2007). Client outcome data as well as client satisfaction with services is likewise important for both the individual worker and the agency.

In the fourth phase, implementation should be fully in place and feedback used for adaptation and refinement of the model, training, coaching, and supervision. The development of this fairly universally supported framework underscores the significance of fidelity in the use of empirically supported phases of implementation – or fidelity to the process – as being as important as is fidelity to the use of a particular treatment.

Trauma-Focused Example Using the EPIS Framework

With funding from the National Institute of Health, several California Evidence-Based Clearinghouse for Child Welfare (CEBC)-affiliated implementation scientists from the Child and Adolescent Research Center in San Diego developed a model of implementation specifically designed for child welfare and other child-serving systems. The EPIS model (Aarons et al., 2011) involves four phases of implementation that are aligned with the synthesis described above. The four phases of the EPIS framework include considerations that guide the distinct but interconnected steps necessary for rolling out EBPs in child welfare systems. Based on the EPIS model, CEBC, which has reviewed and rated over 350 practices in its online program registry (www.cebc4cw.org), has developed a selection and implementation guide specifically for child welfare, *Selecting and Implementing Evidence-Based Practices: A Guide for Child and Family Serving Systems* (Walsh, Rolls Reutz, & Williams, 2015). This guide is available on the CEBC website and offers in-depth information and guidance about each of the phases of the EPIS model.

The EPIS framework has four distinct but interconnected phases – Exploration, Preparation, Implementation, and Sustainment. These phases are quite consistent with the four phases identified by Meyer et al. (2012) and discussed above. In the EPIS framework, contextual factors in each phase are examined at two levels: (1) the outer level which includes larger, often external factors that can support or impede implementations such as federal, state, or local policies, funding, mandates, and collaborations and (2) the inner level which includes what is happening within a community or organization that is implementing a practice such as policies and procedures, staffing, and organizational culture and climate. It is critical to take the time and effort to engage in the implementation process in order to avoid selecting practices that are not a good fit, or implementing practices in a way that does not result in the positive outcomes that they have been shown to achieve. It is also

critically important to assure that key agency leaders, including senior and mid-level managers, are educated about the implementation process, to assure that they understand the need to attend to organizational infrastructure to support the innovation. This infrastructure involves not only decision-support data systems but also attention to how coaching and supervision in the new practice will occur.

To further illustrate the phases of EBP implementation, the following description provides an example of how the EPIS model might be used to implement new practices in child welfare systems.

Leadership from a county-run child welfare system, Golden Poppy County, which covers a large geographic area involving both urban and rural areas has decided to expand their services array to include an evidence-based treatment for children who have experienced trauma. Currently, children are referred to mental health treatment at a variety of contracted agencies when there are concerns about trauma. These agencies are not using specific trauma treatment practices, and the county has concerns about the effectiveness of the general mental health services being provided.

Starting with the first phase of the EPIS framework, Exploration, the Golden Poppy County leadership begins by creating an Implementation Team. Their Implementation Team includes senior leadership, the day-to-day leader(s) who are charged with making this change, as well as Child Welfare leadership who oversee county contracts. In addition, their Implementation Team includes cross-system leadership to represent the needs and interests of the Mental Health system, where the new trauma treatment will be implemented. This core group will meet and determine who else should be on the team (community stakeholders, family/youth representation, etc.). This team is responsible for leading the change effort and determining the support, resources, and timeline for the exploration process.

Exploration

Once the group is formed, the next step is problem identification or clarifying what the existing problem is to explore what types of practices would be the best fit for the needs of the community. The team chooses to do this through a process from the quality improvement world called "Ask Why 5 Times." This process allows the team to delve deeper into understanding the roots of the problem. Following is a depiction of the Ask Why 5 Times exercise in Golden Poppy County.

Problem: Children and youth in Golden Poppy County do not have access to trauma-focused Evidence-Based Practices.

Initial suggestion: There need to be more Trauma Treatment programs for children and youth in place.

Question: Is that the correct response?

Ask Why 5 Times.

Why are the mental health services currently in place not meeting the need?

Answer: They are not focused on trauma.

Why are the services not focused on trauma?

Answer: There is not an assessment process in place to identify trauma symptoms or history.

Why aren't trauma assessments occurring?

Answer: The children are not being referred for trauma, but are frequently being referred for external behavior problems or depression.

Why aren't the children being referred for trauma?

Answer: There is not a screening in place, and caseworkers are not looking for trauma.

Why is there not a screening in place for trauma?

Answer: This hasn't been a focus for Golden Poppy County.

Having looked deeper into the issue, the Implementation Team now has a few areas of focus and is able to narrow the focus and prioritize the next steps. Even though the initial goal was to adopt an evidence-based trauma treatment, the Implementation Team realizes that before they explore evidence-based treatment adoption, there needs to be a screening and an assessment process in place to determine the nature of the trauma exposure in the children coming to the attention of child welfare. Better understanding of the nature of trauma exposure will assist the Implementation Team in selecting a practice or practices that would best meet the needs of the children and youth in their community.

The team decides to start with focusing on screening for trauma-related needs among youth involved in child welfare services. As part of a needs assessment, Golden Poppy County takes a deeper look at the tools used for trauma screening. They also review the data on their current demographics (including ages of children, cultural and language issues, etc.) in order to choose a screening tool that will best meet the needs of the system. It is decided to start by reviewing tools that could be used with children over the age of 8 as this is the group that is most often referred for mental health services. The team decides that once this screening is in place, they would examine tools that could be used for screening trauma in younger children. The team also conducts interviews with targeted child welfare staff to find out more about current general mental health screening that is currently in use. Once they gather this information, they focus on identifying potential solutions and reviewing screening tools. To research tools, the team uses the National Child Traumatic Stress Measures review database (http://www.nctsn.org/resources/online-research/measures-review) as well as the CEBC measurement tools section and also conducts a literature review. The team compares screening tools on factors such as cost, the number of items, empirical support for the tools, type of administration, respondent type, age range, ease of use, length of time to complete, cultural appropriateness, and language.

Based on this review, the team decides that the Child PTSD Symptom Scales (CPSS) would be the best fit for their needs. The team also decides that once the screening tool is piloted and once there is more data on the ages, symptoms, and history of the children being referred for mental health services, they will focus on developing an assessment process and make decisions about which trauma treatment practice(s) to adopt. As the final step in the Exploration Phase, the

Implementation Team creates a written summary documenting what they had learned during this phase before moving on to the Preparation Phase so that there would be a written record of how the decision to use the CPSS was made.

Preparation

The next phase of EPIS is preparation. During this phase, the team works to be sure that there is leadership buy-in to adopt CPSS by presenting information on the tool and its potential benefits and how it can be efficiently used by staff. It is important to highlight that the implementation of this screening tool will only be successful if there is an organizational culture change that reflects acceptance and understanding of the benefits of screening. Leadership messaging is critical to this culture change. In addition to leadership buy-in, an implementation support system is developed. The team creates a specific coordinator role to lead the rollout of the screening process, including providing help to orient workers to the procedures related to conducting the screening and ensuring that the collected data is tracked and sent to the correct person to analyze. The team also designs feedback systems to help them to monitor fidelity. In addition, they identify stakeholders that will be critical to the success of the project which include several workers who will be participating in the pilot. They also create a process to get feedback from clients. The team identifies a funding source to help cover the costs of the tool as well as the time for training staff on it. They also work to ensure that all of the logistics and legal requirements for using the tool are in place. Finally, during the Preparation Phase, timelines for the rollout of the screening pilot and initial thoughts on how to expand the pilot are discussed. Now that all of this work to prepare for the actual implementation is complete, the team is ready to move into the active implementation phase.

Implementation

During the Implementation Phase, the team ensures that there is still buy-in from leadership. To do this, the team involves leadership in helping roll-out the training by having them welcome the participant in the pilot on the first day of formal training and participate so that they have an understanding of what is required to successfully roll out the tool. The team also engages the workers who have served as stakeholders by using them to act as champions among their peers.

The Trauma Champion is:

Knowledgeable about trauma and its impact.
Viewed by peers as applying trauma knowledge in their work.
Able to communicate their knowledge to clients as well as professional colleagues.
Attentive to secondary traumatic stress.
Actively promotes self-care for self and others.

This includes the champions acting as mentors and support to the staff involved in the pilot. Before scheduling the training, the team had carefully reviewed the timing of the rollout so that it is not usurped by competing priorities. They begin the pilot with training for the workers on how to use the screening tool with clients, and on the process for collecting and sharing the results. Part of the rollout includes the implementation of the systems that were identified during the Preparation Phase for monitoring fidelity and for collecting data. Finally, as the pilot proceeds, the team meets to plan how to scale up the screening effort to go beyond the initial pilot units.

Sustainability

Once the pilot is underway, the implementation process moves into the final phase of EPIS, Sustainment. The reality is that efforts to promote sustainability actually have been occurring since the Exploration Phase. After the initial implementation, continuing to look at funding needs, how to train new staff to use the screening tool to account for turnover, expanding beyond the pilot, and continuing to monitor fidelity are all important components of sustainability. Looking at outcomes and how to use the data as well as how to make refinements to the process are also critical during this phase.

An Iterative Process

Now that the screening has been implemented, the team reconvenes to make decisions about assessment tools and about which practices to implement. They again start with the Exploration Phase and follow a similar process as before using data that they are collecting about screening to help shape the decisions about assessment and treatment practices that will be the best fit.

This very brief example is meant to illustrate the process and does not indicate an endorsement of any specific tool or practice. For more detailed information and assistance on using the EPIS model, the full guide, *Selecting and Implementing Evidence-Based Practices: A Guide for Child and Family Serving Systems* is available on the CEBC website and includes tools and worksheets to help walk consumers through each of the EPIS phases.

Subsequent Chapters

In the following sections of the book, we highlight organizational interventions for safety, permanency, and well-being. Each chapter addresses the successes and challenges in fidelity to the implementation process. We first consider both macro- and

micro-interventions for safety and stabilization. In Chap. 14, the authors outline a guiding framework for the integration of trauma-informed care in public child welfare, with a focus on organizational policies, practices, workforce development strategies, and evaluation methods that have been successfully used to create a trauma-responsive culture in two separate child welfare systems. In doing so, they illustrate how the goals of safety, permanency, and well-being are promoted in an effective manner.

Building upon this framework of care, Chaps. 15 and 16 focus on specific tools that public child welfare leaders can use to assess and monitor progress toward the goal of creating a trauma-informed system of care, and promoting and maintaining a secondary traumatic stress-informed workplace. Chapter 15 describes a trauma-informed organizational readiness tool that has been used successfully in six sites across the country. It highlights the manner in which this tool can be used both at baseline and follow-up points to measure fidelity to the implementation *process*. Chapter 16 describes an organizational assessment measure for secondary traumatic stress, highlighting its use with child welfare staff. In addition to providing an evaluation strategy for child welfare personnel, these tools can be used to design a trauma-informed organizational development plan.

In Chap. 17, we discuss preprofessional preparation for child welfare, focusing on the development of BSW and MSW preparation for trauma-informed child welfare practice. Strategies covered include behavioral interviewing and recruitment outside of child welfare for supervisory positions and above. Chapter 18 presents a nationally renowned trauma-training approach used and evaluated in child welfare.

Successful and sustained implementation of the trauma-informed principles and strategies outlined in this text are only realized when this guiding framework is successfully integrated into the agency's workforce development and support practices, with the aim of developing a workforce that is attached to the agency. In fact, a healthy, committed child welfare worker is one that is capable of delivering trauma-informed care in a sustained way, and who works in an environment that is physically and psychologically safe, empowering, trustworthy, and collaborative.

In this section on workforce attachment (permanency), physical safety and psychological security are presumed, and activities are focused on "healing," creating optimism and competency through the integration of current and past traumatizing work experiences. Two approaches for achieving these goals of strengthening the workforce's attachment are highlighted. Chapter 19 discusses an innovative approach to trauma-informed supervision and support that provides child welfare workers with the knowledge and skills to downregulate and process responses to working with trauma-exposed clients on an ongoing basis without sacrificing engagement. Chapter 20 describes professional development approaches to equip the worker with the skills needed to navigate the delivery of trauma-informed services.

Finally, the summary chapter discusses challenges and pathways to success for bringing the trauma-informed framework described in the book to scale across child welfare systems in the USA, in order to create the organizational well-being.

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Chapter 14
The Tale of Two Counties United by Their Pursuit of the Best Interest of Children Through Trauma-Informed Practice

James Henry and Amy Perricone

Introduction

Translating trauma theory into actual child welfare practices within two very diverse counties in two states has produced successful implementation models for national replication. The stories of these counties provide road maps for the components necessary in becoming trauma informed. Too often over the past 10 years, academics and trauma theorists have developed manuals and curricula, written about what trauma-informed child welfare should look like and trained child welfare staff on understanding trauma, but failed to provide evidence on successful model implementation. This chapter provides a detailed history of two public child welfare agencies, one operating within a centralized state system and the other a decentralized state system, and their journey toward trauma-informed care. Both counties were united by local leadership's desire and commitment to provide the best opportunities for children and families interfacing with the child welfare system for safety, permanency, and well-being through becoming trauma informed. Each partnered with the same trauma center, the Southwest Michigan Children's Trauma Assessment Center (CTAC), located within a university. They received ongoing training, consultation, and technical assistance. One accessed funds through a SAMHSA National Child Traumatic Stress Initiative grant and the other financed the project through county funds and a federal IV-E Waiver project.

Despite being two extremely distinct and different child welfare agencies (in population, race, urban versus rural), the two counties integrated the key components of a trauma-informed child welfare system to operationalize and then produce positive outcomes for children. Both sites created strong leadership teams from the

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grassroots up following initial intensive trainings. The leadership teams from both counties voiced definite interest in creating trauma-informed communities prior to any formal commitment to partner together. Each leadership team recognized significant gaps in identifying and addressing trauma and complex trauma in children and families within child welfare. They were passionate, energetic, and willing to change their organizational practices and policies to become more trauma informed. Both county leadership teams sought to change current state and local practices by utilizing a trauma screen for immediate identification of potentially traumatized children so as to better identify the impact of trauma. Both counties sought to develop clinical trauma assessment centers to assess the multiple domains including neurodevelopment, social communication, and the child's perception of their world.

To achieve their goal of a trauma-informed system, each of the two counties' leadership teams launched initiatives that were a calculated risk. No well-defined road map existed that detailed a specific pathway. Rather, leadership chose to begin through a series of trauma trainings to shift staff perception from traditional child welfare practices to being trauma informed. The leadership both encouraged and challenged frontline staff and supervisors to consider changing their practices to be more trauma informed. A critical moment occurred when the two counties moved from training to an intensive staff consultation model. The consultation model built resident experts within the two organizations to operationalize and extend trauma-informed practices into the culture and daily practices of the organizations. Identifying and addressing secondary traumatic stress (STS) was a priority within each county leadership team. Leadership within the two counties instituted different STS models, yet both were successful in increasing retention and improving office culture. The key factors intersecting both models were the recognition of the emotional and physical impact of exposure to trauma, creating organizational psychological safety, leadership's ongoing communication of staff value, and staff resiliency building activities.

A Rural County Initiative: Example 1

The first story begins in a small rural area in a Midwestern state, where two counties are managed by the same public child welfare agency and director under the umbrella of a state centralized system. This dual county has a joint population of approximately 66,000, with a child poverty rate of approximately 32%.

Goals of the Program

In 2010, the recently appointed child welfare director (who had formerly been a participant in trauma training by CTAC while being a program manager in another county) contacted CTAC, communicating a desire for trauma training and other implementation support to develop a trauma-informed child welfare system.

The director stated that he was committed to having his entire agency utilize trauma-informed practices. This would be a local grassroots effort, as the state office had not endorsed trauma-informed practices. He was of the belief that state officials needed local county models to convince them to adapt to a trauma-informed practice model statewide. The local director's commitment and leadership to trauma-informed practices and policies was, and continues to be, the primary factor in implementation success. His leadership style is collaborative, open, and participatory. He has motivated staff through his continuous efforts to refine and change past practices to better meet the needs of the children and families. He institutionalized changes by creating new trauma-informed policies.

Staff Qualifications

All staff training commenced in 2010 with three trainings on understanding trauma, the impact of complex trauma to brain development, and how to build resiliency. The training goals were to (a) shift child welfare to include identification of trauma impact in case decision making and planning, (b) empower staff through understanding their role in mitigating the effects of trauma and building resiliency in children and families, (c) workforce resiliency through identifying and addressing secondary trauma stress. Even though the trainings received exceptionally positive feedback and goals were noble, the director, along with CTAC, believed that more intensive technical support was necessary if actual staff practices were to change.

Several significant agency actions occurred that moved staff from just receiving trauma training to utilizing new trauma-informed practices along with actual implementation of a trauma-informed systemic model. The most important and impactful piece of the process was the creation of a "resident expert team" within the office in consultation with CTAC in 2012. This team consisted of 10 staff including the director and program manager who were committed to leading the changing of office past practices. The team members were defined as the "trauma champions" who believed it was necessary to be trauma informed to better serve their children and families. The team members were willing to risk staff scrutiny to move forward the integration of trauma into practice. Their mission was to learn more about trauma, share that information with staff and community members, and discuss as much as they could about using trauma-informed practices in child welfare. Some of those practices included: (a) identifying trauma with clients, (b) considering the impact of trauma on their decision making and planning, (c) responding to the needs of children differently following removal, (d) building capacity within their counties for trauma-informed assessment, (e) procurement of evidence-based/evidence-supported trauma-informed treatment, (f) providing psychoeducation and training to their school districts and other community partners, (g) identifying and addressing secondary traumatic stress. The team sought to make trauma and trauma-informed practices the common language for all staff. Individually, they became the models for other staff to emulate; together, they became an internal force for trauma that

other staff either wanted to join or at a minimum could not ignore. They were able to share with staff how much trauma was impacting their children and families, as well as themselves.

Program Components

The resident expert team, with the director's leadership, operationalized some key trauma-informed practices that resulted in local office-wide trauma-informed practices and policy changes. These include (a) trauma-informed removal teams, (b) trauma screening on all children in foster care and ongoing child protective services, (c) practices to identify and address secondary traumatic stress, (d) community partnerships to conduct trauma-informed assessment for children screening positive for traumatic stress.

Developing trauma-informed removal practices was the first area tackled by the resident expert team. Following training on trauma-informed removal by CTAC, the team and the county director decided that any removals of children from their biological parents would include a trained trauma team member to specifically address the needs of the children. Team members were trained on what children most often need at removal, how to attune to children's feelings, statements to create safety, and how to transition children to foster/kinship care placements. A protocol for trauma-informed removal was established by the team and director that became institutionalized through new local policies. Over the past four years, the trauma team members continue to participate in removals. A video on trauma-informed removal, with team members participating alongside community partners (law enforcement, community mental health), was produced by the agency for training new staff on how to execute trauma-informed removals.

The "resident expert team" led the implementation of CTAC's Trauma Screening Checklist (Henry, Black-Pond, Richardson, 2010). The one-page trauma screen identifies potential traumatic events that children in child welfare experience as well as behavioral, affective, academic, and relational symptoms associated with trauma. Team members tested the screen to determine its value for identifying trauma, helping others recognize how trauma often manifests in behaviors and affect dysregulation, as an engagement tool, and its use in case planning, along with the amount of time necessary for screening completion. The team quickly recognized the value in the screen's utilization. Within a relatively short period of time, a directive, along with a subsequent policy, was instituted to screen all children in ongoing child-protective services and foster care. The trauma screens were to be completed every three months as a progress monitoring instrument. Child welfare staff have bought into the value of completing the screen. Several staff report that conducting the screen has been a key first step in helping them understand trauma and utilize trauma in case planning. Some staff are utilizing the trauma screen on the parents of the children believing that the screen, although designed for children, assists

them in identifying and addressing the parent's trauma. In the last four years, over 1000 screens have been completed. The aggregated data indicate that the mean number of potential traumatic events is five different types of trauma, 70% of the children have at least three or more different types of traumatic events, and over 34% of the children aged six and above have had least six different types of potentially traumatic events.

Providing trauma assessments for the children screening for trauma has been a priority for the team. The team and the director engaged community partners (community mental health, private providers, local university) to develop a trauma assessment protocol. The community team was trained by CTAC to deliver a modified trauma assessment to meet the needs of children screening positive for trauma. The team began conducting trauma assessments utilizing local professionals committed to developing the assessment resource in the community. After almost two years of the child welfare trauma team leading implementation, the local university took ownership of conducting trauma assessments. Trauma team members are still on a committee that oversees the management of the trauma assessments.

What Makes it Trauma Informed

Workforce resiliency became a major goal of the director and the trauma team. The director, frustrated over the continuous loss of staff, partnered with CTAC to provide intensive training and consultation for staff, supervisors, and management on identifying and addressing secondary traumatic stress (STS). His insistence on practical steps beyond the identification of STS produced a series of actions that, when fully integrated with otherwise effective management practices, significantly changed office culture and the retention rate. Management implemented an STS training as a component of new staff orientation. Each staff learns about what STS is, its symptoms, and how to address STS. Supervisors conduct weekly staff conferences separate from case reviews, to inquire and process the impact of the work on staff personally. In 2014, a crisis response team was developed and trained by CTAC to provide emotional support for staff following a crisis incident (i.e., the death of a child). The team consists of staff and supervisors trained in Psychological First Aid (Brymer, 2006) modified for child welfare (Henry, 2012). Following a critical incident, two team members meet with the staff and supervisor to provide psychological and emotional support, and an opportunity for staff/supervisor processing of the event. At times, the director has requested that CTAC provide debriefing for the entire staff following a critical incident. The outcomes of the multiple pronged approach to workforce resiliency have been extremely positive. Performance improved dramatically, while turnover was all but eliminated. Over a three-year period, they experienced zero child welfare turnover. In that same time period, the staff were tasked with taking the lead in a statewide child welfare change initiative, despite the overwhelming new workload required to do so.

Challenges

The primary challenges in the implementation of trauma-informed practices have been: (a) the absence of state official buy-in to support trauma-informed care, (b) the lack of financial resources to support systemic trauma-informed changes, including trauma assessment and evidence-based/supported practices, (c) the inability to be creative with state monies to provide more intensive trauma-informed services due to categorical funding that does not allow for flexible funding, (d) initial staff skepticism about another "new idea" in child welfare, and (e) state office expectations/priorities that must be met that have nothing to do with trauma-informed practices. These challenges are roadblocks that have not prevented trauma-informed implementation, but have certainly slowed its progress. The director has taken a grassroots approach where he and the staff have independently pursued trauma-informed child welfare practices because it has been the "right thing" to do. Their efforts demonstrate that significant changes can happen without financial resources if: (a) the leadership is passionately pushing forward, risking failure, believing that trauma-informed practices are in the best interest of children and families, (b) partnerships between centers of trauma expertise provide ongoing consultation beyond training over extended periods of time without financial compensation through grants and/or other means to assist in sustainability and implementation, (c) the staff can learn and implement new practices when they experience collaboration, support, and respect across agency roles to achieve a common goal, the well-being of children.

Evidence for Success

The child and staff outcomes have been extremely positive. The number of children removed and placed into care has significantly declined from 63 in 2013 to 30 in 2015. Another important difference has been the 30% reduction in the length of time that child protective service cases remain open. Such dramatic changes are attributed by leadership to renewed caseworker engagement with clients, trauma screening leading to early identification of familial needs, and availability of trauma-informed community services including trauma assessment and evidence-based trauma treatments.

Staff retention following the implementation of STS practices and policies has been phenomenal. In a two-year period, there were no changes in staff. This is in stark contrast to a contiguous county north where there was over a 60% loss of staff within the same period. The leadership attributes this remarkable statistic to the focus on changing the office climate and culture, and institutionalizing STS practices throughout the office.

An Urban County: Example 2

Population Served

In stark contrast to the first, the second county that has championed trauma-informed child welfare is located in the west, a large urban area within a decentralized state system. The county child population is 68,164, with a child poverty rate of 12.27%. In a 12-month period, the county receives on average of 6500 reports of child abuse or neglect, with a 25–30% acceptance rate. The county practices under an alternative response model with a long history of family engagement strategies. Similar to the first county, the director has been key in leading the efforts to become trauma informed. The director's personality is vastly different from that of the Midwestern director, as he is fiery, demanding, and is more authoritative in using his personality and role to leverage what is best for children and families. He is a fierce advocate for family preservation, having the lowest rate of congregate care in the state. His conversion to trauma-informed child welfare practices has been relatively recent, but that has not compromised his passion, urgency, and willingness to change his organizational and community practices. Being within a decentralized system provides him with the power and flexibility to make decisions based on the needs of his county. This includes utilizing his state funding to initiate and sustain trauma-informed practices within child welfare but also to support community agencies wanting to participate but not having the funding to do so.

Child welfare's shift to trauma-informed care had begun prior to 2014 when national experts from the Southwest Michigan Children's Trauma Assessment Center (CTAC) trained child welfare and community members on understanding trauma- and brain-based models of intervention. The county was also a participant in the state's Title IV-E waiver intervention on trauma screening and assessment that was awarded in 2013. The CTAC Trauma Screening Checklist, which was also utilized in the Midwestern county, was chosen by the county officials to be the screening tool used. During the first year of screen utilization, he paid the local university to evaluate the validity of the screen. A trauma care coordinator was hired to coordinate their organization and community trauma efforts. No efforts prior to 2014 had been made to begin trauma assessment.

Staff Qualifications

In late 2014, the trauma care coordinator, in conjunction with management and the director, hired CTAC's director to provide three one-day trauma trainings to all child welfare staff and interested community members including mental health, private therapists, in home supports, attorneys, probation, schools, and court personnel. Following the training, the director, who participated in the training, proclaimed

that he had been doing child welfare wrong for 30 years. Becoming trauma informed became not just another federal and/or state initiative, but his passion. He committed to refining or changing past practices to trauma informed, believing that the shift would better serve the children and families in child welfare. His commitment started a two-year partnership with CTAC to build a trauma-informed practice that still continues.

Following the initial training, a series of six half-day trainings on special trauma topics including trauma screening, trauma assessment, resiliency-based case planning, secondary traumatic stress, and trauma-informed approaches to birth families were presented. Following the trainings, a discussion that involved the director, his management team, and CTAC concluded that more training would not produce system change given the limitations of large trainings in changing practices without on-the-job coaching and follow-up (Fixsen, Blasé, Naoom & Wallace, 2009). However, the director was extremely interested in providing neurodevelopmental comprehensive trauma assessments to his agency's most complex children for three primary reasons. First, to better understand the needs of the children through a trauma lens and resiliency-based recommendations beyond traditional therapy. Second, to obtain increased buy-in from child welfare staff in becoming trauma informed through observing the assessments. Third, to train the community mental health clinicians (public and private) on how to conduct neurodevelopmental trauma assessments. CTAC had conducted over 3000 trauma assessments at that time through a transdisciplinary model involving medicine, social work, speech and language, occupational therapy, and psychology.

Program Components

In the trauma care coordinator's search for a large venue with one-way mirrors for purposes of observing assessments, she contacted the local university's Marriage and Family Development clinic staff, who planned to observe the assessments to ensure that all the technical challenges were resolved. Five months later, their director became the director of the first trauma assessment center in the county utilizing the CTAC trauma assessment model. For one week a month, for five months, two CTAC staff (director and clinician) conducted over 16 assessments while simultaneously training mental health clinicians in the model. Child welfare staff/supervisors/managers, who observed an assessment, became champions for the assessment process with peers, significantly increasing the staff's desire to become more trauma informed.

The director and management staff, with CTAC input, created a Request for Proposals for two levels of neurodevelopmental trauma assessments: moderate and comprehensive. The neurodevelopmental testing and psychosocial interview process was modeled from the CTAC protocol. Several agencies and/or private providers bid on the moderate level, with only two agencies (the university and a private non-profit agency) bidding on the comprehensive level. Both local funding and Title IV-E Waiver monies were utilized to pay for the assessments, with an expectation

Medicaid would contribute to the payment for those agencies who were a Medicaid provider. The awarding of these contracts for trauma assessments was a significant change from business as usual. This was viewed as extremely positive by the child welfare staff, who could now refer for comprehensive trauma assessments when children screened in positive for trauma. The trauma assessment contracts have been a major milestone in operationalizing trauma-informed practices within the county. In the Midwestern county, this process could not have occurred as the county has a centralized system where contracts and finances are determined at the state level. CTAC has been operating for over 16 years in the Midwestern state with no state contract ever issued, and being paid one-third the amount that the western state pays for individual assessments.

Determining who receives a trauma assessment following completion of the trauma screen by child welfare is based on the number of endorsements on the screen. The county director, with management support, determined that 6–10 endorsements on the screen warranted a moderate-level trauma assessment. Those scoring 11 or above receive a full comprehensive assessment. The director chose the threshold primarily on financial considerations, knowing that he could not afford to pay for the number of assessments if the threshold was lower. In 2015, 849 children were screened; of those, 24% met the criteria of six or more endorsements. Of the children who met the screen in criteria, 52% were referred for a moderate-level trauma assessment, and 48% were referred for a comprehensive assessment. There are currently six moderate-level providers conducting trauma assessments. Community Mental Health conducts the majority of the moderate-level assessments completing approximately 70% of the assessments in this category over the past year.

Two transdisciplinary trauma assessment teams are now conducting comprehensive neurodevelopmental trauma assessments. One center, the nonprofit agency, has social work, speech and language, and occupational therapy, and the other center, within the university in the Department Human Development and Family Studies, Center for Family and Couples Therapy, has a clinical team of therapists and an occupational therapist. In the past year, 91 comprehensive assessments have been conducted, followed by Family Team Meetings to discuss the results and recommendations from the report. The family meetings also focus on prioritization and developing an action plan with the family, department, and community to assist with the follow through with the recommendations.

To ensure that the completed trauma assessment becomes a living document directing treatment planning and services, the director and the management team developed contracts for Trauma Treatment Coordinators (TTC) with private agencies. The purpose of the TTC is to coordinate with providers and other services to ensure that all the recommendations in the assessment occur. TTCs are primarily for more complex and/or higher-risk removal cases. The TTC coordinators are trained in trauma-informed practices to work with both children and families. They serve the families in their homes and orchestrate the service providers in achieving the recommendations. They spend up to 30 h of case time with 15–17 h of direct time with the client/family. Direct contact can occur in the client's home, community, family meetings, and school, medical, or therapy

appointments. Direct contact also includes crisis intervention with the family, as the program provides access to 24-h crisis support. Other case contact includes collaboration with treatment team members, training/education of individuals within the child's system (teacher, aide, coach, etc.), coordination of services and communication with team members. The initial design for the program anticipated a three to five month service length; however, once implemented, the TTC service is operating at a seven to nine month service length. The county is finding the greatest success with the TTC program when the larger support network and community for the child and the family are included in both the psychoeducation and hands-on skill development. Families in the child welfare system are often isolated and have a limited support network. The main focus of the TTC program is to provide trauma education to the family and support network through the development of behavioral interventions with all involved support systems and to collaborate with the treatment team and child-involved systems to create a unified approach to treatment and healing.

Five years prior to the implementation of the trauma intervention, the county had developed an in-home coaching program that primarily focused on life skills and safety support development. Coaches provided up to 5 h of in-home support for families with an average length of service of four to five months. With the implementation of the trauma work, the five contracted coaching agencies were invited to participate in the trauma-informed training in an effort to further develop a service array of trauma-informed providers. With the additional training and support the coaching program is able to provide hands-on trauma-informed brain-based coaching to both the child and the caregiver within the home. There is psychoeducation, but more importantly coaches, model and teach regulation skills, parenting skills, and processing of familial arguments. Coaches are trained to provide new interactional experiences in the family to assist in rewiring the child's and the caregiver's brains through alternative experiences. Coaches can work with the TTC's to create an integrated approach to service delivery, and can also provide a step-down service or continuation of the trauma-informed service at a lower intensity. Coaches are also assigned to families that do not meet the criteria for the more intensive TCC service model. The coaching program was developed through collaboration with several community partnerships and has been integral to the county's success in achieving child welfare outcomes. The county continues to provide continuous trauma training for provider agencies as part of the partnership and commitment to providing quality trauma-informed service.

In an effort to increase evidence-based clinical treatment services in the county, the director paid for a Trauma Focused Cognitive Behavioral Therapy (TF-CBT) trainer to train and consult with 50 clinicians. Half the clinicians were within Community Mental Health and half were private providers. This decision was made because evidence-based treatment, primarily TF-CBT, was often recommended in the trauma assessment. Having the capacity to provide treatment in conjunction with resiliency-based case planning (need for relatedness, mastery/efficacy, affect regulation skills) strengthened a comprehensive approach to addressing trauma and building resiliency.

After the project began, it was realized there also was a gap for trauma training for foster, kin, and birth parents. A train the trainer on the NCTSN's Resource Parent Curriculum was offered for 30 professionals and resource parents. The county replaced their traditional foster parent training with this curriculum and also required all existing foster parents to attend this training. The external providers who attended this train the trainer offered this curriculum for birth parents required to take parenting classes.

What Makes It Trauma Informed?

To promote a trauma-informed agency and ongoing learning, the county requires all caseworkers and supervisors to have at least 20 h of annual trauma training and all other support staff to have at least 10 h. There is an incentive of gift cards for anyone who gets over 40 h of trauma training. It is also a requirement for any agency the county considers "trauma informed" for their staff to have at least 20 h of trauma training. To promote excitement for the project, there was a "Resilience Story of the Month" to be able to share with the agency individual stories of families and how the trauma project has impacted them.

Another effort to integrate trauma-informed child welfare across the community was a book club by DHS involving 60 people from Community Mental Health, private providers, probation, schools, caseworkers, and other partners that read and discussed Trauma Systems Theory (Saxe, Ellis & Brown, 2016) as a trauma-informed systemic model. Through this collaboration, much discussion stimulated thought about what it means for a whole system to become trauma informed. The group took some of the concepts and ideas to implement them into the Trauma Treatment Coordinator Program. After the book study, the group wanted to continue to meet and continue these conversations. The group morphed into the Trauma Practice Group, which continues to meet monthly and discusses different topics and barriers. Foster parents and a birth parent were also added to participate in this group. The Trauma Practice Group consists of clinical supervisors, workers, providers from many different agencies as well as foster parents and birth parents. A separate group called the Trauma Leadership Group meets quarterly and consists of the leaders of the agencies. The Trauma Leadership Group discusses budgeting and high-level decision making, and oversees the Trauma Practice Group.

Workforce resiliency has been a priority in building their trauma-informed system. Following several secondary traumatic stress trainings, management sought to implement an STS curriculum and the Resilience Alliance (NCTSN, 2014) was chosen. The curriculum, developed in New York City with child welfare workers, provides a series of structured activities focused on the value of building collaborative alliances among staff, creating optimism, regulation techniques, and staff efficacy. Resilience Alliance was started in October 2014 and was voluntary for staff to sign up for bimonthly groups. The groups are capped at 20 and are co-facilitated by an internal resilient staff and an external therapist. The curriculum gives the groups

structure and prevents them from diverting into venting or negativity. The groups provide staff with education on STS reactions as well as tangible techniques and a level of support to manage them. Groups are held over the lunch hour and food is provided to show staff the support of management. All levels and roles are invited to these groups to break down the "us vs. them" mentality that STS can create. There are 12 modules with an additional 12 "open modules" in the curriculum. For the first 12 modules, people who attended the groups had a 5% turnover rate as opposed to a 29% turnover for those who did not sign up for a group. For the full 24 modules, there was a 17% turnover within the groups compared to a 38% turnover outside the groups. When the 24 modules were scheduled to end, those who were in the groups did not want the groups to discontinue. One member called it the "weight watchers for resilience." They believed that many of us know what we need to do for self-care and resiliency, and Resilience Alliance is the forum and provides the accountability and reminders to stay on track. The curriculum is free as long as the developers are cited, and the agency pays the external facilitator and provides stipends to the internal facilitator. Losing one caseworker is projected to cost the agency $24,887 (American Public Human Services Association, 2005) so if the program prevents even just one worker from leaving, it would be cost effective.

Evidence for Success

The Resiliency Project has yielded positive results. There were 60 child welfare staff who participated in the first two Resiliency Project groups compared to 69 staff who did not participate. Among the first 12 groups, only 5% left the agency compared to 29% in the control group who left the agency. In the next 24 groups, 17% of the Resiliency Project left the agency versus 38% of the control group. These findings strongly suggest the value of identifying and addressing secondary traumatic stress in retention of staff. Retaining staff is especially important, given a 2005 study by Flowers, McDonald, and Sumpski that found that foster children who only had one caseworker achieved timely permanency in 74.5% of the cases. As the number of caseworker changes increased, the percentage achieving permanency inversely dropped, ranging from 17.5% with two caseworkers to a low of 0.1% with six or seven caseworkers.

In an effort to monitor child well-being outcomes for children involved in this project, in April 2014, the county began using the Treatment Outcome Package (TOP) developed by Kids Insight and Dr. David Kraus to measure child well-being. The TOP is a researched and validated instrument that reports on multiple different domains such as suicide, violence, mania, social conflict, school functioning, depression, sleep, assertiveness, eating issues, incontinence, worrisome sexual behavior, and substance abuse. This tool captures information from many different professionals, caregivers, and even the children themselves. The TOP provides reports that show different perspectives on how the child is doing in their well-being

and categorizing ratings into healthy, mild, moderate, and severe. Kids Insight gives monthly aggregate reports that show how the county is doing overall in each domain as well as individualized data per child.

The data indicates that 139 comprehensive trauma assessments were conducted in 2015. These assessments were performed on children/youth who received at least six endorsements on the child trauma screen. Of those 139 trauma screens, 91 screens indicated neglect, 86 indicated parental substance abuse, and 77 indicated exposure to domestic violence. Within the behavioral indicators, 76 were endorsed as having explosive behaviors, 73 were endorsed as oppositional, and 70 were endorsed as hyperactivity, distractibility, and inattentiveness. With regard to mood, 74 were reported as having quick explosive anger, 67 had explosive mood, and 40 were endorsed as having flat affect.

Of the 139 trauma assessments completed, 50% had TOPs completed. Of the children who completed the TOP, 84% reported improved overall well-being, whereas only 16% reported a decline in well-being. The data from the caregiver TOP indicated that 80% of the caregivers reported improved child well-being compared to only 20% reporting a decline in well-being. In overall ratings combining all those completing the TOPs (children, caregivers, professionals, attorneys, teachers on 109 children), 89% reported improved child well-being. The findings strongly support the efficacy of the trauma-informed model in improving child well-being. These are some of the first, if not the first, child well-being measures in child welfare reported. They provide statistical support for trauma-informed child welfare in improving child well-being.

The other important statistic that suggests the value of creating a trauma-informed system incorporating the past learnings in child welfare is that the number of out-of-home placements has declined from 375 children in 2013 to 301 children in 2015.

The findings from the two counties provide quantitative support for the value of trauma-informed practices in improving child well-being, reducing placements, and increasing workforce resiliency. These two unique and pioneering counties provide trauma-informed models that challenge other states and counties to adopt trauma-informed practices if they want to improve child welfare outcomes and retain staff.

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Chapter 15
Trauma-Informed Organizational Readiness Assessment

Marciana Popescu and Virginia C. Strand

Are Child Welfare Agencies Prepared for Effective Trauma-Informed Practice?

While much has been written about the need for child welfare to develop trauma-informed agencies and support the implementation of evidence-based trauma treatments, less attention has been devoted to how agencies become ready to implement either new trauma-informed practices or evidence-based trauma treatments. Strategies to prepare for, sustain, and evaluate successful implementation *processes* are less well developed. This chapter introduces a trauma-sensitive organizational readiness tool designed to measure agency readiness for trauma-informed practices. When used repeatedly over time, it also provides a feedback loop to the agency about changes in target structures and processes, as well as identifying areas needing ongoing strengthening or improvement.

In 2015, over 683,000 children were reported to be victims of child abuse and/or neglect (U.S. Department of Health and Human Services, 2017) . The numbers are likely higher, as this data reflects cases of abuse that were reported and verified, with the prevalence of child maltreatment being underreported (Fallon et al., 2010), due to multiple factors, including different reporting sources, training of professionals involved, lack of confidence with applying established criteria, or concern for the consequence of reporting (Schnitzer, Slusher, Kruse, & Tarleton, 2011; Flaherty et al., 2006). To add to the complexities of accurately recording the incidence and

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prevalence of trauma for children coming to the attention of the child welfare system, both public and private agencies need staff who are trained to detect, document, and monitor trauma in children and adolescents. Kisiel et al. (2014) found that children who had been exposed to complex traumas exhibited higher levels of functional impairments as compared to those with more simple traumatic events, and indicated that revised theoretical frameworks for intervention are needed to fully capture how to provide adequate services not only for children already known to the child welfare system, but also for potential (undetected) children suffering the effects of complex trauma (Kisiel et al., 2014).

In response to high incidence of abuse and neglect, and to the increasing pressures created by policy reformulation and changing protocols, professional communities are striving to implement strategies that seek to both prevent and mitigate such traumas. Often these services fall under the umbrella of child welfare services, and consequently, child welfare agencies are faced with the need to become increasingly trauma informed in their practice (Ko et al., 2008).

Donisch, Bray, and Gewirtz (2016) found that child welfare and juvenile justice service providers are identifying trauma in their cases more frequently and that there is a growing interest for staff at these agencies to become more trauma informed. Some agencies are starting to transition toward a more trauma-informed approach, and consequently, are seeing a decrease in the posttraumatic symptoms of their cases due to the increase and consistent use of evidence-based trauma treatments (EBTTs) (Bartlett, Barto, Griffin, Fraser, Hodgon, & Bodian, 2016). However, to ease the transition to a more trauma-informed approach at the agency level, it is crucial to be able to assess whether an agency is able and ready to effectively adopt and sustain new trauma-informed practices, including evidence-based treatments.

There are several factors that have been found to predict a readiness to change at an organizational level. Lehman, Greener, and Simpson (2002) found that some of the strongest factors that contributed to a readiness to change included stable leadership, overall stable environment, and some level of budget sustainability/sources of funding. The increased level of stability leads to higher reported levels of staffing, better communication among staff members, and generally more open attitudes toward change. Lehman and colleagues also postulated that an agency with higher levels of resources would be more open to change.

Gotham, Claus, Selig, and Homer (2010) analyzed organizational readiness in relation to other organizational characteristics, such as agency size and the impact of larger systems on an agency. Their findings indicate that smaller agencies, in comparison to larger programs, were able to show more change over time. The study also noted that agencies with more program/training needs or agencies that are under pressure to change need to have a rigorous and structured process to ensure consistency as new interventions are developed and implemented.

Change Theories: How Do We Measure and Sustain Change?

Change is difficult to pursue, even when the status quo becomes stressful and clearly damaging for the organization and its target client population. Change theories identify facilitating frameworks and recognize reasons for resisting change. Functionalists (Merton, 1968) discuss change from the perspective of adaptation – change as "fixing" elements that are threatening the status quo. Within this paradigm, change is linked to goals, socially reconstructed and enacted based on past actions (Weick, 1979) and regulated by standards. Under this model, external systems constrain the change process. Parsons expands the paradigm (acknowledging the increased complexity of institutions and the impact on systemic changes) and provides a four-function scheme for organizational change: goal attainment/governance protocols; adaptation/implementation protocols; latent pattern maintenance/policy protocols; and integration/social emotional protocols (Powers and Fernandez, 2012). Development/life-cycle theories define change as imminent and incremental, and coping mechanisms as adaptive tools that allow for an effective integration of change at various organizational levels following a prescribed model (van de Ven and Poole, 1995).

Change theories, beyond their descriptive and explanatory functions, suggest that structure is critical for effective implementation of agency-based changes. In each of the theories identified above, structure serves very distinctive functions when it comes to effective change: at its best, it provides a safe, learning environment for staff who are in the process of understanding the need for and the benefits of the proposed changes. Structure also allows for incremental measures of the impact of change – creating motivation for staff to go through the process of change. In the move toward an evidence-based approach to practice, structured change can provide the science behind each element of organizational change.

Aarons and Palinkas (2007) indicated that staff found a structured approach in implementation of an evidence-based practice (EBP) helpful, in that it allowed them to see the organized way in which new services would ultimately be delivered to clients. This structured implementation of a new treatment model provided the staff with a *common language,* which led to a consistent attitude toward treatment implementation, increasing their readiness to change.

For the study described in this chapter, we adopted the change theory implicit in the National Implementation Network Research (NIRN) implementation framework (Fixsen, Blasé, Naomi, & Wallace, 2009). This framework provides the kind of structured approach identified by Aarons & Palinkas (2007) in that it outlines a change process emphasizing a sequential, stage-based approach to implementation as well as identifying critical implementation components, or drivers. Essentially, implementation of a new practice (change) is achieved through (1) the identification of strong adaptive and technical leadership committed to a new approach (in this case of evidence-based trauma treatment), (2) an organizational infrastructure that is flexible, supports staff through data-driven decision-making and attention to the influence of outside systems, and (3) the capacity to select, train, coach, and supervise staff in any new practice.

Goal of the Intervention

Developing the Organizational Readiness Assessment Measurement Tool

How do we know if an organization is ready to implement an evidence-based practice? There have been a number of efforts by a variety of researchers to measure organizational readiness for change. The implementation science and organizational change literature (Greenhalgh, Robert, MacFarlane, Bate, Kyriakidou, 2004; Helfrich, Weiner, McKinney, & Minasian, 2007; Metz & Barley, 2012; Weiner, Amick, & Lee, 2008) provided the background for developing the trauma-sensitive Organizational Readiness Assessment (ORA) survey used in the study described below. In developing the survey, three existing tools were reviewed: (a) the Organizational Readiness for Change (2009) grounded in the Promoting Action on Research Implementation in Health Services (PARIHS) framework, which focused on organizational readiness to implement evidence-based practices in the health sector; (b) the Organizational Readiness for Change survey (ORC: Holt, Arrmenakis, Field, & Harris, 2007; Lehman et al., 2002) that focused on motivation and institutional resources for organizational change; and (c) the NCTSN Organizational Readiness and Capacity Assessment tool that measured agency readiness for implementing trauma-informed clinical treatments (www.nctsn.org) (Strand, Popescu, Abramovitz, & Richards, 2015, p. 8).

A review of the literature suggested that there were two dimensions that were important to capture with our measure: (1) the level of organizational readiness for *trauma-informed practice*, and (2) readiness for implementation of an *evidence-based practice in general*. The Organizational Readiness Assessment (ORA) tool developed for this project collected information on staff demographics, educational history, and history with the agency. It incorporated an organizational readiness scale, consisting of 33 items, measuring the staff's perceived readiness organized around the three NIRN drivers: leadership, organization, and competency.

Consequently, items inquired about perceptions of *technical and adaptive agency leadership* (leadership driver), *organizational supports* such as written policies and procedures, data systems, staff attitudes toward change, and facilitative agency practices (organization driver), and *training and supervision for trauma treatment* (competency driver). The measure asked about staff attitudes toward the use of evidence-based practice, familiarity with evidence-based trauma treatment, and the history of staff training in trauma generally and in evidence-based trauma treatment specifically. Following repeated measures, seven items were added, creating Factor 9, to inquire about staff perceptions with regard to the impact of external systems on agency practice, an important dimension of the organization driver.

Implementing the Measure within an Organizational Change Framework

The measure was used with six not-for-profit agencies that sponsored programs or services under contract with the local child welfare agency specifically for child welfare clients. Most of the agencies were multi-service family service agencies and one agency was a residential treatment center serving only children in the public child welfare system. The use of the readiness assessment at each stage of implementation (exploration, installation, initial implementation, and full implementation) is described below.

Exploration Six schools of social work were invited to participate in the project, based on their previous work in promoting a trauma-informed social work educational model that incorporated course work and field experiences. The schools together identified three major selection criteria for selecting participating agencies: (1) a strong link with one of the partner schools of social work and a history of collaboration on social work field placements; (2) some level of exposure to or experience with evidence-based trauma practices; and (3) a strong leadership, committed to innovation and evidence-based trauma-informed practices. The first level of assessment included a key informant interview at least one senior leader from each agency, in order to document the history of the agency with evidence-based practice (adoption, implementation, and maintenance), and understand the services provided and the population served (Strand et al., 2015). Using these criteria, the faculty liaisons at the partner schools identified six agencies providing mental health services to child welfare clients, which were interested in becoming more trauma informed.

Each agency identified an implementation team to lead the initiative at the agency. The key functions of an implementation team are to (1) ensure implementation, (2) engage the agency community and (3) create hospitable environments (NIRN Active Implementation Hub, 2015). This generally means that while senior leadership must be represented, those in management and supervisory relationships, who will actually be implementing in their departments, programs, or units, should be at the table. Each implementation team met at least monthly with the faculty consultant from the school of social work partner.

Installation Tasks in this phase include acquiring resources, preparing organizations, preparing implementation drivers, selecting and preparing staff who will receive the evidence-based treatment, and making administrative changes. In the agencies participating in this project, this typically meant establishing funding for the training in the evidenced-based trauma treatment, deciding which staff in which programs would be trained, and identifying assessment measures to be used at intake and follow-up as a measure of client change. It also often entailed training staff in trauma assessment tools, if this was the first time a standardized measure was being utilized, developing a data tracking system, and preparing support staff for the implementation and collection of data from the assessment tools. Training in foundational

trauma knowledge was also often provided, to establish a common baseline of trauma knowledge before the introduction of an evidence-based practice.

During the installation stage, the trauma-sensitive organizational readiness instrument (ORA) was fine-tuned and administered to all six agencies, providing a baseline assessment of organizational readiness. A factor analysis of the baseline data across the six agencies resulted in eight initial factors: (1) technical leadership, (2) adaptive leadership, (3) attitude to evidence-based practice, (4) use of client data systems, (5) staff attitude toward change, (6) trauma-informed practice, (7) written policy/systems, and (8) training/supervision (Strand, Popescu et al., 2015).

Seven of the eight resulting factors aligned with the three implementation drivers that are crucial for effective implementation of innovations and changes at the organizational level – leadership, competency, and organization (Metz & Bartley, 2012). An eighth factor (Factor 3) was used as a standalone factor focusing on agencies' exposure to and familiarity with evidence-based practices. A critical strategy was the development of a "gap analysis report" for each agency after each administration of the organizational readiness measure. This report identified gaps in readiness and suggested which driver needs to be strengthened and addressed as part of the next phase of the agency's implementation processes.

Initial Implementation In the initial implementation phase, tasks include assessing and adjusting the implementation drivers, managing change, assessing fidelity, deploying data systems, and initiating improvement cycles. In our project, this typically meant strengthening the competency driver through training in an evidence-based trauma treatment. Importantly, for almost all the agencies, consultation calls with the trainer for 6–10 months was provided in order to support the clinician in the implementation with fidelity with their own cases. It also meant continued work in assisting agencies to develop decision support data systems.

As the project continued with initial implementation, it became clear that there was an element missing from our analysis: the impact of external systems' changes on the implementation process in general, and organizational readiness for adopting and maintaining trauma-informed practices in particular. Thus, after the second follow-up, the ORA instrument was revised to include a ninth factor, measuring external systems' changes and their perceived contribution to an agency's progress through implementation. Revisions to the instrument followed a participatory approach, involving the faculty liaison from the six schools deciding what items would best measure the impact of external systems on organizational readiness for trauma-informed practices. As a result of a reiterative process, Factor 9 included seven items, and had moderate to high reliability, with Cronbach's Alpha coefficients running between 0.637 and 0.805. Factor 9 was added to the organizational driver in subsequent analyses.

Full Implementation During the full implementation stage, tasks include monitoring and improving implementation drivers, achieving fidelity and outcomes, and monitoring organizations and systems supports. The measurement process continues to build on existing data, providing agencies with reports that reflected their changes in readiness, and providing an opportunity for building evidence-based strategies to strengthen each driver and improve client outcomes.

Challenges to Implementation

The use of rigorous measures by child welfare agencies comes with its own challenges, caused either by internal factors (attitudes of staff toward change, change in leadership, rapid staff turnover, high caseloads, etc.) or by external factors (added stress by changes in policy/policy mandates imposed on agencies, budget cuts, access to EBTT training, larger social issues affecting the client population). The added layer of complexity when using a trauma-informed readiness assessment creates other challenges, well aligned with the current challenges in the child welfare field: acknowledgement of trauma and proper early identification through consistent trauma assessments; implementation of EBTTs with fidelity – and the ability to use client data to adjust implementation as needed; staff retention and loss of capacity; and supporting an agency-wide trauma-informed practice, within the context of competing mandates and priorities. Yet it is exactly such challenges that the use of an adequate trauma-informed measure of organizational readiness can prevent and/or address: regular adminisration of measures will identify factors that could contribute to increased readiness, and establish a capacity building strategy that will prepare agencies for a more effective implementation of trauma-informed practices. Current child welfare policy is framed with three central goals: safety, permanency, and wellbeing for traumatized children and their families. Through consistent measures, and proper use of data, an agency can start by establishing a climate in which safety, permanency, and wellbeing become the norm for practice as usual. As the field is moving toward evidence-based practice as a standard of care, the agencies need to best prepare for adopting, implementing, and maintaining high standards of care while promoting a more trauma-informed organizational culture.

Evidence of Success

Three agencies have completed three follow-up measures, indicating at least the beginning of full implementation, and one agency has completed four follow-up measures. The full implementation stage allows us to analyze agencies' progress and identify the impact of the measurement in supporting their work. The limitations of the instrument in capturing all relevant aspects of organizational changes and moves toward trauma-informed practices also became evident during full implementation.

Agency Profile

A total of 1540 respondents completed the baseline survey in the installation phase. Of the 1506 that completed the gender question, 81% identified as women and 19% identified as men. The agencies had a balanced proportion of younger staff, and more experienced staff, with 26% being there under a year, 43% for 1–5 years, 16%

for 6–10 years, and 15% employed with the agency for 11 years or more. Participants reflected a diverse representation of all positions in the agency (26% direct care, 13% case managers, 19% clinicians, 14% management, 11% administration, and 17% other). The agency staff's knowledge of or exposure to EBPs was predominantly good or excellent, and reaffirmed the relevance of this criteria in selecting participant agencies for this project.

Differences in staff profiles were most noticeable in the nature of the positions represented in the sample and with years at the agency. All but one of the agencies had a majority of staff that had been there 5 years or less; one agency had a majority of its staff (73%) that had been with the agency 5 years or less; and one agency had a majority of staff employed with the agency for 6 or more years (52%). One child welfare agency had a much higher percentage of direct care staff (51%, compared to the mean of 14% for the other five agencies), while one agency had a much larger proportion of clinical staff (49% compared to a mean of 12% for the other five agencies).

In terms of educational background, out of 1505 respondents, 13.8% have a high school diploma, 40.7% have a college degree, and 41.4% have a master's degree. Of those with a college degree, 16.3% have a BSW and of those with a master's degree, 55% have an MSW degree. The vast majority of clinicians (63.1%) and about a third of all managers (31.3%) hold an MSW degree.

Changes in Organizational Readiness

All six agencies completed the baseline organizational readiness assessment (ORA). Each factor received a score based on the percentage of staff endorsing the factor. As discussed elsewhere (Strand et al., 2015), the survey items cluster into 9 factors, and each of the facots is aligned with one of the NIRN drivers (Leadership, Competency, Organization), with the excepton of Factor 3, an umbrella factor. The alignment is as follows:

Leadership: Factor 1, Tehnical Leadership; Factor 2, Adaptive Leadership
Comepetency: Factor 6, Attitude toward Trauma-Informed Practice; Factor 8, Traning and Supervision.
Organization: Factor 4, Decision Support Data Systems; Factor 5, Staff Attitude toward Change; Factor 7, Policy and Systems; Factlor 9, Impact of External Systems

A factor with a score of less than 67% was determined to be in need of strengthening. Baseline data revealed that scores on the leadership factors for all agencies were at the cut-off or above, as were the scores on Factor 3: attitude toward evidence-based practice (EBP).

The baseline values for attitudes toward trauma-informed practices are also high (F6 = 69.65% of max). The factors that fell below the cut-off were those that loaded on the organizational driver: Factors 4 (*use of client data),* 5 *(staff attitudes toward change)*, and 7 (*written policies/standards).* When Factor 9 was added to later analyses, it also scored below the 67% cut-off score. Factor 8 (*training, coaching, and supervision)* was the lowest, scoring at 48.03% of the maximum score.

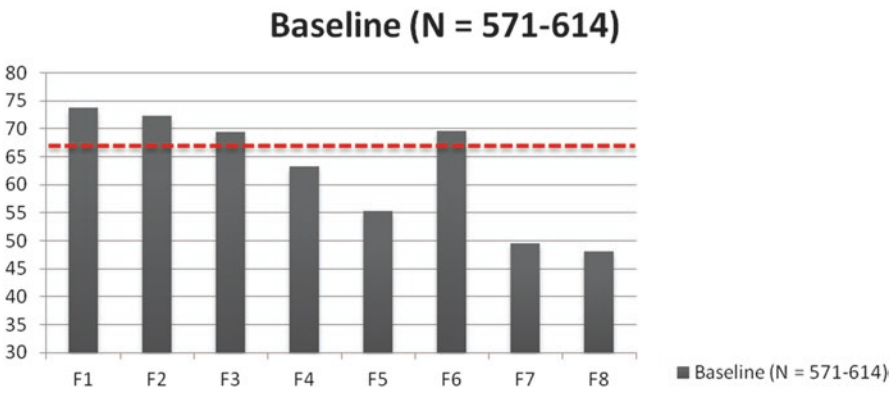

Fig. 15.1 Organizational readiness factors at baseline

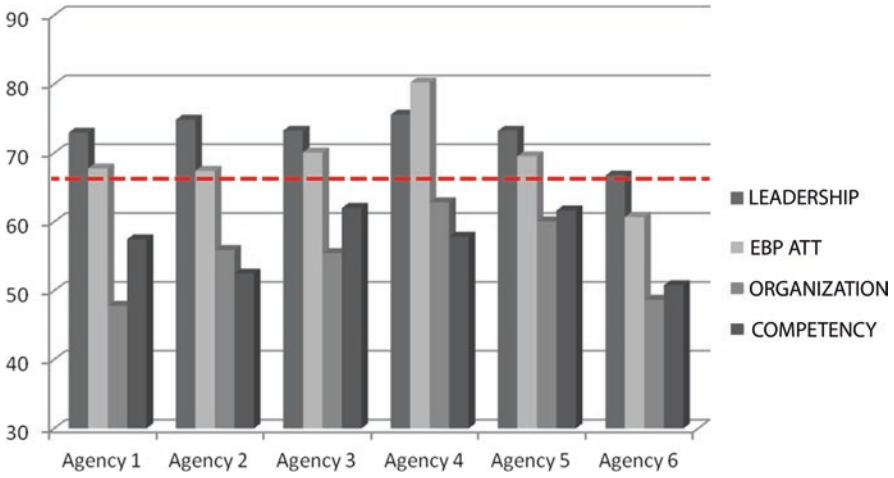

Fig. 15.2 Driver comparison at baseline

All agencies also reflected a similar profile at baseline, with strong leadership drivers and strong attitudes toward EBP and challenged by lower scores on the organization driver and on training in trauma, a competency driver factor (Fig. 15.2).

Installation All agencies completed the installation stage. A major element of this stage was the training in foundational trauma knowledge, as a means of readying the staff for training in an evidence-based trauma treatment. The *Core Concepts of Child and Adolescent Trauma* curriculum, initially developed by the National Child Trauma Stress Network (NCTSN) and adapted for social work education and agency training by the National Center for Social work Trauma Education and Workforce Development (NCTSWEWD), was used for staff training. A total of 27 Core Concepts training sessions were provided to participant agencies, of which eight were offered during the installation stage. Initial EBTT training was also

provided during the installation stage (10 training sessions), preparing the staff for implementation.

During installation, all agencies completed a first ORA follow-up. Results indicated growth across all factors, with the exception of Factor 5 (staff attitudes toward change). This factor had a slight but statistically significant decrease ($p = 0.025$), indicating an increase in staff resistance to change. This is not uncommon in any organizational change processes. Factors 2, 3, 7, and 8 had a statistically significant increase, with factors 7 and 8 recording significant leaps – 7 percentage points, for Factor 7, and close to 8.8 percentage points for Factor 8 (as compared to the maximum score).

The first follow-up gap analysis reports were used as planning tools by the implementation teams at each agency to identify growth, the specific elements that contributed to this growth, and to plan for strategies in the areas that remain low.

Initial Implementation To date, three agencies have completed the initial implementation stage. This stage was characterized by training staff in an evidence-based trauma treatment, adopting and implementing specific fidelity tools, training staff on collecting client data that contributes to monitoring fidelity, and adapting existing organizational policies, or working on creating new ones to support the agencies' move toward trauma-informed practices. Cyclical rebounds back to installation and exploration occurred during this stage, with agencies learning through multiple external systems' changes, and staff turnover, how to best maintain the momentum, and continue addressing both training/coaching needs and the use of client data and the emphasis on fidelity to the EBTT models selected.

During the initial implementation stage, three agencies completed a second follow-up measure. Results indicate consistent growth or sustaining growth on all but one driver. When considering the growth pattern for the implementation drivers, it is the competency driver that increased to and beyond the two-thirds threshold of capacity (Fig. 15.3), while the organizational driver (although consistently growing) remain below the 67% cutoff threshold for all three agencies.

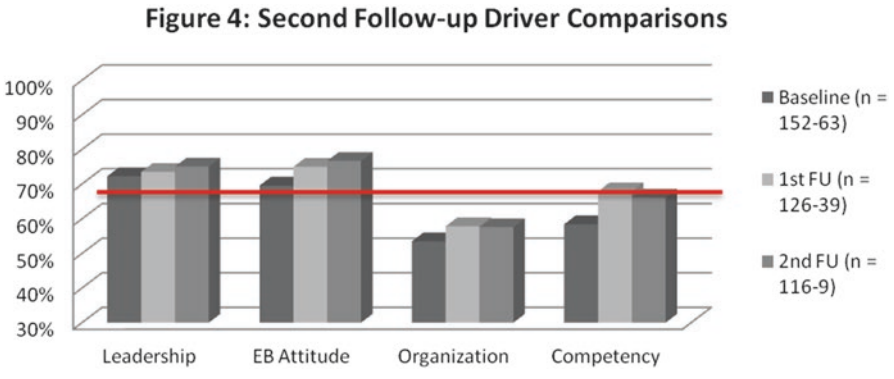

Fig. 15.3 Second follow-up Driver Comparisons

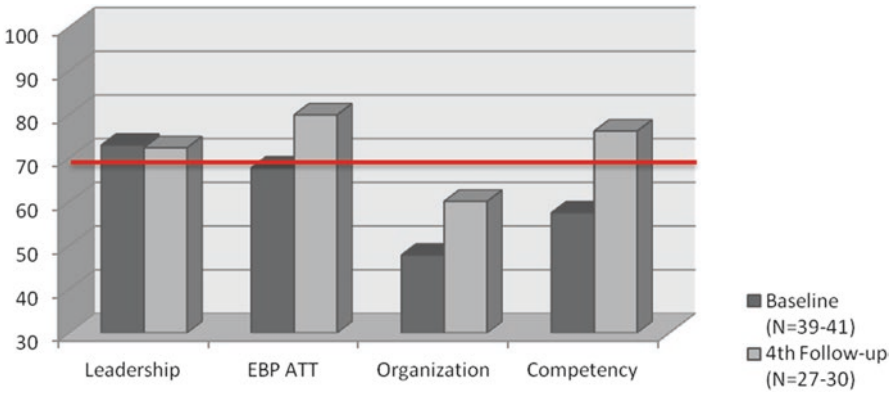

Fig. 15.4 Changes in drivers' values at full implementation

Full Implementation To date, one agency has completed the full implementation stage. This agency (1) identified a portion of its programs for implementation of an EBTT, (2) trained staff from the identified services on the core concepts of trauma; (3) adopted trauma assessment tools, (4) identified an EBTT that fit the population served and trained clinicians in this treatment; and (5) currently focuses on a more rigorous monitoring of fidelity. During the initial implementation, the agency identified additional programs to implement the EBTT, selected a second implementation team, which then started its own implementation process for these programs in order to bring along staff and train additional clinicians in the selected EBTT. This agency completed assessments at five points (baseline and four follow-up measures), tuning into fine details of readiness, and addressing elements of organizational change that would ensure sustainability of the model at the agency level (see Fig. 15.4).

It is important to notice the growth dynamics, as the agency continued to address drivers and factors within drivers, based on the organizational readiness reports it received at each implementation stage. The organization driver remained lowest, yet it increased significantly between the baseline and the final follow-up measure. For the last two follow-up measures, the value of the organization driver drops. The inclusion of a factor measuring the impact of external systems appears to account for this. The most dramatic increase occurs for the competency driver – which increases steadily, reaching strong values by the third measure (exceeding the threshold two-thirds of maximum score) and continuing to improve to a solid 76.18% of the maximum score by the fourth follow-up.

This is a significant illustration of strong fidelity to the implementation model – with data-informed adjustments and changes at each implementation stage, leading to consistent growth throughout. The agency's commitment to training, supervision, coaching in implementation of its selected EBTT (Trauma System Therapy) with fidelity, and use of data to improve and change practice as usual are the best outcomes of its direct work on organizational readiness for trauma-informed evidence-

based child welfare practices. The complex dynamics of such work are somewhat visible in the progress of growth for the agency (Fig. 15.3) and a closer look to the progression of each factor within the drivers further illustrates the changes in the staff's motivation and challenges to the sustainability of such a model. However, it is through the consistent use of the NIRN implementation framework that this agency is now better positioned to address such challenges, and guide new staff into the model.

Cultural Competency

Taking into account the diverse population served by each agency in this project and their geographic catchment areas (African-American, Hispanic, Native-American, or Southeast Asian, representing the majority of children in the child welfare system in these areas[1]), one notable limitation is the lack of proper cultural assessment at the agency level to best identify cultural competency elements as indicators of organizational readiness in relation to the populations served.

Application: A Guideline for Addressing

Organizational Readiness in Child Welfare Agencies

The NIRN organizational change framework that was adopted for the implementation of this project proved to be an effective perspective not only for increasing organizational readiness but also for ensuring fidelity to the specific EBBT and allowing for continued adaptation and change during implementation to fit the needs of the agencies. While measure and methodology were important in framing this project, the most important aspects remained the process of implementation and the consistent measures allowing for on-going adaptation for the next level of change while exploring patterns of organizational readiness and growth (NIRN) in a participatory learning process.

Three elements emerge as we contemplate the implications of this project for child welfare practice: the importance of understanding organizational readiness, the usefulness of trauma-informed measures of organizational readiness for effective

[1] *New York* – 44.5% of children in out-of-home care due to abuse were Black/African American (State Fact Sheet, NY, 2015); African American children make up about 60% of the CWS population (though there are fewer, in terms of numbers, compared to 10 years ago) – Child Welfare Brief; *Houston, TX* – In 2013, 41.3% of children in foster care in TX were of Hispanic/Latino heritage. Another 23.1% were African American/Black; 33% of children in foster care in TX were Hispanic natives, but only represented 22% of all children in TX; and the number of Hispanic/Latino children involved in the TX foster care system has increased from 33.6% to 41.3% from 2002 to 2013 (Leung and Cheung, 2013).

implementation of evidence-based models of practice, and the enhanced items inquired about perceptionscapacity for field instruction by field linking in an effective partnership with a school of social work.

1. ORA: *Understanding organizational readiness and the process of change and organizational growth*

As discussed at the beginning of this chapter, child welfare agencies, while under major pressure to adopt evidence-based practices and improve client outcomes, are not prepared for an effective adoption and implementation of such practices. Often, they struggle with deciding what needs to be done to facilitate such changes, in the context of rapid policy changes, high caseloads, and high staff turnover rates. The first step in dealing with this challenge is to understand how to approach change (as a process). When such change aims to establish a trauma-informed culture, the instruments used to measure organizational readiness need to capture the agency's capacity for understanding, assessing, and addressing trauma.

Integration of data into a planning process supports consistent training increasing the staff's motivation and commitment to change. The use of consistent measures over time allows agencies not only to identify training needs, but to also capture changes in such needs, and use data to further engage agencies in deciding what training would benefit most of their growth at each given stage in the organizational life. One aspect that was seen as a major benefit for ALL participants was the access to training – be it the main training on the core concepts of trauma and specific trauma assessment tools or the EBTT training and ongoing (or time limited) consultation and coaching for an implementation of the model with fidelity. The experience of the one agency that reached the full implementation stage indicates that the sustainability of this model depends on the ability of the agency to replicate the model in-house, train its leadership, and provide ongoing training and consultation through the implementation teams to address loss of capacity (due to staff turnover) and adaptation needs (either related to macro policy changes or to changes in the client population).

2. *Accurate measures of readiness for trauma-informed practices contribute to sustainable positive changes*

Of the agencies that participated in this project, the one that completed five measures (baseline and four follow-ups) also started a second cohort, implemented a second implementation team, trained its entire staff on the core concepts of trauma, and committed to consistently using trauma assessments and monitoring client outcomes. The use of data to inform growth and support its shift to trauma-informed practices helped it develop a sustainable model. One of the agencies that completed just two measures, and is now in the process of administering a third, noted how important it is to engage the staff in the readiness assessment process, and how the reports received lead to an increase in their commitment to evidence-informed practices.

3. *Intentional partnerships between child welfare agencies and schools of social work*

While measuring organizational readiness is crucial to any adoption or implementation of new models of practice, many times such an enterprise is difficult for agencies already overworked, struggling with high staff turnover and with limited access to training. An element of capacity that determines long-term sustainability and effectiveness of any new practice model is the ongoing collaboration between agencies and schools of social work that provide the next generations of child welfare workers and clinicians. Not only does this provide support to the agencies, but also allows the evaluation (of organizational readiness) to be located outside the agencies. Most importantly, as agencies developed their capacity for trauma-informed practices and for evidence-based trauma treatment, they also increased the capacity for field placements in evidence-based trauma treatment, thereby contributing to the ongoing development of a trauma-informed workforce. All agencies in this project are consistently working on strengthening trauma-informed internships and becoming learning organizations.

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Chapter 16
Organizational Assessment of Secondary Traumatic Stress: Utilizing the Secondary Traumatic Stress Informed Organizational Assessment Tool to Facilitate Organizational Learning and Change

Ginny Sprang

> *The most universal challenge that we face is the transition from seeing our human institutions as machines to seeing them as embodiments of nature. … Perhaps treating companies like machines keeps them from changing, or makes changing them much more difficult. We keep bringing in mechanics – when what we need are gardeners* (Peter Senge, 1999)

Statement of Need

A notable challenge to the implementation of trauma-informed care in a child welfare setting is addressing the impact of indirect trauma on the workforce. In 1995, Pearlman and Mac Ian proffered that professionals with significant vicarious trauma exposure, such as those exposed to graphic images and stories of violence, the witnessing of human cruelty to others, the recounting of harms to vulnerable others through court testimony, and exposure to trauma-related reenactments, could experience significant and enduring psychological distress as a natural consequence of their work. This prediction has been supported by numerous studies that document secondary traumatic stress (STS), a condition that mimics the symptoms of post-traumatic stress disorder, in professionals working with traumatized populations (Cieslak et al., 2014; Cunningham, 2003; Figley, 1995; Nelson-Gardell & Harris, 2003). Several authors note the salience of this issue in child welfare: documenting that these workers have higher rates of STS than community- and school-based mental health professionals (Sprang, Craig, & Clark, 2011); identifying supervision challenges common in child protection settings that create risk for STS (Bride & Jones, 2006: Kelly & Sundet, 2007); and noting certain demographic profiles that

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predict vulnerability (i.e., younger workers, women) that are inherent in the child welfare workforce (Sprang, Clark, & Whitt–Woosley, 2007; Van Hook & Rothenberg, 2009). The harms created by STS exposure are not just an intrapersonal phenomenon; Showalter (2010) writes "It can negatively affect the ability to provide services, maintain personal and professional relationships, lead to higher turnover rates, loss of productivity, and diminished capacity to enjoy life" (p. 240). These multifaceted impacts create a challenge for organizations, like child welfare, that serve traumatized populations. These challenges extend beyond mechanical manipulation of structure and process, and require innovations in how the organization learns and adapts to the trials. Several national studies document that the quality and effectiveness of child welfare services to vulnerable children in need of protection is a function of the characteristics of the organization that provides this service (Glisson & Green, 2011; Webb, Dowd, Harden, Landsverk, & Testa, 2009). In fact, children who are served by a system with positive social contexts have better clinical and functional outcomes than children served by systems where the environment is negative (Glisson, Dukes, & Green, 2006; Glisson, Green, & Williams, 2012). These are the contexts where organizational gardeners can use assessment strategies to create and sustain adaptive change toward becoming more responsive to the problem of STS in the child welfare workforce.

Dunphy (1996) offered that the impetus for all planned change in an organization is a problem that impedes continuous adaption and growth. Indeed, STS has emerged as a threat to the health, well-being, and stability of the child welfare workforce, and as such poses a challenge for those charged with assessing and managing threats to the organization. This chapter describes an approach to the organizational assessment of STS policies and practices that enables child welfare leaders to reliably evaluate how STS-informed their agency is, develop a roadmap for addressing challenges, and track progress toward organizational change in this area over time. These strategies facilitate the management of STS in the child welfare workforce, an essential component of trauma-informed care.

Goal/Purpose of Tool

The Secondary Traumatic Stress Informed Organizational Assessment (STSI-OA) (Sprang et al., 2014) is an evaluation tool that can be used by organizational representatives at any level to evaluate the degree to which their organization is STS-informed and able to respond to the impact of STS in the workplace. The STSI-OA was developed using an expert consensus model to generate the items and overall model, and was field tested extensively in a variety of service systems, including child welfare, mental health, juvenile justice, healthcare, and the education system. The tool was designed to operationalize an organization's role in addressing STS by outlining a series of policy, practice, and training activities that would enable a unit to address STS in the workplace based on its unique characteristics and needs. In this way, the tool describes what an STS-informed organization would look like,

if all the activities were enacted fully, based on the current literature relevant to STS risk and protection, and principles of organizational learning and development (Crossan, Lane, & White, 1999; Dodgson, 1993). Using this framework, it is acknowledged that for a child welfare organization to adequately address STS in its workforce, it would need to be capable of learning, and responding to workforce trends and issues in a single-loop or double-loop manner. Argyis & Schon explain "organizational learning involves the detection and correction of error. When the error detected and corrected permits the organization to carry on its present policies or achieve its present objectives, then that error-detection and correction process is single-looped learning. Double–loop learning occurs when error is detected and corrected in ways that involve the modification of an organizations underlying norms, policies and objectives" (1978, 3). The combined ability of the organization to achieve both goals, also called deutero-learning, is a characteristic of a learning organization, and a process that is enabled by the use of the STSI-OA.

This assessment tool asks raters to evaluate the degree to which their agency's policies or practices are congruent with the proposed activity using Likert scale ranking, and identifies policies and practices that may need to be adopted so that adequate adaptation and growth can occur. The outcomes of the assessment can be used by child protection leadership, the training team, or consultants to create a blueprint for organizational learning and change. Once a baseline assessment is completed, a total score, as well as domain scores can be used to track progress toward desired change over time.

Description of Tool

The STSI-OA is a 40-item organizational assessment tool that categorizes STS prevention and intervention activities into six strategy domains: organizational promotion of resilience-building activities (7 items); the degree to which an organization promotes physical and psychological safety (7 items); the degree to which the organization has STS relevant policies (6 items); how STS-informed leadership practices (9 items) and routine organizational practices (7 items) are; and how well the organization evaluates and monitors STS and STS policies and practices in the workplace (4 items) (see Table 16.1). Next to each assessment item in these domains are choices based on the degree to which the organization is addressing the specified practice or protocol, including "Not at All," "Rarely," "Somewhat," "Mostly," "Completely," or "Not Applicable." For purposes of this assessment, STS is defined as the trauma symptoms caused by indirect exposure to traumatic material, transmitted during the process of helping or wanting to help a traumatized person. Resilience is an individual's ability to adapt to stress and adversity in a healthy manner, and organization, as used in this context, refers to the workplace setting that is the target of the STSI-OA assessment.

Since individuals are the primary learning entities in an organization (Dodgson, 1993), the STSI-OA was designed so that any member of an organization can

Table 16.1 Sample items from the STSI-OA

The organization protects the physical safety of staff using strategies or techniques to reduce risk (e.g., panic buttons, security alarms, multiple staff, etc.)
The organization provides training on how to manage potentially dangerous situations (angry clients)
The organization has a risk management policy in place to provide interventions to those who report high levels of STS
Supervisors promote safety and resilience to STS by routinely attending to the risks and signs of STS
The organization promotes resilience-building activities that enhance specific skills that enhance a worker's sense of professional competency

complete the assessment, with the intent that the responses of multiple reporters, representing different points in the organizational hierarchy would be aggregated to present the most comprehensive view of organizational strengths and challenges. In the child welfare context, this would include front line workers, supervisors, regional administrators, centralized coordinating personnel, and leadership. Intra-agency comparisons can be made to detect communication barriers, and differing perceptions of strength, need, and progress.

For a child welfare agency to embrace a trauma-informed approach to care, it must develop a workforce development and protection strategy that is in alignment with the values and principles of this trauma responsive model. In fact, the *12 Core Concepts* (NCTSN Core Curriculum no Childhood Trauma Taskforce, 2012) for understanding traumatic stress responses in children and families includes recognition that working with trauma-exposed children and youth can evoke distress in providers, which in turn impacts their ability to provide quality care. The Substance Abuse and Mental Health Services Administration (2014) has identified a commitment to the prevention and treatment of secondary trauma as an essential workforce development and protection strategy for agencies pursuing trauma-informed care, and has noted that establishing organizational standards that normalize STS as an accepted occupational hazard and not an individual fault, failure, or deficit is an important strategy for preventing turnover and increasing workforce retention. Failure to include STS into any trauma-informed care initiative in the child welfare system would represent a barrier to effective implementation, and would ultimately undermine the success of the agency to provide trauma-sensitive care to children.

Challenges to Implementation

The most appropriate way of assessing how an organization responds to workforce issues is not always readily apparent, and without reliable tools and methods, the child welfare agency can engage in assessment processes that fail to discover contrary experience, and therefore act in ways that sustain existing beliefs (Argote, 2013; Dodgson, 1993). Considering the nature of STS, an organization would need

to acknowledge the fears and potential defensiveness associated with identification of such a problem by allowing for anonymous responses to the organizational assessment, and through normalizing the phenomenon in child welfare practice. The STSI-OA allows for confidentiality in response, and focuses on categorizing respondents by role in the agency (front line worker, supervisor, manager, etc.) rather than title.

Certain learning inhibitors also can be present and represent significant challenges to implementation of an organizational assessment about the STSI-OA. There is the tendency for supervisors or regional managers to focus on parochial versus system-wide issues and problems, and in doing so under- or overestimate the scope and impact of the problem. This can lead to less attention being paid to problems that are not as salient to policymakers and those with the opportunity to address the impact of STS. For example, there is likely a difference in the perception of the impact of indirect trauma between front line workers and those who are more removed from direct contact with trauma survivors. However, communication about necessary policy and procedure is likely more frequent among supervisors and administrators who have less exposure. Another learning inhibitor is the perceived gap between what individuals in an organization say they do and what actually occurs. These distorted reports can be caused by defensiveness, a lack of awareness, or misunderstandings, but can prevent effective organizational assessment of efforts toward addressing STS in the workplace. Implementation of the organizational assessment using the multiple respondent format, and in the context of a training and organizational change process allows for a reciprocal process of assessment and learning.

Deutero-learning requires some organizational flexibility so that attempts to address STS can be formalized and institutionalized toward sustainability through policy and protocol. Child welfare agencies are often enormous bureaucracies embedded in large systems, which may not be nimble to learning and change. The STSI-OA allows for "organization" to be considered as any unit of a child welfare agency that is open to change so that deutero-learning can occur at the unit, or broader organizational level. Furthermore, formalized policy and protocol change is more likely when standardized measures of the construct being addressed are available.

Evidence for Success

A study of 629 respondents to the STSI-OA representing every region of the United States was conducted to standardize the tool. Of the total respondents, 69.7% self-identified as female, almost 60% of respondents were less than 45 years old and 2% were 65 or older. Approximately 65% reported 6 or more years as a professional helper, with the largest percentage of respondents (26.2%) indicating they have worked as a professional helper for 11–20 years. Just under 30% of respondents work for an organization with less than 50 employees and almost a 28.5% reported

Table 16.2 General description of the scores by domain and total on the STSI-OA with quartile cutoffs

Domain	Mean(standard deviation)	Median (lower quantile, upper quantile)
Resiliency building activities	23.77 (10.6)	23 (18,27)
Promoting safety	23.19 (10.5)	22 (16,28)
STS-informed policies	17.92 (10.2)	16 (12,21)
STS-informed leadership practices	28.89 (15.3)	27 (19,36)
STS-informed routine practices	20.88 (12.7)	18 (13,25)
STS monitoring and evaluation	11.17 (8.2)	9 (6,14)
Total	125.82 (57.5)	114 (89,146)

their agency has over 500 employees. The STSI-OA sample represents multiple service systems including child welfare (14%), community mental health (30%), juvenile justice (21%), educational settings (13.8%), healthcare (5.8%), first responder groups (3.2%), and tribal settings (3%); it has been completed by a range of personnel, including front line CPS workers (26.3%), direct service providers (25.1%), supervisors/managers (23.3%), and senior managers/directors and C-level professionals (12.7%). This use of the STSI-OA in this diverse respondent pool allows for investigations into the utility and applicability of the tool across settings and respondents.

Total scores can range from 0 to 200, with higher scores indicating a higher level of competency in each of the domains assessed: promoting resiliency, promoting safety, STS-informed policies, STS-informed leadership practices, STS-informed routine practices, and STS monitoring and evaluation. Composite scores were created for each of the domains examined and Table 16.2 presents the mean composite scores for all respondents. The mean total score for all respondents was 125.82 (SD = 57.5).

The STSI-OA has excellent internal consistency at 0.97 for the total score, indicating that calculating a total score is reliable. Domain scores are also in the excellent range from 0.88 (Promoting Safety) to 0.94 (Resiliency-Building Activities and STS-Informed Leadership Practices). The STSI-OA has a significant, moderate, and positive relationship ($r = 0.438$, $p = 0.001$) with a 30-item version of the Trauma System Readiness Tool, indicating convergent validity. Test–retest reliability at 90 days is good at 0.813.

Application/Strategies

Organizational assessment of STS involves the development of individual and organizational competencies that respond to contexts that shape practice. Specifically, the STSI-OA facilitates the application of specific competencies that would advance the well-being and effectiveness of child welfare organizations, and that are consistent with the trauma competencies endorsed by the Council on Social Work

Education, and the American Psychological Association (as developed by the New Haven group). These include:

- "Assessing and evaluating organizational policies for their potential to increase worker safety, decrease trauma exposure, and decrease vicarious traumatization" (CSEW, 2012).
- "Demonstrate understanding that institutions and systems can contribute to primary and secondary trauma and offer strategies to reduce these barriers as appropriate" (p. 306, Cook & Newman, 2014).
- "Engaging institutional leaders in the development of trauma informed workplace policies and practices that benefit practitioners, clients and communities" (CSEW, 2012).
- "Demonstrate knowledge about the role of organizations in building resilience, prevention, and preparedness (universal precautions)" (p. 306, Cook & Newman, 2014).

Cultural Competency

As discussed in Chap. 4 of this book, a key component in organizational cultural competence includes policies and procedures that provide support to individual practitioners. An STS-informed organization, as operationalized by the STSI-OA, manifests as culturally responsive in two primary ways. First, an STS-informed child welfare organization can demonstrate cultural competence by monitoring and evaluating organizational policies, practices, and norms around STS to capture the unique needs and response patterns of the dominant and subordinate cultures within its milieu. This is achieved by monitoring workforce trends (i.e., attrition, absenteeism, social isolation, increased conflict, and compassion satisfaction) in racial, ethnic, geographic and SES diverse groups, and responding to what is learned in this evaluation process via action and communication that is culturally sensitive and responsive to the needs of all workers. Next, an organization can promote safety and resiliency by recognizing individual risk and protective factors that may manifest based on past or current trauma experiences, as well as demographic and cultural characteristics. This allows for organizational responses such as peer support, reflective supervision (Gilbert, 2001), and referral to employee-assistance programs to be crafted in such a way that nuanced expressions of distress can be recognized, properly addressed, and satisfied in a culturally competent manner. Consistent with the organizational learning and development model described earlier, this may involve ensuring that current policies and practices are delivered with congruence across racial, ethnic, and cultural groups (single-loop learning), and that new practices are developed to augment the deficiencies noted in the current organizational praxis (double-loop learning). Since the ultimate goal of a learning organization is to combine both approaches, the STSI-OA provides a conduit for evaluating the degree to which a child welfare agency is achieving these goals as they relate to culturally competent STS prevention and intervention.

Organizational Change Framework in Application

The STSI-OA is one strategy for facilitating the implementation of STS-informed activities into an organization, and has the benefit of being a tool for measuring the success of such efforts. A toolkit of strategies is under development to facilitate the application of STSI-OA principles and results (scores) into an organizational change process. This involves using the STSI-OA to drive goal setting around STS practice and policy development in a measurable and sustainable manner. For example, STSI-OA developers utilize a "How STS-Informed is your Workplace" exercise that uses color coding to identify STSI-OA strategies (within the six STSI-OA domains) that have been tested in the specific unit and are ready for spread (coded green); strategies that are being enacted but not yet tested/verified (coded yellow); strategies that are still in the planning stage and have not been implemented (coded orange); and those that need attention and are not being addressed (coded red). This color coding maps onto the response categories of the STSI-OA and allows for the creation of a visual representation of STS policies, practices, and activities that can guide goal setting. Teams use this coding strategy to color their "organizational house," and in doing so create a visual representation of the organization's baseline efforts at becoming STS-informed. This coding is repeated at intervals (baseline, midpoint, post-training) to track change visually over time.

Conclusion

Creating a trauma-informed child welfare organization requires attention to how indirect trauma impacts the workforce and the role and responsibility of the agency to protect its own workforce. As an adjunct to assessing the impact of child welfare activities on the safety and permanency of maltreated children and their families, it is important to design evaluation systems that build capacity and help organizations learn, and that are sensitive to the impact of trauma on the workforce. In the "organization as a garden" metaphor offered by Peter Senge at the beginning of this chapter, this type of organizational assessment equips leaders with the information needed be a gardener, not a mechanic, and to grow and nurture their workforce.

The STSI-OA is an example of a rapid assessment tool that can facilitate this developmental process, and support this type of trauma-informed care transformation in public child welfare.

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Chapter 17
Trauma-Informed Strategies for Staff Recruitment and Selection in Public Child Welfare

Virginia C. Strand

Introduction

Trauma-informed recruitment and selection strategies have been slow to be developed in public child welfare. There has, however, been significant work undertaken in reference to a number of general recruitment and selection strategies. These strategies include using realistic job previews (RJP) to acquaint potential employees with the realities faced by clients and workers in the public child welfare system, developing screening instruments and other protocols, including web-based formats, and exploring the association of both BSW and MSW training with retention in contemplation of assuring that educational background is a qualification for hire. Less attention has been paid to marketing, compensation, the implication of unionization and work place conditions in hiring, or in the development of comprehensive recruitment strategies. In this chapter, we review some of the general strategies and what it would mean if they became more trauma informed, with special attention to the utility of trauma course work in the educational background of recruits.

Experience in working with traumatized children and adolescents is often part of the job experience for those interested in employment in public child welfare. Increasingly, new recruits may have experience working with children and adolescents in groups home or residential centers in the private or not-for profit service system. Candidates may also have worked in adolescent or young adult in-patient psychiatric centers as mental health aides. All of these work experiences provide practice experience with clients exposed to trauma.

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Recruitment Strategies: Realistic Job Previews

In 2003, the Children's Bureau funded a number of projects aimed at increasing recruitment and retention. From these projects came a number of examples of RJPs. As described by Faller et al. (2009), an RJP is a mechanism used to acquaint prospective employees with an accurate portrait of a job. It is an effort to educate the candidate about a position, often with the intention of assuring that those that are hired come with knowledge of the job. There are many different forms that an RJP can take – including videos, verbal presentations, job tours, and brochures. Child welfare agencies have focused on a video format, often in a DVD or streaming format. The hope is that familiarity with the kinds of tasks associated with a job in child welfare will help reduce turnover, which is very costly for child welfare agencies.

John Wanous (1989) offers several recommendations on implementing a successful RJP. In his opinion, using the RJP early in the application process (or before) may be more effective because candidates become more invested in the job as they exert more effort in the application process. By telling the candidate to consider the RJP information carefully and to make a thoughtful decision about accepting an employment offer, the organization presents itself as being caring and trustworthy as well as encouraging the applicant to make an effective job choice (Wanous, 1992).

Roth and Roth (1995) recommend that the "spirit" of the RJP be present during all phases of the recruiting process, including on-campus recruiting, the RJP video, information shared during the interview, and all informal contacts. Pitt and Ramaseshan (1995) found that RJPs have the most significant impact on applicants' decisions to accept a job offer and on turnover if:

The information presented accurately portrays both the positive and negative aspects of the job.
The information presented deals with a job very specifically, rather than a broad-brush overview of the job or the organization.
The information presented provides several aspects of the job rather than focusing on only a few elements.
The information presented appears to come from a credible source. Typically, employees currently performing the job are one of the most credible sources.
The information presented is that which is the most important for the applicant to know before deciding to accept the job offer.

To present these job previews in a manner that is trauma informed, it would be important to set them in the context of a work environment that can trigger one's own history of exposure to traumatic stress, as well as create the risk of vicarious traumatization. Like other jobs (in law enforcement and emergency medical services) that expose staff to traumatic events, it is important to prepare potential recruits for this possibility, as well as to provide information about the agency resources (training, supervision, co-worker support) to assist staff with such eventualities.

Selection Strategies: Educational Background in Trauma

It is becomingly increasingly likely that candidates may have had trauma course work in their educational programs at the bachelor or masters level. In social work programs, 23 MSW programs indicate either a trauma specialization or certificate in trauma. Since 1980, funding to prepare current and future child welfare staff at both the BSW and MSW levels has been available through Title IV-E funding for student stipends. Currently, 209 programs in 46 states sponsor Title IV-E programs (see http://www.uh.edu/socialwork/New_research/cwep/title-iv-e/). Many states offer Title IV-E funding at their various campuses across the state. In addition, since 2013, the National Child Welfare Workforce Institute (NCWWI), another Children's Bureau program, has sponsored child welfare traineeships at 13 schools of social work (see www.ncwwi.org). Many programs are beginning to include course work about trauma; the NCWWI traineeships, in particular, are required to do so as a condition of funding.

Research suggests that staff with a BSW or MSW have higher retention rates and job satisfaction. For example, Ellett, Ellis, Westbrook, and Dews (2007) in a review of the literature found that:

States that minimally require a BSW or MSW degree experience far lower turnover and vacancy rates than other states (Russell & Hornby, 1987).

MSW professionals who were mentored or served as mentors have higher salaries, career success, and satisfaction than MSW professionals without these mentoring experience(s) (Collins, 1994).

MSWs require less training and supervision than other child welfare staff, and for this reason, requiring the MSW for practice is cost effective (Abramczyk, 1994).

Individuals with degrees in social work are better prepared than others for work in child welfare (Albers, Reilly, & Rittner, 1993; Dhooper, Royse, & Wolfe, 1990; Leiberman, Hornby, & Russell, 1988; Pecora, Briar, & Zlotnik, 1989).

Overall performance of MSWs was significantly higher than that of non-MSWs, and education, specifically holding the MSW, "appears to be the best predictor of overall performance in child welfare work" (Booz-Allen & Hamilton, Inc. 1987, p. iii).

Graduates of IV-E programs have higher levels of skills, confidence, and sensitivity to clients (than other CW employees) (Hopkins, Mudrick, & Rudolph, 1999).

Graduates of IV-E programs are more likely to remain employed in child welfare than other employees (Harrison, 1995; Robin & Hollister, 2002) and are more satisfied (Ellett et al., 2007, pp. 275–276; Vinokur-Kaplan, 1991).

Findings from a recent study suggest that agency directors may want to explore opportunities to connect current employees with Title IV-E programs, as research suggests that those with agency employment prior to pursuit of an MSW are more likely to be committed to the agency. Therefore, it is increasingly likely that students graduating with a BSW or MSW are likely to have had some exposure to trauma in their coursework. Exploration with potential recruits about their course

work, including specific attention to what they have learned about the impact of trauma on children and adolescents, the relevance of trauma-informed intervention, and the importance of self-care will reveal the degree of familiarity with trauma and its impact.

Core Concepts of Trauma Informed Child Welfare Practice

The development of the Core Curriculum on Childhood Trauma under the auspices of the National Child Traumatic Stress Network (Layne et al., 2014) and modified for graduate social work education (Strand, Abramovitz, Popescu, Way, & Robinson, 2014) provides an important tool for training a trauma-informed workforce. The child welfare adaptation of the course, entitled *Core Concepts of Trauma Informed Child Welfare Practice*, has been disseminated to schools of social work since 2010. Two-thirds of the schools teaching the course have a Title IV-E scholarship program. As reflected in the evaluation findings discussed below, at the completion of this course, students feel more confident and competent about their ability to work with traumatized children and their families.

By building the capacity for trauma-informed thinking and evidence-based trauma treatment into the workforce practices of schools of social work and child serving agencies, it advances a key priority of the Substance Abuse and Mental Health Services Administration (SAMHSA). The *Core Concepts of Trauma Informed Child Welfare Practice* course has emerged as an excellent tool to prepare students for child welfare practice. It has now been adopted by 32 schools of social work and taught 82 times since 2010.

Population Served

The course is delivered as an elective in an MSW program, usually to students in their Advanced year. A similar course is under preparation for BSW programs.

Staff Qualifications

Faculty teaching in an MSW program are eligible to teach the course following their participation in a year-long faculty learning collaborative to orient them to the Problem-Based Learning (PBL) method of instruction and to the trauma conceptual framework. The school of social work must commit to offering the course and to participating in an evaluation.

Course Components

The *Core Concepts of Trauma-Informed Child Welfare Practice* course has been developed specifically to prepare MSW students for trauma-informed child welfare practice. Two conceptual frameworks underlie this course. The first is a trauma paradigm based on 12 Core Concepts articulated by the National Child Traumatic Stress Network (http://www.nctsn.org/resources/audiences/parents-caregivers/what-is-cts/12-core-concepts), which offers an effective lens through which to view and understand the overwhelming and often-enduring effects of adverse life experiences on children and adolescents. The second is the use of PBL as the key pedagogical framework.

The articulation of the trauma conceptual framework occurs through the use of 12 *Core Concepts for Understanding Traumatic Stress Responses in Children and Families*. These concepts reflect an expert consensus about the issues needing attention in order to fully understand the child's and the family's experience of traumatic events and focus on understanding the role for trauma-informed intervention. They highlight the need for a moment-to-moment understanding of the child's experience, as well as an understanding of its impact on development, the family care-giving system, the influence of the family's culture on both the experience of and response to trauma, and on how the child and the family experience the traumatic event.

Child welfare workers are at heightened risk for secondary traumatic stress because of daily contact with traumatized children and families, and from interaction with a system that does not always respond in preventive and organizationally supportive ways that can mitigate the effects of chronic exposure to trauma. This condition leads to both personnel and economic losses that ultimately impact children's and families' relationships and attachments to child welfare workers. The Core Concepts also identifies that working with trauma-exposed children can evoke distress in providers that makes it more difficult for them to provide good care. The course incorporates knowledge about secondary traumatic stress and strategies to address its impact.

The primary pedagogy adopted for teaching this course, PBL, uses a methodology that parallels the evidence-based practice approach. Here, evidence-based practice is conceptualized as a process and not an end product. In the *process*, students learn how to develop a clinical question, search for evidence, appraise evidence, formulate and apply interventions, and evaluate them for fidelity of implementation as well as client effectiveness (Sackett, Rosenberg, Gray, Haynes & Richardson, 1996). The PBL method of instruction reinforces this process. Students are encouraged through the class format to access the "best available evidence" and evaluate how it applies to *individual cases*.

The PBL method relies heavily on the student taking an active role in learning. Students are presented with real-life client situations or problems. They assume responsibility for identification of the knowledge they need to solve the problem or address the situation, and for searching and obtaining that knowledge. It has been

suggested that the primary skills developed in students with the PBL approach are those of critical thinking and self-directed learning (Altshuler & Bosch, 2003). Of particular note, PBL harnesses the adult learning principle of active learning. Introduction of new material (1) builds on prior knowledge; (2) can be "chunked" into manageable units, often through self-paced learning exercises; (3) holds personal relevance and clear applicability to learners' lives; (4) gets presented within a meaningful context (often a case vignette) that simulates professional practice conditions; and (5) typically begins by presenting a challenging problem or question learners must answer in order to competently address it.

The course contains five case vignettes, and collectively include examples of cases in child protection, preventive services, foster care, and adoption. Collectively, the cases represent each major developmental stage from preschool through adolescence. Each case reflects a highly realistic real-life setting, presents responses appropriate to the developmental age of the child, gives details of the trauma history or exposure, and attends to both the cultural context for the case and to pre-existing pro motive and protective factors.

The cases unfold in stages to simulate real-life clinical practice and foster the development of clinical judgment based on an ongoing process of formulating and testing hypotheses (Nelson et al., 2007). An extensive facilitator guide provides suggestions for actively exploring and applying trauma principles in relation to each case. After each section is presented, the facilitator encourages students' systematic analysis of the case to identify important facts and formulate hunches.

Evidence for Success

Every time the course was offered, the faculty were asked to collect pre- and post-test data from students in the course, in accordance with the protocol outlined in the Fordham IRB. Data were received from 79 schools, and there were 1336 students enrolled in the course over these 6 years. Nine hundred and eighty-five pre- and post-tests were matched for a return rate of 73.7%. The purpose of the evaluation was to determine how effective the course was in increasing students' self confidence in working with traumatized children and their families. Data collected during the evaluation included demographics, confidence levels, course design feedback, as well as responses to open-ended questions.

The primary objective of the course is to increase the confidence in working with traumatized children, adolescents, and their families. Response were collected on 12 items, using a nine-point Likert scale. Changes between pre- and post-test were measured using a matched t-test. The analysis determined that there was a statistically significant increase in confidence from the pretest mean of 5.27 to a post-test mean of 7.79 ($df = 674$, $p < 0.0001$). The effect size (r) value is 0.6813, indicating a significant change in the predicted direction. While the course was highly effective, some challenges emerged: overuse of case studies; minimal effectiveness of some group activities/projects; and the lack of time allocated for more in-depth discussions of the

core concepts learned in this class. However, exposure to this type of coursework in trauma during educational preparation appears to be effective in preparing students for child welfare practice.

Selection Strategies: Screening

Using screening tools more widely at the time of recruitment is a strategy that could aid in identifying candidates who are a good fit for child welfare work. It has been determined that staff with the personal qualities of resilience and optimism are less vulnerable to the long-term effects of secondary traumatic stress. Recent studies from research conducted with soldiers preparing for combat could inform selection in child welfare. In the military, it has been found that individuals with profiles reflecting resilience, optimism, and hardiness may do better. There is also some evidence that positive psychological capital (Schaubroeck, Rolli, Peng, & Spain, 2011) and problem-solving capacity (Skomorovsky & Stevens, 2013) contribute to resilience and assist soldiers exposed to trauma.

In the 2011 study of Army personnel deployed in Iraq, it was hypothesized that persons who maintain higher levels of optimism, hope, and resilience (captured in the construct of "positive psychological capitol") will appraise the environment associated with their combat deployment as being less distressing. Findings confirmed this hypothesis. Research also suggests that the tendency to experience purposefulness in activities, to have a sense of control over life experiences, to attach positive meaning, and to perceive stressors as challenges in life may protect individuals against stressful events (Skomorovsky & Stevens, 2013). These may be important variables to consider in the selection and training of child welfare personal, and the development of screening tools that can assist in such screening may be worthwhile for public child welfare to pursue in the interest of attracting candidates who will perform effectively in an environment of ongoing exposure to trauma.

Research in child welfare has begun to explore personal characteristic associated with job satisfaction and organizational commitment. One of the more commonly occurring findings is that commitment to child welfare and/or to the profession of children and families is associated with organizational commitment and job satisfaction. Ellett, Ellis, Westbrook & Dewes (2007) examined the association between human caring, self-efficacy, and perception of organizational culture and intention to stay among a group of staff committed to the agency. Findings are significant in that they suggest that the personal characteristics of human caring and self-efficacy are a more important influence in a staff member's decision to stay than the impact of the organizational culture. These are consistent with the findings of Conrad and Kellar-Guenther (2006) that those with higher levels of compassion satisfaction (comparable to human caring) had lower levels of compassion fatigue. Similarly, Anderson (2000) found that CPS workers with an engaged coping style – as manifest in problem solving, cognitive restructuring, social support, and ability to express

emotions – were more prevalent in veteran CPS workers and moderated a tendency toward depersonalization and a reduced sense of personal satisfaction. However, even in these workers, it did not decrease emotional exhaustion.

A comprehensive selection strategy might include trauma-informed behavioral interviewing, and the application of screening tools such as that suggested above. Some agencies have experimented with a combination of web-based testing, viewing an RJP video that accurately predicts the realities of child protective service work, and select screening.

Selection Strategies: Behavioral Interviewing

Behavioral interviewing is designed to present potential employees with questions that require a candidate to answer in terms of *what they have done* in an identified situation, as opposed *to how they might handle* a hypothetical situation. Recent research suggests the association of certain personal characteristics and job satisfaction. Coetzee and Stoltz (2016) found that career adaptability was positively correlated with job success, job satisfaction, and organizational commitment. Exploration in the initial interview about the individual's ability to innovate and adapt to circumstances in past employment may contribute to positive job outcomes in child welfare. Career adaptability and career- and work-related outcomes, such as success in the workplace, work engagement, job satisfaction, job embeddedness, and organizational commitment (Ferreira, 2012; Rossier, Zecca, Stauffer, Maggiori, & Dauwalder, 2012) have been found to be associated with retention.

In an interview assessment developed by Connecticut Department of Child and Family Services, behavioral anchors were developed for a range of core and role-specific competencies. Core competencies included adaptability, client focus, communication, organizational awareness, problem solving and judgment, results orientation, and teamwork. Role-specific competencies included developing others, impact and influence, innovation, leadership, relationship building, self-management, and strategic thinking. Examples of questions to probe for core competencies are:

Client Focus

Give an example of how you provided service to a client/stakeholder beyond their expectations. How did you identify the need? How did you respond?

Tell me about a time when you had to deal with a client/stakeholder service issue.

Describe a situation in which you acted as an advocate within your organization for your stakeholder's needs, where there was some organizational resistance to be overcome.

Problem Solving and Judgment

- Tell me about a time when you had to identify the underlying causes to a problem.
- Describe a time when you had to analyze a problem and generate a solution.
- Tell me about a situation where you had to solve a problem or make a decision that required careful thought. What did you do?

Teamwork

Tell me about a time when you worked successfully as a member of a team.
Describe a situation where you were successful in getting people to work together effectively.
Describe a situation in which you were a member (not a leader) of a team, and a conflict arose within the team. What did you do?
Examples of question to explore for role-specific questions include:

Impact and Influence

Describe a recent situation in which you convinced an individual or a group to do something.
Describe a time when you went through a series of steps to influence an individual or a group on an important issue.
Describe a situation in which you needed to influence different stakeholders with differing perspectives.

Innovation

- Describe something you have done that was new and different for your organization that improved performance and/or productivity.
- Tell me about a time when you identified a new, unusual, or different approach for addressing a problem or task.
- Tell me about a recent problem in which old solutions wouldn't work. How did you solve the problem?

Relationship Building

- Describe a situation in which you developed an effective win/win relationship with a stakeholder or client. How did you go about building the relationship?

- Tell me about a time when you relied on a contact in your network to help you with a work-related task or problem.
- Give me an example of a time when you deliberately attempted to build rapport with a co-worker or customer.

Self-management

Describe the level of stress in your job and what you do to manage it.
Describe a time when you were in a high-pressure situation.
Describe a time when things didn't turn out as you had planned and you had to analyze the situation to address the issue.

These can be modified to fit a specific position. For example, under core competencies, client focus questions could be adapted to highlight aspects of clients that in child protective services versus those clients in adoption, preventive services, or foster care. In role-specific competencies, self-management questions could further highlight secondary traumatic stress response.

Selection Strategies: Recruitment from Outside the Agency

Child welfare agencies, particularly public ones, typically recruit for supervisors and managers from within. This can be a valuable incentive for retention and offer meaningful pathways for career development. The effectiveness of this promotion strategy may be outweighed, however, by the need in the current climate to become more trauma informed, which could be accelerated through hiring of some "content" experts from outside child welfare, thus creating a more open structure, and one more conducive to the development of trauma-sensitive supervision and management capacity.

Recruitment from outside the agency, for a certain percentage of mid-management positions, could create a more diverse workforce. One rationale for considering this is that managers are typically not union positions and thus more flexibility in hiring is available. If going that route, this is another place where behavioral interviewing might be employed. The following, while designed by the Connecticut Department of Children and Families for use with supervisors, is relevant for managers as well. It identifies five competency areas: (1) aligning performance for success, organizational ability, and coaching, (2) communication, building trust, and cultural competence, (3) collaboration and customer focus, (4) professional knowledge and skills, decision making, and stress tolerance, and (5) team leadership and facilitating change. Examples of the kinds of questions that would get at some of the personal qualities of resilience, optimism, and positive thinking associated with personal resilience include:

1. Aligning performance for success, organizational ability, and coaching.
   Describe a situation where you were able to capitalize on someone else's strengths to help accomplish a goal.
   Tell us about a situation when you had to motivate other people to get a job done.
2. Communication, building trust, and cultural competence.
   Tell us about a time when you had to communicate in an assertive way to get an important point across.
   Describe a situation when you had to significantly change your normal approach to working with someone because of cultural issues.
3. Collaboration and customer focus.
   Describe a situation where you advocated strongly for the needs of staff or coworkers.
   Describe a situation where you were a member of a team that was having difficulties and took action to try to help the team.
4. Professional knowledge and skills, decision making, and stress tolerance.
   Tell us about a time when you had to defend a decision you had made to others who were in positions of authority and who felt you had made a mistake.
   Describe a situation when a crisis occurred and you had to shift priorities and tasks rapidly in order to resolve it.
5. Team leadership and facilitating change.
   Tell us about a time when you demonstrated your best leadership skills.
   Describe a situation when some of your colleagues were complaining about a change that was being made and you spoke up in support of the change.
   In summary, recruitment from outside the public agency may provide a source of knowledge and expertise that could augment the experience of working only in a public agency caseworker position before being promoted. While one would not want to lose the experience that comes from working in direct practice positions prior to supervisory and management experience, the use of some positions for outside recruits could strengthen the candidate pool.

Cultural Relevance

The issue of disproportionality and disparity in child welfare makes it imperative to recruit staff from diverse racial and ethnic groups in the United States. Having more staff who represent the client population, however, is not sufficient to address the concerns about disproportionality and disparity in child welfare. Of those staff selected, screening mechanism need to be more fully integrated into the selection process, using the existing technologies that include screening and behavioral interviewing, to assure that competent and culturally competent staff are hired. New staff need to then be trained, coached, and supported. The following chapters in this book address the kind of strategies that are being innovated. Work still needs to be done regarding their effectiveness.

Challenges

A huge challenge in child welfare remains retention, especially in jurisdictions that are plagued by high-profile child fatality cases that result in fearful, demoralizing work environments. The need to stabilize the agency organizational environment to reduce the concerns about physical and psychological safety have been addressed in earlier chapters, but bear repeating here. It is difficult to recruit staff into such an environment and expect them to stay. Given that an agency is working to reduce these stressors, using state-of-the art technologies to recruit and select, and adapting them to be more trauma sensitive is a crucial step. As described in this chapter, not many of the existing tools are designed specifically to recruit staff characterized by the resilience and optimism found to be helpful in other high-stress profession. The need to attend to that, as well as to address the other issues mentioned at the start of this chapter and not covered here (marketing, compensation, the implication of unionization, and work place conditions in hiring, or in the development of comprehensive recruitment strategies) remain challenges to recruiting and sustaining a trauma-informed work force.

Resources

R&R projects

https://www.childwelfare.gov/topics/management/workforce/recruit-hire/staff-selection

North Carolina http://files.ctctcdn.com/fa43a05f001/d484e6cd-6e74-4411-a2b1-cb3892d26100.pdf

Georgia – an employee selection protocol

Of the realistic job previews http://www.cpshr.us/workforceplanning/documents/06.02_realistic_job_preview.pdf

Screening and staff-selection resources listed on the Gateway Resources

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Chapter 18
Training the Child Welfare Workforce on Trauma-Informed Principles and Practices

Lisa Conradi and Jennifer Hossler

Purpose of the *Child Welfare Trauma Training Toolkit*

The primary goals of the *Child Welfare Trauma Training Toolkit* (CWTTT) are to educate child welfare professionals on the impact of child traumatic stress among children and families, as well as to teach strategies for using trauma-informed child welfare practice to enhance the safety, permanency, and well-being of children and families involved in the child welfare system.

Beyond dealing with the aftermath of child abuse, front-line child welfare workers assist children and their families with some of the most challenging and complex problems facing our society including poverty, substance abuse, and mental health issues. While the child welfare workforce interfaces with trauma and traumatic stress reactions on a daily basis through its identification and investigation of child abuse cases, it wasn't until recently that child welfare leadership acknowledged the critical nature of training the workforce on trauma-informed principles and practices (Ko et al., 2008). This was due, in large part, to a child welfare system focus on a child's physical safety, that is, ensuring that the child is safe from physical harm and placed into a loving and nurturing environment (Wilson, 2014). While the promotion of physical safety is a critical component to any child welfare system response, it is not sufficient.

Researchers and practitioners have begun identifying that children who have experienced child abuse have experienced a *traumatic* event. As such, these children are at higher risk for developing child traumatic stress reactions that can have both short- and long-term implications for their development, relationships, behavior, mood, and cognitions (Cook et al., 2005). As Richardson, Coryn, Henry, Black-Pond, and Unrau (2012) argue, child welfare workers who are not trauma-informed can

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potentially misunderstand the child's experience, which can be detrimental to the client–worker relationship. The lack of trauma-informed training can also affect the worker's understanding of the child's symptoms, especially disruptive behavior problems, and the need for appropriate mental health treatment interventions. Therefore, it became clear that training the child welfare workforce on trauma and its effects, as well as practice strategies to mitigate those effects, was essential (Conners-Burrow et al., 2013).

In order to address this need, the National Child Traumatic Stress Network (NCTSN) Child Welfare Committee created the first version of the *Child Welfare Trauma Training Toolkit* (CWTTT) in 2007. The CWTTT was initially designed to serve as a training curriculum for Bachelor's and Master's level child welfare caseworkers to help increase their knowledge and use that to inform concrete practice changes. In 2012, based on feedback gathered from child welfare leadership and jurisdictions across the country, staff from the Chadwick Trauma-Informed Systems Project (CTISP, 2013) revised the curriculum and created an updated version for dissemination.

Description of the Toolkit

The updated version reflected the *Essential Elements of a Trauma-Informed Child Welfare System,* which were identified by the Child Welfare Committee of the NCTSN (2012) and were designed to align with overarching goals of the child welfare system: Safety, Permanency, and Well-Being. The "Essential Elements" provide a helpful framework to conceptualize the components of a trauma-informed system for children and families and are as follows:

1. *Maximize physical and psychological safety for children and families.* The term psychological safety refers to an individual's "sense of safety, or the ability to feel safe, within one's self and safe from external harm" (Wilson, 2014). At its most fundamental level, recovery from trauma requires a sense of safety, and providers must recognize safety is both physical and psychological.
2. *Identify trauma-related needs of children and families.* Where possible, a trauma-informed approach suggests the use of a reliable and valid screening tool for identifying the client's trauma history and traumatic stress responses, and to direct referrals for assessment and treatment when indicated.
3. *Enhance child well-being and resilience*. Trauma-informed care seeks to support positive relationships in the child's life and minimize disruptions to familiar and positive figures. It seeks to do so while also supporting referral to specially trained mental health professionals who are schooled in evidence-based treatment models.
4. *Enhance family well-being and resilience*. Families may find it difficult to be protective if they have been affected by trauma, and they may need help and support in order to draw on their natural strengths.

5. *Enhance the well-being and resilience of those working in the system*. Trauma-informed organizations must consider their staff's physical and psychological safety and actively work to promote effective interventions for secondary traumatic stress.
6. *Partner with youth and families*. Consumers being served—and often their family members who have been involved in the service system—have a unique perspective and can provide valuable feedback on how the system can better address trauma among those served.
7. *Partner with agencies and systems that interact with children and families.* It is important that those aspiring to provide trauma-informed care partner with others in parallel service systems in identifying and addressing trauma. Working with allied professionals who know the clients and family can help in developing an appropriate service plan and prevent potentially competing priorities.

Population Served

The CWTTT is intended for child welfare workers, supervisors, and administrators. However, it can be easily adapted and delivered to other professionals who work with the child welfare system. The CWTTT has frequently been adapted to include many cross-system partners, including therapists and other mental/behavioral health professionals, educators, probation officers, and law enforcement. There are many added benefits to a mixed audience approach, including ensuring consistent information and language is shared across systems, as well as opportunities for learning about other professional roles, outside of the child welfare sector. Participants who have been involved in cross-sector trainings find value in learning from other systems, and have reported a mixed audience has enhanced their understanding of the various professional roles often encountered when working in, or with, the child welfare system.

The CWTTT has also been adapted to provide information about trauma to support staff working with, and within, child welfare systems. This may include staff in clerical or other reception area roles, as well as maintenance, advocates, and visitation monitors. The first Essential Element is focused on enhancing psychological safety of those served by the child welfare system. Often times, support staff may be the first point of contact for children and families receiving services, so providing them with a knowledge base of how trauma may impact children and families, as well as their role in enhancing psychological safety, is a critical step to building trauma-informed child welfare systems.

Staff Qualifications for Delivering the Child Welfare Trauma Training Toolkit

Trainees come from a variety of educational backgrounds, including BSW, MSW, LCSW, MA, MFT, PhD, PsyD, and other degrees in the clinical or human services field. Some jurisdictions have included paraprofessionals in the training, like

clerical staff, visitation monitors, resource parents, and parent partners. Additionally, trainers themselves come from a variety of educational backgrounds, similar to the ones listed above. While there is no certification process currently in place to be a trainer for the CWTTT, knowledge of, and experience working in the child welfare system is necessary. A good foundation and understanding of trauma and how it impacts the brain, body, development, and overall well-being of children and adults is also critical for any trainer. Ideally, a child welfare professional and mental/behavioral health professional would co-train the content, ensuring both sectors are represented. This enables both the child welfare practice and the clinical/therapeutic roles and perspectives to be highlighted, in addition to facilitating more robust discussions on content and case examples.

Program Components

There are a total of 14 modules in the CWTTT, with the first six modules focused on providing an overview of trauma and its effects, while the remaining modules dive deeper into the Essential Elements and encourage the participants to identify concrete strategies that they can integrate into their daily practice. The modules are as follows:

Module 1: *Introduction – The Essential Elements of a Trauma-Informed Child Welfare System.* This module provides the rationale for a trauma-informed child welfare approach by exploring the impact of trauma on the Child and Family Service Review (CFSR) goals of Safety, Permanency and Well-Being.

Module 2: *Child Trauma and Child Traumatic Stress.* This module highlights the prevalence of child trauma, defines acute, chronic and complex trauma, neglect, historical trauma, child traumatic grief, and child traumatic stress.

Module 3: *How Does Trauma Affect Children?* This module highlights the short- and long-term effects of trauma, the relationship between trauma and PTSD, and the use of psychotropic medication.

Module 4: *What Is the Impact of Trauma on the Brain and Body?* This module provides an overview of brain development during childhood and highlights the impact of trauma on a child's brain at different stages of development.

Module 5: *What Is the Influence of Developmental Stage?* This module focuses on the relationship between developmental stage and trauma, highlighting how children of various age groups may be impacted by trauma.

Module 6: *What Is the Influence of Culture?* This module highlights the intersection of culture and trauma, including issues related to racial disparity and disproportionality, immigration, refugee families, and historical trauma.

Module 7: *Essential Element 1 – Maximize Physical and Psychological Safety for Children and Families.* This module helps participants define psychological safety and identify strategies that they can use with their cases.

Module 8: *Essential Element 2 – Identify Trauma-Related Needs of Children and Families.* This module helps define trauma screening and assessment as they

apply to children and families in the child welfare system. The "Child Welfare Trauma Referral Tool" is introduced as a potential screening tool to help child welfare workers make sense of case information and direct referral practices.

Module 9: *Essential Element 3 – Enhance Child Well-Being and Resilience.* In this module, participants are exposed to various strategies for enhancing a child's well-being and resilience, particularly through promoting protective factors, and referral to trauma-focused mental health services, as needed.

Module 10: *Essential Element 4 – Enhance Family Well-Being and Resilience.* This module highlights the importance of strengthening and supporting birth families and resource (foster, kinship, and adoptive) families.

Module 11: *Essential Element 5 – Enhance the Well-Being and Resilience of Those Working in the System.* This module explores the issues of secondary traumatic stress (STS), including sources of STS in the child welfare system and signs of STS in workers.

Module 12: *Essential Element 6 – Partner with Youth and Families.* This module explores the benefits of partnering with youth and families in service planning and programming.

Module 13: *Essential Element 7 – Partner with Agencies and Systems that Interact with Children and Families.* This module focuses on cross-system and inter-agency collaboration. Common barriers to system collaboration are discussed, in addition to strategies for working with partner agencies and systems.

Module 14: *Summary.* In this module, participants are asked to apply everything that they have learned in Modules 1–13 to a case vignette.

The CWTTT is both didactic and experiential and includes lecture elements as well as multiple activities to assist the participant in better integrating the material into their daily practice. The CWTTT includes a *Trainer's Guide*, *Participant Guide*, a corresponding PowerPoint slide kit, and a draft evaluation of the training that may be used by the trainer. Integrated throughout the curriculum are five case vignettes that are utilized as part of many of the activities in the CWTTT. They were designed to represent familiar cases to the workers so that they could take the information provided throughout the curriculum, and apply it to a case in the culminating activity. These vignettes reflect a wide range of ages, trauma type, and presenting concerns. The facilitator is welcome to utilize these vignettes to help participants identify trauma-informed case planning within those scenarios. Participants are welcome to apply their own cases and truly take the information presented within the CWTTT and apply it to cases that they see each and every day.

What Makes the CWTTT Trauma –Informed?

The CWTTT has played a pivotal role in assisting child welfare jurisdictions across the country in their efforts to become more trauma-informed (Conners-Burrow et al., 2013). With its focus on educating child welfare workings and cross-system

partners on trauma and its effects, while also highlighting the "Essential Elements of a Trauma-Informed Child Welfare System," the CWTTT provides practical strategies that aid staff members and larger systems in preparing for the implementation of trauma-informed practices. For example, between 2010 and 2012, nine child welfare jurisdictions across the country participated in a Breakthrough Series Collaborative on "Using Trauma-Informed Child Welfare Practice to Improve Foster Care Placement Stability" (TICWP-BSC; Conradi et al., 2011). One of the primary vehicles utilized in order to increase child welfare staff training and education within each of the jurisdictions was the CWTTT (Agosti, Conradi, Halladay Goldman, & Langan, 2013). In 2011, the Administration on Children, Youth and Families (ACYF) funded five sites across the country to develop trauma-informed child welfare systems. Many of these sites utilized the CWTTT as part of their implementation efforts to spread the concept of creating a trauma-informed child welfare system across their individual state (Bartlett et al., 2016; Lang, Campbell, Shanley, Crusto, & Connell, 2016).

Building on this work in 2012, the Chadwick Center for Children and Families received continued funding from Substance Abuse and Mental Health Services Administration (SAMHSA) as part of the NCTSN to develop the Chadwick Trauma-Informed Systems Project – Dissemination and Implementation (CTISP-DI) project. The goal of CTISP-DI was to develop trauma-informed child welfare systems, with a large component of that involving training the child welfare workforce. With the second edition of the CWTTT ready for dissemination, CTISP-DI offered a rare and unique opportunity to disseminate the curriculum to child welfare jurisdictions across the country. Between 2012 and 2016, five child welfare jurisdictions received ongoing training, support, and consultation from CTISP-DI staff to assist with implementing the CWTTT within their jurisdictions. These five sites included: Orange County, CA; Custer County, OK; Winona, Olmsted, Dodge, Steele, and Waseca Counties, MN; Volusia County, FL, and the state of Rhode Island. Child welfare workers, administrators, supervisors, and support staff, along with a host of cross-system partners from mental health, juvenile justice, education, and others, were trained on the revised version of the CWTTT.

Training in these five states looked very different for each jurisdiction. Some states already had trainers identified and experienced in providing the CWTTT through their Department of Human Services (DHS), while others had partnerships with their local child welfare training academy, creating a unique public–private partnership for delivering the training. One county had already been providing the training to child welfare workers, using a private consultant and experienced CWTTT trainer, and continued this practice throughout the project. Other jurisdictions had no infrastructure at all to provide the training; however, with ongoing support, consultation and the delivery of a train-the-trainer model by CTISP-DI staff, these jurisdictions have developed training teams of their own. This ensured implementation of the CWTTT continued across their county or state, and also helped with sustainability efforts of not only the training curriculum itself, but the essential elements of a trauma-informed child welfare system.

Adaptations

Much has already been mentioned about the flexibility of the CWTTT, both in terms of how the training is delivered and in what time frame, as well as who the intended audience may include. As previously mentioned, the CWTTT is intended to be delivered over a period of two consecutive training days. However, if only one full day is available, an effective strategy for this option is to provide the first six modules all in 1 day. The first six modules are often referred to as the *Trauma 101* content, as this information reviews what trauma is, how it affects children, the impact on the brain, body, and development, as well as the influence of culture. These modules lay the foundation for the rest of the curriculum, and provide scientific and practical information on how trauma impacts children across their development.

After this material is delivered, there are a variety of ways to cover the remaining material, which are all of the Essential Elements. Some jurisdictions have chosen to complete the remaining content on a weekly or monthly basis, focusing on one Essential Element per week/month. This could be done in 1 h segments, or longer, if there is time. Others have combined two Essential Elements and delivered the content that way, over a period of 2–3 h per weekly/monthly session. One benefit of this method is that once child welfare workers have the *Trauma 101* knowledge, it gives them a foundation for conceptualizing cases with a trauma-informed lens. By allowing for time in between sessions that focus specifically on the Essential Elements, child welfare workers can put into practice the concepts they learn, and bring examples or questions back to the group for feedback. For example, a child welfare worker may share an example of a client interaction which enhanced psychological safety (module 7) for that particular client/family, or may bring back a question to the group about screening practices (module 8). The *Trainer's Guide* provides detailed agendas for delivering the training in other formats, including four half-day trainings, or 72-h trainings. The general idea is that delivery of material is flexible and adaptable, depending on the need of the organization.

While struggling to find two full days can be a challenge for some child welfare jurisdictions, others have extended the training beyond the intended 2 day format. The state of Rhode Island has extended the CWTTT training to include three full days of training. In partnership with their statewide training academy, the training was extended in an effort to allow workers to receive incentive credit. Each worker is mandated to obtain a certain number of hours per year, and by expanding the CWTTT training to 3 days, all workers who attend receive incentive credit that counts toward their yearly mandate. This training is optional, but given that workers can receive credits they need annually, attendance has been consistently high and training sessions tend to be full.

Additional material was added, including videos on brain architecture from the Center on the Developing Child at Harvard University, and *ReMoved*, a 13-min video narrated by a 10 year old girl as she navigates her way through the foster care system. All of these videos are free and can easily be found online. Rhode Island also added content on Adverse Childhood Experiences (ACEs), which is introduced

in module 3. There is a 16 min TEDTalk by Dr. Nadine Burke Harris titled: *How childhood trauma affects health across a lifetime.* This is a great additional resource for this section if time permits. This video is also free and easily available online. Rhode Island also includes a panel on the third day of training. Members of the panel tend to differ in each training session, but usually consist of a mix of youth alumni, therapists trained in evidence based practices, foster/adoptive parents, and various other professionals who work in the field of child traumatic stress. The panel begins with each panelist giving an overview of their perspective of the child welfare system and trauma. The participants are encouraged to ask questions of the panelists. The panel has been highly successful and has received excellent reviews. Including the panel on the last day is a good way to bring the Essential Elements to life. Other states, including Michigan, have implemented similar panel discussions, which can fit well with modules 9 and 10, and often involve parent and other caregiver voices, youth, and cross-system partners like therapists and educators.

Another consideration for adaptation includes the use of a trauma screening tool, which is discussed in module 8. This module focuses on identifying trauma-related needs of children and families, using "The Child Welfare Trauma Referral Tool" as an example throughout the module. As the field of child welfare has become increasingly involved in discussions around screening children and youth for trauma, many tools have been developed, or are in the process of development. While there is a shortage of research-based and validated tools, given this is an emerging trend, many state and/or county child welfare jurisdictions are beginning to consider the implementation of a trauma screening tool, and many have already implemented such a tool. This particular circumstance allows an opportunity for child welfare jurisdictions to adapt this module of the CWTTT to include a tool that is consistent with what the organization has chosen to implement. In Oklahoma, researchers at the Department of Human Services developed their own trauma screening tool, after a thorough review of available tools. The CWTTT training in Oklahoma was adapted to reflect this, so module 8 now includes information on how to administer and score the new trauma screener that has been implemented statewide.

Child welfare jurisdictions in many states, including California, Florida, Maryland Michigan, Oklahoma, and Rhode Island have expanded the training audience beyond child welfare workers. Many states and counties have included mental/behavioral health professionals, educators, juvenile and criminal justice professionals, law enforcement, and support staff including clerical, maintenance, advocates, and visitation monitors. Minor adaptations to the training were made for cross-system groups, primarily in some of the language contained in the curriculum. For example, where the curriculum refers to a "child welfare worker," this language was changed to "child welfare professional" in cases when members from other systems participated in the training. The overall content was not adapted, and was delivered in its entirety to participants over the course of two full days of training.

There are additional activities, videos, and other resources that have been consistently added to the training, including a host of other NCTSN resources. Multiple additional resources have also been added to module 11, focused on enhancing the well-being and resilience of the child welfare workforce. All of these additional

resources can be accessed on the CWTTT learning center site on the NCTSN website, which can be accessed here: http://learn.nctsn.org/course/view.php?id=25.

Developed by the NCTSN CWTTT Training and Implementation (T&I) committee, the learning center site contains a host of resources to promote the implementation and sustainability of the CWTTT, in addition to providing concrete tips and strategies for trainers who are delivering the training. Resources on the learning center site include: (1) General information on the CWTTT and toolkit materials available for download, (2) Train-the-trainer videos, (3) Training tips from experienced trainers – one for each of the 14 modules, (4) Trauma tips newsletters for each of the seven essential elements, (5) Implementation resources – including tools for pre-training planning screening and assessment, implementation approaches, sustainability, and evaluation, (6) Webinars, and (7) Map and directory of experienced trainers across the U.S. All additional resources can be found under the *"Tips from Experienced Trainers"* tab.

The learning center site has proven to be a valuable resource for trainers across the country who are consistently providing CWTTT training in their communities. This type of ongoing learning allows trainers to learn from each other, talk about adaptations they have made to the training or structure for delivery of the training that fits with their system, as well as share new videos, activities, or other content they have implemented into the training. Updates are consistently made to the site as new resources, tools, research, and other information are continually being developed, shaping the way trauma-informed practice evolves in child welfare across the country.

Child Welfare Trauma Training Toolkit and Cultural Competency

The CWTTT seeks to enhance the participant's understanding of the interconnectedness of race and culture through a variety of different modalities. In the earlier version of the CWTTT, some slides on culture were incorporated into the second module on "What is Child Traumatic Stress?" It also included some flexibility with the vignettes, highlighting that they could be tailored to meet the need of the participants within a given child welfare jurisdiction. In this first version of the curriculum, the content primarily focused on helping individual child welfare workers have a greater understanding of the intersection of culture and trauma in their work with specific children and families on their caseload.

The most recent version of the CWTTT notably enhanced the section on culture by creating module #6, "What is the Influence of Culture?" This module provided much more detail of the impact of culture on trauma, racial disparity and disproportionality, trauma and immigration, refugee families and trauma, historical trauma, and the Indian Child Welfare Act (ICWA). While it continued to focus on helping individual child welfare workers have a greater understanding of the intersection of culture and trauma in their work with specific children and families, it also began to

introduce elements related to how the child welfare agency itself can be more trauma-informed as well as the broader child welfare system. It also included an activity focused on cultural case scenarios, which asks participants to review a cultural case scenario as a group, determining which of the already identified components of culture might be applicable for the child or youth. The group is then asked to identify strategies for how a child welfare worker might intervene in a trauma-informed and culturally responsive manner. The cultural case scenarios are utilized throughout other activities in the revised CWTTT as well.

Challenges to Implementation

One of the greatest challenges that has been identified in the training and implementation of the CWTTT in a child welfare jurisdiction is allocating the time necessary for the initial training. There is a large amount of content, all of it equally important, to cover in the 2 days, or 16 h allotted for the training, which includes a 1 h lunch break and two 15 min breaks each day. Child welfare administrators and staff members have expressed difficulty in being out of the office for two full days, as that ultimately takes them away from their primary duties as a service provider. Further, we know that our work does not stop, even when we are dedicated to professional development and increasing our knowledge base when it comes to the latest research, science, and strategies for working with children and families.

While the CWTTT is intended to be delivered over two full consecutive training days, there are alternate training agendas presented in the *Trainer's Guide* to address this issue in an attempt to provide suggestions for others ways in which the training may be delivered. If two full days does not work in a given system, perhaps four half-day trainings would be a better fit. Or perhaps even shorter sessions are needed; in which case, 72-h sessions may be delivered. Other systems have provided the first six modules in 1 day, and then broken up the remaining modules, the essential elements, into weekly 1- or 2-h sessions to focus on one element at a time. The idea is that the format and structure for which the training can be delivered is flexible, and should fit within the realities that any particular system or jurisdiction can provide to ensure the needs of both staff and clients are represented.

An additional challenge to implementation is leadership buy-in and support for administration and supervisors. Through the CTISP-DI project as well as trainers across the nation, it has become evident that leadership buy-in for the implementation of the CWTTT is critical. As with any change in procedure, policy, or practice, having leadership support is a critical component for successful implementation and sustainability. One strategy for engaging leadership is inviting them to participate in the training themselves. This assists them in understanding the value of moving towards a more trauma-informed approach, provides them with critical information on trauma, and trauma-informed systems, and ensures consistency in ideas, language, and strategies that can be shared across an entire organization. If leadership "gets it," they are more likely to support the rest of the organization in "getting it" as well.

There has been discussion among the CWTTT T&I sub-committee members about developing more guidance and concrete strategies for supporting supervisors in this work. Once a child welfare workforce has received CWTTT training, how can supervisors sustain the concepts of the training within their workforce? Again, inviting supervisors to attend the training is a great place to start. Organizations may want to consider offering a separate training for supervisors and administrators. In this forum, the content is delivered as it is originally intended, while allowing for discussion among leadership for ways to support their workforce with the concepts of trauma-informed child welfare. Given this trend and discussion happening across the county, it is likely that resources for leadership to support their workforce will be developed in the next few years.

Evidence for Success

While research on the CWTTT is currently limited, there are several efforts currently underway, or in the works, to evaluate the effectiveness of the CWTTT. In addition to the efforts described previously, CTISP-DI has conducted evaluations of CWTTT training in Florida and Oklahoma. However, these evaluations focused primarily on knowledge-based domains, using a pre/post-test method, and participant satisfaction with the training as a whole. In Custer County, OK, 31 participants completed the pre-test, and 24 participants completed the post-test. In Volusia County, FL, 39 participants completed the pre-test, and 32 participants completed the post-test. In both communities, results from the pre/post-test indicate, across the board, significant improvements of trauma-related knowledge. Types of information collected included understanding the relationship between a child's trauma history and his/her emotional reactions, and identifying a child's coping skills and strengths. Evaluations also examined a participant's intent to make practices changes, including assisting children who are having a strong reaction to trauma, and assisting their co-workers on becoming trauma-informed. Overall, participant's indicated a strong intent to integrate a trauma-informed lens into their daily practice.

Results from both Rhode Island trainings, and CONCEPT in Connecticut are also in the process of being collected. Rhode Island has pre/post-test data from approximately 80 participants, and 3 month follow-up data from approximately 40 participants. So far, results suggest significant improvements in some of the evaluation domains (e.g., exposure to trauma-related content, general and specific trauma-related knowledge, and supervisory practices) and limited change in some practice-related domains. CONCEPT has pre/post/and 3 month follow-up data from over 400 managers and supervisors, and over 600 child welfare caseworkers. These results are in the draft process, and will be available in the near future.

The lack of a valid and reliable evaluation tool that can be completed with fidelity across the country is a hot topic of discussion in the CWTTT world at this time. There are efforts underway within the NCTSN to develop such a tool, and to conduct a

thorough evaluation of the effectiveness of the CWTTT. This is certainly one of the limitations of the CWTTT (at this time); however, efforts are underway and it is hopeful that a formal evaluation process could be in place within the next year or two.

Application Strategies

Due to the interactive group activities throughout the curriculum, the CWTTT is ideal for training with small to medium size groups of 20–30 participants, however, can be adapted to accommodate larger groups if necessary. The training is intended to be delivered face-to-face, over two full days. However, it can be adapted into one of the formats described earlier in this chapter. Trainers should ensure the training space is large enough for the group, and offers some space for activities. Each participant should have a manual provided to them or download the material before the training.

Train-the-Trainer Models

Train-the-trainer models were delivered in Rhode Island, Volusia County, FL, and Custer County, OK. Participants included 30–40 child welfare administrators, supervisors, and case workers, in addition to other cross-system partners, as identified individually by each child welfare jurisdiction. Some partners at the table included mental/behavioral health, juvenile justice, education, and law enforcement. After the 2 days of content was delivered, a third day of training took place specifically for those participants who would be training the CWTTT in their community to provide guidance and instruction on training on the content. There was discussion between participants and trainers about questions/concerns with training on the material, as well as some general training tips that could be applied in any training situation. Lastly, participants were given a chance to break up into teams, and practice training on one of the modules, giving them experience training on a particular concept with the material fresh in their minds, as well as an opportunity to receive feedback from the larger group.

Ongoing Consultation

One final component provided to these three communities (Rhode Islne, Volusia County, FL and Custer County, OK) was monthly consultation calls over a period of 6 months. This allowed for communities to discuss strengths and challenges of delivering the training, both from a logistical standpoint as well as from a content standpoint. Additionally, training tips were reviewed on an ongoing basis, and were especially helpful for new trainers. These ongoing consultation calls with the three communities provided for a unique learning opportunity for each of them to share strengths and challenges to implementing this new curriculum in their systems, as well as learn valuable lessons and strategies shared by others.

Conclusion and Recommendations

Based on the training efforts to date using the CWTTT, multiple recommendations for future practice should be considered. First, child welfare systems should consider a thoughtful implementation structure that includes training, follow-up coaching and consultation, and the use of champions who spread this practice among their peers. Secondly, training on the broad concepts and on information is not enough. The individuals doing this work are hungry for concrete practice changes that they can make each day in their work that make a difference. While some time can be focused on presenting information and concepts, it is critical to drill down to specific practice changes that can be made at each level of the organization to better facilitate its capacity to become trauma-informed. Thirdly, all efforts need to occur across multiple levels of the organization. Trainings should not only include front-line caseworkers, but should also include supervisors, managers and administrators. Individuals at all levels of the organization have the capacity to make key improvements and to make sure that the practice changes that are identified are truly implemented. Finally, evaluation of this work is critical. Most jurisdictions utilizing the CWTTT reported that they collect satisfaction surveys on the training that is conducted, but they have not evaluated if training on the CWTTT has led to true practice change. Evaluation of training to enforce system change is a daunting task with multiple challenges and barriers. However, without an evaluation of the training, it is difficult to determine its level of effectiveness. Systems are encouraged to build an evaluation plan into training and implementation efforts throughout every step of the process.

Equipping the child welfare workforce with the knowledge, training and skills in order to do their jobs in a trauma-informed manner has become increasingly critical in recent years. In its earliest iterations, training focused solely on helping frontline caseworkers better identify and intervene in a trauma-informed manner. When the first version of the CWTTT was published in 2007, it was designed to meet this growing need. However, over time, it became clear that the journey towards becoming trauma-informed not only focuses on increasing the knowledge and expertise of a particular front-line caseworker, but also on transforming the larger system into one that recognizes and responds to trauma on all levels. Training alone in this work is not sufficient; the focus must be on true practice change that can only be accomplished through thoughtful and engaging implementation efforts.

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Chapter 19
Indirect Trauma-Sensitive Supervision in Child Welfare

Brian C. Miller

Trauma-informed child welfare, in addition to sensitivity to the effects of trauma on our clients, must also include responsiveness to the effects of indirect trauma upon staff. Indirect trauma is a term that incorporates the concepts of secondary trauma, compassion fatigue, and vicarious trauma (Knight, 2010). Indirect trauma-sensitive supervision (ITSS) is a key component of trauma-informed child welfare practice, and is the cornerstone of implementation of trauma-informed practices. Trauma-informed care ultimately defines nothing more than best care for our clients. And, in parallel to this principle, the principles of ITSS are ultimately principles that define good supervision.

Trauma has a ripple effect that extends from the primary client to family members and professional helpers (Figley, 2002). The importance of supervisory support has been noted from the inception of our awareness of the importance of trauma-informed approaches (Chrestman, 1995; Meyers & Cornille, 2002; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Sommer, 2008; Trippany, Kress, & Wilcoxon, 2004). Supervision is one of the variables that mediate the development of indirect trauma (Farrenkopf, 1992; Follette, Polusny, & Milbeck, 1994; Jackson, Holzman, Barnard, & Paradis, 1997; Pearlman & Mac Ian, 1995; Rich, 1997; Way, VanDeusen, Martin, Applegate, & Jandle, 2004.)

ITSS is, at its essence, an approach in which the supervisor recognizes the effect that trauma work has upon workers, proactively employs specific methods of anticipating and monitoring the signs of strain in workers, and guides the use of protective strategies.

Child welfare models of intervention for indirect trauma must evolve to incorporate the mounting evidence of the ineffectiveness of "coping strategies," or individual "self-care" that have heretofore been the proposed solutions for indirect

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trauma (Bober & Regehr, 2006; Killian, 2008). As our models of intervention evolve, they must begin to focus upon in-place mitigation of the effects of secondary exposure to trauma material, rather than notions of post-work recovery strategies such as yoga, exercise, or better nutrition.

Supervision must be considered primary among those in-place strategies. In spite of academic consensus about the central importance of this critical support, definitions of the structure and content of these supervisory encounters have consisted of broad statements of principle and are difficult to operationalize. This chapter describes a supervisory approach to mitigate the effects of indirect trauma that can be immediately applied within an operational, competency framework. The framework includes both a description of the *qualities* of effective supervision for indirect trauma, and the *competencies,* or content, of the supervisory approach.

Description of Indirect Trauma-Sensitive Supervision

Population Served

The principles of ITSS apply to all supervisors in the child welfare system. It is a truism that virtually all clients in the child welfare system have experienced trauma, and therefore indirect exposure of workers is a usual and expected part of the child welfare role. All child welfare supervisors, therefore, have a responsibility to possess—or to acquire—the ability to support their workers in the face of their continuous exposure to indirect trauma.

Staff Qualifications

Although casework-focused supervision such as ITSS parallels the clinical supervision structure, there is no assumption that the child welfare supervisor possesses a clinical supervision background, or has had formal training in clinical or in supervisory practices. Indeed, any supervision model that is viable in child welfare must allow for the fact that many child welfare supervisors do not possess graduate degrees, clinical training or licensure.

Whatever the credentials of the supervisor, the knowledge and skills necessary to do ITSS are evolving throughout the field, and therefore will be defined as “advancing competencies” rather than pre-requisite competencies. The prerequisite qualifications for ITSS are: (1) Acceptance of the profound importance of trauma-informed care and providing support to workers for indirect trauma exposure, and; (2) The personal attributes of an effective supervisor, for example, genuine concern for supervisee’s growth and concern for clients (3) Motivation to acquire skills in the ITSS approach simultaneous to the provision of supervision.

Program Components

The defining characteristics of ITSS are found in both the *qualities* of the supervision—the fact that the components are integrated into existing supervisory processes, adaptive to the stage of development of the worker, and supports an orientation of intentional learning; and in the *components* of the supervision—emphasis on reflection, assessing worker strain, and a stance of radical compassion.

Integrated

Any approach to supervision directed at reducing harmful effects of indirect trauma must be integrated into the existing supervisory processes. This assumes, however, that the existing supervisory practice already includes the prerequisite of routinely scheduled supervision, and that supervision is given priority within the organization. It is understood that the time demands of few, if any, organizations can support frequent supervision for the sole purpose of monitoring the effects of trauma work on the staff. With the exception of critical incidents, which stand alone, the qualities of trauma-informed supervision must be integrated into existing supervision as part of the routine operations of the organization. Ideally, the performance evaluation function will be provided by an organizational supervisor different from the supervisor providing ongoing supervision of the helping functions (Bell, Kulkarni, & Dalton, 2003). A framework for balancing the multiple functions of supervision will be discussed.

Stage Adaptive

Developmental models of supervision propose the fundamental idea that organizational supervisors should vary their supervision to match the needs of their trainees' level of development in their job (Watkins, 1994). For the purposes of staging supports for indirect trauma-informed supervision, the developmental stages of workers can be defined concretely as the period during the orientation or on-boarding processes for a new employee, the novice worker during the first year, and the experienced employee. Implicit in the stage adaptive guideline is that supervision will continue indefinitely as part of a normalized workflow—albeit in an evolving manner—and is not limited to supervision required for certification or licensure. The objective of stage-adaptive supervision is to progress from high directedness and high support to increasingly low direction and support as indicted, but never to completely eliminate supervisory supports.

Initial Supervision The focus of the supervision during the on-boarding period (at minimum, the first 2 weeks of employment) anticipates the effects of trauma exposure. Knight (2013) found that students were at greater risk of vicarious trauma if they reported that their education didn't prepare them for dealing with the intensity of their work. Supervision during initial entry consists of a combination of the organization's on-boarding or pre-service training and orientation, daily supervisory check-ins, and weekly scheduled supervision. It is fundamental that during this stage that didactic instruction concerning the signs of indirect trauma and general principles of coping skills be given. Training and supervisory contacts should: (1) normalize the expectation that strong emotional reactions will sometimes occur in the child welfare role; (2) communicate that skills can be employed to successfully manage intense affect, and what those skills are; (3) coach self-monitoring, and instruct specific signs of strain to which the worker should remain alert; (4) define indications of secondary trauma, and how the worker seeks assistance; and (5) communicate the availability of the team for emotional and technical support, emphasizing the role of the supervisor.

Supervision of the Novice Worker (First 12 Months) Weekly supervision is essential for the novice worker. This supervision may consist of any combination of group and individual supervision, but must include the essential qualities of trauma-sensitive supervision as detailed in this chapter. As during the on-boarding, it is important that the supervisor normalize when strong emotional reactions occur, and even expect them. The goal of the ITSS at this stage is to normalize the sometimes-difficult nature of child welfare work, but to frame the emotional or technical struggles as skills challenges. At this point, it can be very reassuring for the supervisor to predict that—as novice workers—their technical ability is expected to be low. It is for that reason that supervisory and team support is expected to be high. As the worker develops an increased mastery, the amount of emotional labor required to accomplish tasks and retain emotional regulation is reduced. In short, the supervisor communicates that the degree of difficulty of the child welfare role is expected to be high at first, and to progressively become less effortful.

Supervision of the Experienced Worker Because of the enormous technical and psychological challenge of child welfare work, supervisory support should be a career-long project. With experienced workers, this translates to less frequent and less directive supervision sessions, but nonetheless ongoing, regularly scheduled sessions. Monthly sessions may be indicated as the worker's technical proficiency develops. As the worker's role proficiency consolidates, the character of the supervision will shift away from technical "how to" skills and will become more reflective as the supervisory continues to monitor the well-being and degree of job strain of the worker.

Stance of Intentional Learning

The next characteristic of ITSS supervision is that it supports the worker in developing a mindset in which difficult, demanding, or even aversive situations within the work are viewed as demands for development of specific skills. Without this

mindset, the worker is at risk of making attributions about their jobs being too difficult, too complex, or too aversive. These demands may relate to technical skills that are required to intervene in child welfare cases, but in ITSS the skills demands extend to skills related to emotional regulation in the face of intense affect. As Sommer (2008) explicated, supervision has typically emphasized the technical skills of our craft, but ITSS must give equal focus to skills needed to manage the affective reactions to the work. In short, a key characteristic of ITSS is a stance that significant reduction of work strain can be expected as the worker gains mastery over the technical aspects of the work; and that emotional distress can be reduced through intentional focus upon acquiring skills to support emotional regulation during trauma work.

Components of Indirect Trauma-Sensitive Supervision

Reflection

The cornerstone of ITSS is the consistent and deliberate addition of reflection into the supervisory process. Successful supervision in any context can be described as a balance of relatedness and knowledge. Reflective supervision has long been included in treatment protocols in infant mental health and evidence based trauma treatments such as Child Parent Psychotherapy (Osofsky, 2005). As intended here, reflection simply refers to the conscientious and systematic pausing from a focus on problem-solving the specific events of a case under review. In this pausing, we shift our attention momentarily to the effect of the experience upon the helper. Reflection is a discrete supervisory function, and is not therapy. As Bride and Jones (2006) discuss, this boundary is an important one.

Reflection is built into the structure of every ITSS agenda. If a moment of reflection hasn't naturally arisen from the case presentation, time will be preserved during the supervision for specific reflective prompts. The supervisor continuously monitors for evidence of emotionally charged situations (or, conversely, for the absence of emotion in situations that would be expected to evoke an emotional response). If the worker does not pause to reflect and describe the emotion involved, the supervisor will inquire.

The priorities of the supervisory endeavor overall can be stated explicitly in this order of importance: (1) to enhance client welfare (via skills acquisition) and (2) to enhance the well-being of the worker (support to the worker). Traditional supervision has focused to an unbalanced degree on the first—skills acquisition—acquiring the "craft skills," and not enough on the second—supporting worker well-being.

This is the most distinctive quality of ITSS: the intentional balancing of the focus on skills/client interventions and upon helper well-being. Reflection, however, actually serves both of these foci: Intervention strategies can only be identified and effectively implemented when the worker is in a regulated emotional state that allows for problem solving. In this way, supervisory support for enhancing the

worker's emotional well-being is directly related to client welfare. Indeed, it can be said that the ability to maintain a state of emotional regulation during difficult encounters is prerequisite to the effective application of any helping skill.

Additionally, the well-being of the worker also depends upon being attuned to emotional arousal, and intentionally acting to facilitate a return to a homeostatic state when dysregulation occurs. Viewed this way, reflection—and the application of indicated calming or emotion regulation skills—is at the very heart not just of ITSS, but of the helping work itself.

Assessing Worker Well-Being/Indicators of Strain

Falender and Shafranske (2015) discuss the supervisor's role in assessing indicators of strain though their reference refers to the strain in the alliance between the supervisor and worker. In ITSS supervision, a key task for the supervisor is—in collaboration with the worker—to support the worker in assessing for indicators of strain secondary to indirect trauma exposure, as well as indicators of well-being and job satisfaction. Workers typically place a high value on appearing competent and hardy to their supervisor. Therefore, as Knight (2013) states, it is unlikely that a worker will discuss the effects that indirect trauma is having upon them unless the supervisor explicitly asks (Cunningham, 2003; Wells, Trad, & Alves, 2003).

In addition to pauses for explicit queries, the supervisor will personally and continuously assess for indicators of strain observed in the worker. This is one of the key functions of reflection during the supervision session—taking a pause from the thinking, problem-solving mode to scan for signs of strain. Frequently during the reflective prompt, workers will identify an emotion that they did not realize was present, and may even express surprise at the emotions that are present when they stop and attend to their feeling state.

Concurrent with the worker's self-scan, of course, the supervisor is also assessing the worker for indications of well-being and job strain throughout the supervisory session. That is why a foundational competency for the supervisor is the knowledge and skills to assess for the presence of indirect trauma, that is, the common emotional responses to trauma exposure. ITSS supervision is predicated on the belief that many of the untoward effects of indirect trauma can be mediated by effective support. Workers report that one of the most helpful interventions for reducing the effects of secondary trauma is having an empathic and supportive supervisor (Canfield, 2005.) This suggests that the supervisor, as well as the worker, is looking upstream, before the symptoms of fully formed secondary traumatic stress, to the earliest signals of strain. In other words, the goal of ITSS is not only to support workers who are experiencing secondary traumatic stress, but is just as importantly to mediate or *prevent* the negative effects of indirect trauma exposure. This suggests focusing not only upon symptoms but also upon precursors of later symptomatic expression.

Of course, sometimes the signs of worker strain are in the form of manifest expressions of distress: crying, acknowledgement of feelings of being overwhelmed or helpless, saying they are "stressed out," or overt sadness. It is crucial at such times that the supervisor "leans into" such expressions and does not minimize or dismiss them. The ITSS competencies must include an ability to support the worker by bearing witness to the felt distress of the worker in the form of presence, reflected empathy, and an evidenced willingness to accept a role in sharing the decision making, if not actual job tasks, with the worker. In short, the supervisor should create a clear message that they are not bearing the weight of the situation alone, but in partnership with the supervisor and the entire team.

The ITSS supervisor must possess a "toolbox" of strategies they can assist the worker in employing whenever they are emotionally dysregulated. There are hundreds of grounding exercises that could be employed, but most commonly these strategies derive from some mindfulness tradition. Workers can be coached to employ simple strategies such as taking a mindful pause to focus on the feeling of the feet on the floor, then to follow the breath for one inhalation and one exhalation (Fortney, Luchterhand, Zakletskaia, Zgierska, & Rakel, 2013). Finally, in order to support workers in the face of emotional distress and arousal, it should be apparent that supervisors must possess the capability of self-monitoring for signs of strain, or distress, in themselves. As a supervisor, they may not have anyone who is encouraging them to reflect on how they are doing, and what they are feeling. It is important that the supervisor self-monitor, and use defined strategies for remaining in, or returning to, the emotional "window of tolerance."

Responses to sentinel events or critical incidents warrant specific response protocols beyond the norms of ongoing supervision. It is beyond the scope of this chapter to describe supervisory response to sentinel events such as maltreatment of a child within the caseworker's care, or death of a co-worker. This is a supervisory competency unto itself. For the sake of this chapter, it should be noted that child welfare supervisors should have an identified response protocol, such as psychological first aid, for use when such events occur.

Radical Compassion

Work in child welfare often requires that we work with individuals who may have difficult characteristics. Our clients may be hostile, may have perpetrated child maltreatment or neglect, may live in disorganized, chaotic ways, may have substance abuse problems, and may reject our offers of help. A fundamental of the "trauma lens," however, is that we must be able to experience empathy for the way these behaviors have evolved in response to trauma. We must be able to communicate empathic understanding in order to be helpful to the client. Accepting the goal of radical compassion may be a cultural shift in some child welfare cultures, for whom critical judgment may have traditionally been viewed as integral to the job.

The notion of empathic strain has a specific relevance to ITSS because a significant amount of work strain in child welfare can be attributed to the emotional effort

required to maintain a stance of unconditional positive regard and professional affability, while the authentic emotion of the worker may be one of anger, disgust, or defensiveness. This type of emotional effort can be exhausting, and may even be a primary source of emotional fatigue in doing child welfare work.

For this reason, ITSS requires that the supervisor provide support to the worker in noticing, acknowledging, and expressing the genuine feelings—that may be quite different from the expressed, organizationally desired emotions. Attending to these authentic feelings does not lead to inappropriate or unprofessional conduct with clients. Contrariwise, noticing and attending to these feelings allows us to address them with authenticity and intentionality. It actually makes them safer because they exist in the conscious realm and are expressed rather than potentially being acted out.

This supervisor's goal is to guide the worker towards a stance that might be termed "radical compassion." Radical compassion refers to the intent to offer nonjudgmental empathy for *all* clients we are working with, regardless of their past or current behavior. It is a stance that converts judgment into a more phenomenological, problem-solving approach. For example, the objective phenomenon could be that the client neglected her children's physical and emotional needs because of her substance use. The *judgment* is that she is a despicable person, and that she doesn't deserve help, or that she isn't ready to change. If the worker moves into judgment, every interaction that he has with her will be effortful. Because the worker inwardly harbors feelings of contempt for her, considerable emotional effort is required to outwardly convey an accepting, helpful demeanor. The emotional strain produced by the disconnect between expressed emotion and genuine compassion has been shown to be a source of significant emotional labor (Erickson & Ritter, 2001). Emotional strain of this type is sometimes misattributed to "compassion fatigue," but in actuality it is fatigue produced by the strain of trying to appear compassionate when one doesn't, in fact, feel compassion at all.

The supervisor can support authenticity by normalizing the universality of the experience of such feelings towards our clients. A supervisory task is to assist the worker to understand how—though natural and entirely expected—such feelings are produced by the worker's automatic judgments, such as disdain for, fear of, or anger at a client. Reframing those judgments—towards a stance of radical compassion—is not conceptualized as a "virtue," but rather, as an attainable skill.

Once such "unspeakable" feelings have been identified, they are immediately made safer. The supervisor gives them acceptance, and normalizes them in the worker. Now, the supervisor and worker can work collaboratively to reframe such feelings. This isn't as difficult or unrealistic as it may appear at first blush. Often, just acknowledging the feelings reduces the amount of energy contained within them.

The next step when empathy doesn't arise naturally is to begin to build a model of mind of the client. In what way is this client merely fighting for a sense of well-being, even if ineffectively? Rather than focusing on the client's *motivations*—which always leads to judgments—focus on the cognitive *skills* that the client lacks.

When this is defined as a cognitive skill, it leads naturally to problem solving how to support the client in acquiring the skill. This is a qualitatively different pathway than attributing motives to the client will take us.

The supervisor can guide the worker to support the model of mind: In what ways does this person feel trapped? In what ways are they "just like me"? As expressed in compassion training (Gilbert, 2014), once we get to the "just like me" aspect, compassion will be easier to find. When the supervisor supports the worker to act out of genuine empathy, not only is the work more effective, it requires less emotional strain on the worker. In short, the goal is to make the work less emotionally effortful.

Agenda of ITSS Supervision Sessions

Because ITSS is intended to be integrated into existing supervision processes, the agenda for the supervision will vary based on the supervisory approach already in use. The supervisor may already have a defined agenda for each supervision session that may be directed by a particular treatment model, or may be a developed style of the supervisor. In the case that a defined supervision agenda exists, the ITSS emphases will become embedded into those processes. This assumes, however, that the supervision sessions include either a defined time or opportunities for reflection. ITSS supervision cannot exist without this essential component.

Whether the ITSS supervision occurs within an existing framework, or becomes the framework for supervision, it is helpful to have a notional agenda to help balance the multiple tasks that must occur during supervision. In keeping with the ITSS attribute of technical eclecticism, the framework is a general intent, but each session will be governed by current priorities.

Hot Spots

In accordance with the principle of starting where the client (in this case the worker) is, each supervision session begins with the supervisor collecting current hot spots, that is, current areas of most concern for the worker or for the supervisor. Typically, these are cases that create challenges for the worker for which they are requesting guidance, or cases that the supervisor has prioritized for discussion. If the emotional "temperature" connected to these cases is not too hot, they are merely collected during the discussion for follow-up during the session. It is important that the hot spots be collected for prioritization at this point, because without this step the supervision sessions will lose a degree of intentionality and become reactive to current crisis rather than maintain a sense of forward movement over time. Of course, when the worker is experiencing current distress about a case that will be addressed immediately via a reflective process.

Formulating New Cases

Next, the supervisor invites a discussion of any new clients with which the worker has begun to work. This will be an opportunity to address any of the hot spot cases that are newly identified by the worker or the supervisor during the hot spots discussion.

New cases are formulated according to the ITSS concepts described herein. Because the ITSS supervision model is infused into current supervisory approaches, the formulation is embedded into the case formulation. The ITSS formulation is compatible with any other interventional framework or treatment model. It is within the formulation that the shift can be made from imputing motivations ("she's more interested in her substance use than in getting her kids back") to a model of mind related to cognitive skills ("I think substance use is the only way she knows to manage her distress."). Within the formulation development opportunities will arise to invite reflection ("As you read over the case history, what feelings come up for you as you anticipate working with this family?"). This early phase of case development provides an opportunity to do upstream assessment of anticipated worker strain as they describe their preliminary feelings about the case. Assisting them in the development of compassion for the client—beginning with the model of mind—built into the case formulation and the dialogue that occurs in the development process.

Review of Current Cases

As would typically occur within any supervision or individual therapy, the session begins with a check-in with the worker to assess the general well-being of the worker, and to gather the most pressing cases to consider during the session. Review of current clients on the worker's caseload begins with any of the identified hot spot clients. One of the forms in which ITSS is infused into the process is that the supervisor will take care to not move too quickly into problem-solving the situation of the case before responding to the worker's emotional reaction to the case. This is always the first priority, to engage the frontal lobes before problem solving a case—and this is only possible if the emotions are low and the worker (and supervisor) are in a calm and regulated state. Moving into the cases—and the problem solving mode—has a transactional effect upon the worker's emotional reactivity. Start from a cool processing mode leads to better problem solving and an increased sense of mastery and collaboration with the supervisor. And problem solving, including formulating the case in a manner emphasizing a compassionate theory of mind, supports the state of emotional regulation and sense of competence in the worker. Traditional supervisory models have always tried to bolster the worker's "craft skills" to fulfill their job duties more skillfully. What the ITSS awareness adds is an equal emphasis on supporting the prerequisite emotional state—and the skills needed to return to homeostasis when dysregulation occurs due to an intense experience.

Administrative Communication

In many—if not most—child welfare organizations, workers receive supervision from a single supervisor, who is both the administrative supervisor and the one providing supervision of case activities. The value of putting administrative supervision on the agenda explicitly each session is not only to hold a place for it, but also to keep this function in balance. The need to communicate organizational directives, review documentation, and provide performance feedback holds a legitimate place within the supervision session (unless the organization has the luxury of providing administrative supervision as a discrete function.). A degree of deliberateness is required to assure that this function doesn't overwhelm the support of the worker in their case assignments—including the ITSS elements. Knowing that the administrative tasks are on the agenda allows for prioritizing the earlier tasks appropriately. Again, the framework suggested is the general map—balancing these functions becomes possible over time, but is not always possible within a single supervision session. An emotionally charged case certainly may take an entire session. Likewise, administrative necessity may require an entire session. The supervisor must take the long view of the balance over time, and correct when any of these priorities are not being attended to during the supervision time.

Reflection

Time for reflective supervision is explicitly held on the agenda of each session. As discussed in the previous section on reflection, much of the reflection time will occur organically throughout the case reviews, or will spontaneously arise when the worker describes their emotional state. This may be sufficient time. But each session, the supervisor should take a pause from specific problem solving activities to invite the worker to reflect on their emotional state. Communication and modeling to the worker during supervision should evidence the equal significance of both skills acquisition, and time for reflecting upon the effect of the work upon the worker.

What Makes ITSS Trauma-Informed?

Supervision is the most fundamental and feasible way to migrate trauma knowledge into practice. It is well established that training alone is extremely unlikely to result in adoption of new practice (Beidas & Kendall, 2010). Supervision—when it emphasizes a trauma lens approach—provides ongoing coaching that is essential to adoption of trauma-informed practices at the ground level of case formulation. ITSS provides a model for the continuous support and coaching of trauma-informed practices with clients and of the parallel processes supporting the worker with the effects of indirect trauma.

Advancing Cultural Competency

As stated by Etherington (2009), trauma-informed supervision combines the knowledge we have about trauma and the principles of supervision. Trauma-informed supervision focuses upon how trauma affects the client, the worker, the relationship between the worker and client, and the context in which the work is happening. Each of these domains is affected by the cultural competence of the supervisor.

ITSS processes will both be affected by, and be a chief means of advancing, the cultural competency of the agency. Trauma-informed care itself requires that the child welfare organization be culturally competent. Any intervention—trauma related or not—requires consideration of the factors affecting the individual's unique worldview, including age, social class, ethnicity, religious faith, sexual orientation, or immigration status (Brown, 2008). The descriptors that McGoldrick, Giordano, and Garcia-Preto (2005) use to describe the differences one may see based on cultural factors is particularly true of trauma work: People differ in their experience of psychological distress, how they describe it, the symptoms they experience, their attribution of causes, their attitude toward helpers, and their expectations of improvement.

Reflective supervisory approaches, including ITSS, emphasize the parallel processes occurring between the client and the worker; the worker and the supervisor, and even between the supervision process and organizational factors. Each of the McGoldrick and Giordano descriptors operate in parallel during supervision. The supervisor is tasked with considering the unique cultural factors that influence how the worker experiences indirect trauma, how (or if) they talk about it, and their attitude towards supervision itself.

In this way, ITSS requires that the supervisor transmit cultural competence via facilitating culturally competence case formulations with the worker, while simultaneously modeling cultural competence in the supervision process itself.

Challenges to Implementation

The challenges to implementing ITSS are, in many ways, not unique to this supervisory approach. As will be discussed in the applications section, ITSS is a model that requires knowledge in three levels: child welfare casework approaches, trauma-informed approaches, and the effects of indirect trauma upon workers. This is specialized knowledge and acquisition requires time in the position. And because of the high rate of turnover in the child welfare field, many supervisors are themselves early in their careers.

A well-replicated finding in child welfare research is that supervision is one of the key factors that influence workers to stay in the field, and that the lack of it (or poor quality of it) is a chief reason workers decide to leave (Chen & Scannapieco, 2010; DePanfilis & Zlotnik, 2008; Ellett, Ellis, & Westbrook,

2007; Rycraft, 1994; Strand & Dore, 2009; Tham, 2007). Thus, the availability of experienced, quality ITSS supervisors will determine the success of an organization's trauma-informed efforts; but the lack of it creates the biggest challenge in implementation. Many supervisors in the child welfare system do not have advanced degrees, and even fewer have been formally trained in supervisory approaches.

Because of these factors, implementation of ITSS must begin "where the agency is." Most child welfare agencies are fairly early in their trauma-informed efforts. Most supervisors have not been trained in a supervision model at all, may be new to the supervisory role, and certainly will be new to the components of ITSS. Therefore, most CW agencies cannot consider these elements as prerequisite, but rather should view them as advancing competencies. This will be explicated further in the application section.

Evidence for Success

Given the profound importance of supervision in implementation of trauma-informed initiatives and in supporting child welfare workers, it is regrettable that no evidence-based supervision models have been identified. ITSS consists of a synthesis of principles derived from traditional wisdom in the clinical supervision literature and evidence informed practices from trauma treatment and other fields. As a synthetic model, ITSS has not undergone empirical trials and must be considered to be in the evaluation phase. What is known is that supervision—whether within the ITSS model or other models—is a critical component to the implementation of new practices, and in supporting our workforce.

Application/Strategies

Any child welfare organization implementing trauma-informed approaches must consider the role of supervision in the knowledge dissemination and follow-on coaching function of the implementation process as the pre-requisite of providing organizational support for workers experiencing indirect exposure to trauma. ITSS is proposed as one model for supporting TIC implementation.

The knowledge and skills described within the ITSS model are not assumed to exist already in most CW organizations. Therefore, the competencies that comprise ITSS should be viewed as part of a formative process that supports TIC implementation:

Organizational Competencies

The organization is committed to the agency-wide dissemination of the principles of trauma-informed care.
The organization is committed to the principle that support of workers with indirect trauma exposure is a fundamental principle of trauma-informed care.
The organization prioritizes time within the work schedules of workers and supervisors for reliably scheduled supervision as a necessary component of worker support.

ITSS Supervisor Competencies

The social science field hasn't always clearly recognized that supervision is a distinct competency separate from casework skills or other job competencies. Because this supervision model is competency based, it is tempting to suggest that each supervisory competency is prerequisite to commencing indirect trauma-informed supervision with an employee.

In reality, however, the field is only now beginning to recognize that it is the responsibility of the organization to mediate the effects of indirect trauma in its workers, and to begin to define that response. Managing the effects of indirect trauma has largely been regarded as the responsibility of the individual worker (Dombo, 2015). Because organizational responsibility to worker's indirect trauma is only an emerging awareness, it is unlikely that many supervisors possess all the knowledge and skills described here prior to initiating ITSS. This framework is, accordingly, intended to guide the development of the competencies in a formative process, as opposed to defining a prerequisite set of skills or knowledge base. This is true in the case of the individual supervisor, and is true in the trauma field at large as this knowledge base emerges. Just as the individual worker may be acquiring developing skills in trauma treatment or non-clinical interventions, the supervisor is expected to be acquiring advancing skills in supporting that worker. The "advancing competencies" are:

The supervisor accepts the significance of reliably scheduled, predictable supervision for all supervisees.
The supervisor is able to both model and coach workers in using a trauma lens in case conceptualization and service delivery.
The supervisor has knowledge of the signs, symptoms and risk factors of indirect trauma and its impact on workers.
The supervisor has knowledge of agency support options, referral process for employee assistance, or external support resources for workers who are experiencing symptoms of indirect trauma.
The supervisor has knowledge of the principles/components of ITSS.

An explicit logic model flows from the fact that most child welfare organizations accept the importance of implementing practices that are trauma-informed. When this fact is embraced, it follows that ongoing coaching of child welfare workers is essential to achieve full implementation of TIC practices. Furthermore, child welfare workers need support for symptoms of strain that they may experience because of their daily indirect trauma exposure. Supervision is universally accepted as one of the lynchpins of knowledge transfer and worker support. ITSS provides an explicit framework for moving this logic model into practice in child welfare organizations.

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Chapter 20
Trauma-Informed Professional Development

Barbara Pierce

Introduction

No one wants a call from the police at 2 in the morning, yet, only months into the job at an agency, the on-call child welfare worker gets and responds to calls like that all the time—and irrespective of the hour. They hurry out the door, get to a scene that repeats itself with a sickening regularity, and figure out what needs doing to preserve the safety of a child. Maybe a parent has overdosed or, worse, has died right in front of the child. Or maybe the child has witnessed domestic violence. It turns out this time that the child is the one who called 911. Whatever the scenario, the child welfare worker is supposed to calmly and professionally ensure that the child remains safe and cared for. In the short term, the worker gets some of the child's belongings together, leads the stunned and crying child out to the car, and runs through the 24-h McDonald's hoping to provide a bit of comfort with a familiar and caring gesture. The child then asks about what is happening to their parent and wants to know where they are being taken. If all goes well, the worker finds just the right words to bring calm, all the while hoping the child is sturdy enough and resilient enough to withstand what has happened. The worker also hopes that the child will mean enough to the extended family that they will provide an emergency place for the child to stay. If not, the worker will attempt to find a foster home for the child. Once the worker reaches the office the next morning, maybe a supervisor will ask how the night went or maybe not. One certainty endures: there is much work still to do and little time to dwell on the routine events of the job.

How do workers learn to do this job in a professional, caring, and resilient manner? Professional development is the process of ongoing learning and growing in professional careers such as medicine, nursing, education, and social work. These careers focus on providing services in a manner that upholds the standards of the

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chosen profession. Becoming a professional involves learning the underlying theories of the profession and learning how to do the actual work of the profession. The integration of the two in an actual client setting is fraught with difficulty. Students and new practitioners, to be sure, struggle with that integration. Often enough, the work also involves providing service to those who have experienced traumatic events. As a result of that work, professional service-providers may develop what is called secondary traumatic stress, which means that those treating trauma may themselves wind up traumatized. That is one of the pitfalls of doing social work in child welfare. This chapter considers that phenomenon in the context of the development of social work professionals who intend to specialize in the emotionally-demanding field of child welfare. It will focus on how child welfare workers develop professionally and, using a trauma-informed lens which ultimately involves workers, supervisors, and the agency itself, develop a coordinated effort to produce good child welfare practice and mitigate secondary traumatic stress in the practitioners themselves. This approach promises a more resilient and better-prepared workforce to handle the challenges that child welfare poses.

Surprisingly, few studies of professional development in social work have appeared in the literature and, of those, none focus on a trauma-informed approach to development. What we do know is that professionals must assimilate information and build skills while still in their formal educational programs that they then apply, in an agency-setting, to real people—their clients. The Council on Social Work Education (CSWE) sets standards for the kinds of competencies students should possess upon graduation and has identified work-in-the-field as the principal focus of social work education—its signature pedagogy—which integrates formal learning with on-the-job practice (applied learning) (CSWE, 2015; Lave & Wenger, 1991). Applied learning, as such, is a specialized way of "doing" and calls upon professionals to draw from a range of theories in order to find one or several suited to developing relationships with their clients and assessing the optimal ways of proceeding to meet their unique needs. Professionals then apply interventions based upon two criteria: (1) the best evidence available and (2) the client's needs and wishes. Learning how to do all of that in 2 years of upper-division baccalaureate training or 2 years in a master's program is, admittedly, a lot. By any measure, the process of development from lay person to student to competent professional is a long one. Graduation from a School of Social Work only serves as step one. Beyond that, other challenges await, not the least of which involves learning how to integrate trauma concepts not only into practice but also into self-care. In the end, the fully developed professional self is indivisible from the fully realized personal self.

Theories of Professional Development

Agencies should pay attention to the professional development of their workers. In doing so, they aid in retaining those workers and recouping their investment in initial new-worker training. Clark, Smith, and Uota (2013) found that having agency

support for ongoing continuing educational opportunities and relevant supervision for licensure between the 24th and 36th month after hire and being promoted to supervisor by the 72nd month predicted retention for MSWs in child welfare. Plotted data aside, few theories about how to undertake professional development exist in the literature. Theories of professional development in social work tend to be "borrowed" from two other professions: education and nursing. As demanding a job that child welfare is, we really do not have models to draw from except in the areas of recruitment (Ellett, 2009) and competency models of education (California Social Work Education Center, 2004; University of Southern Maine, 2007). A few models described below, which are drawn from other professions, have applications for social workers but not specifically to child welfare.

Stage Models

Most professional development models deal with how a student or novice transitions into becoming a worker. To be sure, professional development is a career-long process with few models acknowledging that fact. This section will describe some of the existing models.

Both Duchscher (2008) and Schlossberg (2011) identify transitions as the relevant process for professional development. Duchscher (2008) has studied the transitions that occur during the first year of a nursing career and labels them: doing, being, and knowing. Of particular note in this theory is the "reality shock" nurses confront of "doing" on their own; that occurs when new nurses are handed their first full assignment of patients for whom they alone will be responsible. This transition theory is broadly applicable to new social workers who acknowledge the same "reality shock" when assigned their first full caseload. Not the least bit surprising, they feel overwhelmed and afraid (LeMaistre & Paré, 2004).

But while Duchscher only plots the large contours of the transitional year, Schlossberg (2011) offers ways to cope with the stresses associated with transitions via identification of strengths or issues with the situation, self, supports available, and strategies. The less stress a person has, the more these individuals can cope with those stressful episodes that do arise—and for an obvious reason: they tap into their inner strength and resilience, find necessary supportive assistance, and turn to ingrained healthy coping-strategies to lessen the pitfalls that every transition brings.

Larimer (2015) has developed a metaphor-rich model of transition that is called "Riding the Waves." The beginning stage, "testing the waters," involves finding a job and obtaining a license. The second, "jumping in," deals with new-worker orientation and the initial phase of "reality shock." The third, "sinking or swimming," comprises the good-faith attempt to practice as taught and to seek supervision when needed, all at a time when the experience of a full-blown "reality shock" often becomes a critical variable. In child welfare, "reality shock" generally occurs at the 6-month mark and is often the precipitating event in worker-defection (LeMaistre & Pare, 2004). The fourth stage, "treading water," is a watershed moment for the

worker, particularly given that secondary traumatic stress tends to emerge at this time. The final stage, "riding the waves," demonstrates that those new workers who have survived the transition process gain confidence and achieve a heightened sense of self-efficacy, as Ellett (2009) has described. While Larimer's study provides a useful tool in understanding the transition from student to new worker, this model lacks a pathway for ongoing professional development.

The Dreyfus and Dreyfus Model: A Pathway to Professional Development

The previous models catalog stages of emotional development during the first year of practice. They do not necessarily describe how new workers acquire skills. Dreyfus and Dreyfus (1986) developed a model of skill acquisition that spans a career, from novice, to advanced beginners, competent, proficient, and finally, to expert, and that explores ways in which workers develop knowledge and skill within various contexts. So, over time, a child welfare worker learns to practice within a spectrum of task-contexts (working with children in foster care, for example), as well as within what might be called boundary-contexts: cultural, geographical, and agency-specific "boundary-context," to illustrate, comes into play when a worker starts in a rural area and then moves to an urban setting. That transition or shift demands a different type of learning: namely, how to do the job in an urban context. Dreyfus and Dreyfus additionally contend that knowledge and skill become internalized over time; that explains why newer workers, who have yet to "internalize," consult policies and procedures much more frequently than expert workers. By their model, a worker who changes jobs—for us, say, from caseworker to clinical therapist or to a supervisory position—becomes a novice all over again, though this type of novice has plenty of experiences to draw upon. For social workers their novitiates begin at the university where they learn the theories that they will subsequently apply to workplace-related cases. As they shade into "expert," they will learn how to tailor their applied learning to many different contexts in a nuanced, reflective, and thoughtful manner. This model, drawn from Dreyfus and Dreyfus, provides us with a pathway for professional development.

For Dreyfus and Dreyfus, the novice stage functions as a time for learning the facts and rules without nuance or deviation. Field placement in social work is a useful illustration of this stage. Bear in mind, however, that students are not "blank slates" when they walk into their placements—if the universities from which they have come have done their jobs. Theories, intervention strategies, policies and procedures, and a range of rules come along with them. Agencies, to be sure, will communicate other facts and teach additional rules. Pierce (2011) has also found that students expect to learn how "to do" a set of tasks such as safety assessments, case plans, referrals, and so forth. No less important, students expect that working with clients will produce feelings for which they are not fully

prepared to cope with in positive and concrete ways. For that reason, they need the assistance of a professor or agency personnel to teach and model appropriate skills to work with clients, to incorporate theories (especially human behavior theories), and to learn to work as part of a team at the agency (Pierce, 2011). Some of these new skills are engaging and assessing children and families, developing therapeutic and professional relationships, learning professional use of self, devising treatment strategies, and learning how to manage one's own emotions in the process. Having SAMSHA's trauma-informed principles taught and modeled will help these novices to learn from the beginning the most important principles of trauma-informed care. These are: safety; trustworthiness and transparency; peer support; collaboration; empowerment and choice; and attention paid to cultural, historical, and gender issues (SAMSHA.gov). Students and new workers should be socialized to begin their work with traumatized children and families using these principles, and their agencies should use these principles in the workplace as part of the culture of the agency.

According to Dreyfus and Dreyfus (1986), the next stage, advanced beginner, is the stage in which the novice becomes a working professional; for social workers that means becoming fully-fledged caseworker or beginning therapist post-graduation—in this stage, workers attend orientation, learn agency policy and procedures, and take on the challenge of a full caseload. They begin to put into practice previous learning and determine the best ways to adapt theory to the many different client situations they encounter. In this stage, each new case is a learning experience. While there may be some similarities to what they have seen in their field experiences, they begin to realize that no two children or families are the same. They must adjust with each new experience to develop situational knowledge rather than just following a rote pattern of "how to"; that is, to learn how to integrate context into the equation of client services. This is the stage that many workers find intimidating, frustrating, and overwhelming. The reality of carrying a full caseload sinks in, as does "reality shock" (LeMaistre & Paré, 2004). New workers begin to question their career choice and may leave their first job because of lack of support or the feeling that the job is not "right" for them. Barbee et al. (2009) found that workers in child welfare exit mainly because of lack of support and stress. Most new graduates, particularly those who have graduated from Title IV-E or National Child Welfare Workforce Institute (NCWWI) supported programs (Dickinson & Perry, 2003; Leake, de Guzman, Rienks, Archer, & Potter, 2015; Mor Barak, Nissly, & Levin, 2001; Rosenthal & Waters, 2006), though, are better at weathering the storm and are much more likely to grow into competent workers. However, Dickinson and Painter (2009) report that workers disproportionately leave their jobs in the second year post hire while findings from evaluation of NCWWI's first iteration appear to demonstrate that some new workers leave in the first year because of job dissatisfaction and overwhelming secondary traumatic stress as a contributing factor. Secondary traumatic stress was measured in this sample using the Coping Strategies and Secondary Traumatic Stress Scale (STSS), and the NCWWI sample had higher secondary traumatic stress than the norming sample for the scale. Further, they report that higher use of coping skills led to lower secondary traumatic stress

(National Child Welfare Workforce Institute, 2015). New workers do appear to experience that sense of feeling overwhelmed and also begin to experience the emotional stress related to caring for people in traumatic situations. In the same way students need the help of their professors to learn to cope; new workers need the help of their supervisor or peers for positive reframing of experiences and positive role-modeling of resilient practice. Using coping strategies does work! Workers must learn to integrate the self-care plans that they learned about in school and seek support from those around them at work. If collaborative and trauma-informed practice is the agency norm, workers learn from the start to attend to their own feelings and use positive coping skills.

Competent workers have considerable knowledge and skill as they have been on the job for a couple of years and have had lots of opportunities to work with children and families in many contexts. They have more experiences to draw upon when they are presented with new scenarios, and they use situational or contextual knowledge more adeptly (Dreyfus & Dreyfus, 1986). It is in this stage of competence that workers generally take on the role of field or task instructors as they teach new workers the ropes. When asked for advice by novice or advanced beginner workers, they answer with the common phrase, "It all depends on the situation." Competent workers still lean on the rules and procedures, to some degree, but are learning to apply them situationally based on experience. At the same time, they have also cultivated the skill of consciously and intentionally thinking through their actions. This stage is a time for re-thinking the professional role and deepening clinical skill-level through continuing education. In addition, competent workers have weathered the first 2 years of being a new worker and may have experienced secondary traumatic stress. Yet they are still on the job and have matured and developed in ways that allow them to cope with this stress.

Proficient workers, the next stage Dreyfus and Dreyfus identify, have so much practice experience that they almost never have to look at the books or procedure manuals anymore as they have internalized the practice to such a degree that they almost automatically know what to do (Dreyfus & Dreyfus, 1986). They engage in analytic thinking but with an educated intuitiveness that can only come with vast experience, while expert workers practice with "know-how," the ability to diagnose and implement a plan almost automatically. These workers have "seen it all and done it all" and almost nothing that occurs presents a problem or dilemma for them. This automatic practice is hardly foolproof, though; for that reason, expert practitioners should search for new ways of proceeding and must keep abreast of new research and learning. Proficient and expert workers have been on the job for quite a long time, perhaps 10 or more years, and may have experienced considerable secondary traumatic stress but have been resilient enough to thrive. They must be careful to take care of themselves and also to encourage those with whom they work to remember self-care.

It is clear that every level of worker must take care to develop a deep sense of integration by knowing "how-to" in which they put theory into practice in addition to emotionally integrating what is happening to children and families before their eyes. Unfortunately, theories of professional development rarely take the emo-

tional realm into consideration. While Schlossberg discussed transition strain, Duchscher talks about being and knowing, and Dreyfus and Dreyfus integrate skills in various contexts, there does not appear to be an encompassing theory for professional development in child welfare and certainly not one that integrates development in a trauma-informed way. To be sure, most child welfare agencies provide professional development through training opportunities but to be encompassing they will have to take the entire workings of the agency including climate, supervision, worker compensation, education, and peer support and integrate them fully into the daily workings of the agency. Developing a plan to integrate all of these components must happen if adequate professional development in child welfare is to occur.

Program Components

Planning for Professional Development in Trauma-Informed Child Welfare Practice

This author accepts that the above stated theories all have valid points to make regarding professional development. They are all based on learning over time. However, we must add to them by integrating processes that enhance our ability to provide for a trauma-informed context for workers through an understanding of how transitioning into the workplace from the university matters, providing good clinical supervision, and developing a climate of reflective practice. By adding these components to the theories already noted, we derive a more fully developed picture of what professional development for child welfare can look like.

To some degree, all professionals keep a plan for their development in their heads. Some professionals have a clear, step-by-step plan, while others have a vague notion of where they are going and how to get there. Professional development is much more than taking a few continuing education classes and going to supervision every week. Rather, it involves the agency, team, and individual working together as a community of learning (Wenger, 1998) to develop an intentionally trauma-informed approach to the work of child welfare. In fact, a trauma-informed agency not only makes sure that clients are cared for by using a trauma lens, but also makes sure that its workers are cared for using this same lens. Processes are built in for education, supervision, and daily practice that include reflection, self-and-peer-care, positive support, and mentoring. Ultimately, workers must take responsibility for their own personal development, but they do so in the context of the agency in which they work. The remainder of this chapter aims to help professional social workers, their supervisors, and their agencies establish and maintain clear plans for development.

Transition to Work

Plans for development actually start prior to the initiation of formal education. People begin to think about what career they might want to engage in or what they might be good at doing. Some child welfare workers in fact were clients "in the system" while still young; those who were foster children also gravitate to the profession. Many others, however, chose child welfare work for other reasons. Yet all child welfare workers must take stock of their lives and recognize areas that potentially make them emotionally vulnerable when certain practice situations or circumstances in their practice arise. Particularly noteworthy is that workers who experienced significant trauma while still young are at a heightened risk for secondary traumatic stress (Nelson-Gardell & Harris, 2003). So, it is imperative that workers identify those areas of practice in which they are personally and emotionally invested because the lack of objectivity can create "blind spots" potentially capable of leading to the harm of those clients they hope to serve. For that reason, child welfare agencies must recruit people who have emotional maturity and objectivity; after that, supervisors and agencies must help the workforce to develop strategies for clinical supervision that enable workers to be objective. No supervisor can or should be a worker's therapist, but good clinical supervision is encompassing. Care exercised at that level of professional functioning goes a long way in ensuring the ultimate goal: that clients are cared for well. Supervisors and agencies can encourage workers to use supervision well. While technically university preparation is the first step in professional development, arguably the most important step is the transition to work from the university to the first agency job.

As workers transition into the agency they need support and mentoring. Even if the child welfare agency hires an experienced worker, that worker will need support in transitioning into a new practice setting, which can entail a steep learning curve. In child welfare especially, that learning curve includes learning how to manage trauma on a daily basis.

Typically, transitioning into the workforce involves participating in agency orientations and new-worker training that lay out necessary policies and procedures. Many public child welfare agencies already have extensive new-worker training, which includes a combination of in-class and in-the-field activities. Many of these training programs also provide for a reduced caseload during the training phase. When a new worker does have client contact, typically those contacts/home-visits pair the inexperienced worker with an experienced worker or a mentor/peer coach. Through that accommodation, the new worker learns how to apply policies and procedures. Home-visits also allow the new worker opportunities to integrate the theory and interventions learned at university and to experience how ethical dilemmas sometimes arise in practice. This process can be emotionally and physically demanding, yet it is equally rewarding. Through it all, new workers learn the value of good work habits and the importance attached to the timely submission of paperwork and court documents. When good work habits are established early on, the worker figures out how not to drown in a sea of paperwork and how to stay afloat in managing non-client tasks.

New workers must also seek to learn the rules of staying physically and emotionally safe. Working in child welfare can, at times, be dangerous. Clients sometimes lose control, particularly when a child must be removed from the home. New workers have to learn the "feel" of a dangerous situation, when it appears to be escalating, and how to de-escalate it. At times, police backup may be vital; determining when that is the case is thus necessary. Emotionally charged situations—those that potentially put the worker in real danger—are also often the ones that trigger secondary traumatic stress. Workers must pay attention to and heed the training given to them by their organization with regard to personal safety and the techniques of de-escalation. Organizations should also have a policy and train workers on obtaining appropriate back-up when necessary. Supervisors might do well to help workers to role-play various dangerous scenarios so the worker feels better prepared when or if they arise.

Transitioning also involves learning how to become part of the agency-team and the expectations required for that sense of belonging. This acculturation can be positive or negative depending on the climate of the office and/or team, which is why it is vital for agencies and teams to strive for a positive, healthy workplace culture. New workers can become discouraged by the negative attitudes of more experienced workers and the negative "humor" a client-case sometimes occasions. Part of learning to negotiate the job is learning survival skills: negotiating personalities of team members, interpreting worker negativity, and recognizing signs of secondary traumatic stress and burnout. Sometimes workgroups experience so many traumas that their emotional states can spread like a virus to new workers. Make no mistake, developing a plan for coping with negativity is an essential resiliency skill. So, workers should learn how to evaluate their thoughts and feelings about what is being expressed by their colleagues and to reframe whatever is unhealthy in their expression in a more positive manner.

New advanced beginner workers are also negotiating the professional tasks of obtaining licensure and professional continuing education. Many schools provide seminars on licensure, but the process can be deeply anxiety provoking. Workers need to learn to study incrementally, and use good test-taking skills to pass the examination. Experienced workers also need to attend to supervision and continuing education requirements in order to fulfill yearly licensure requirements so that they can attain the highest license possible in their state.

Transitions are difficult for new workers. Agencies and universities each struggle to help new professionals bridge the gap between initial preparation for and actual entry into the workforce. This author has begun a university-sanctioned formal transition-to-work program for some of its graduates, which actually begins before graduation in the field seminar. During the seminar, the professor models positive, strength-based language that students practice. Students also begin to formulate plans for their own development as professionals. After graduation, these newly-minted professional social workers are invited back to campus every other month for a supportive group experience and educational opportunity. Many graduates, it turns out, conceive of the university as a "safe place" to which they can return. These sessions allow advanced beginner professionals to "clear the air" and to

"recharge their batteries," which the workaday world, somehow, has little time for or even precludes. Allowing graduates to "return to the nest" provides for continued growth in a safe and undemanding transitional space and, while there, the new graduates are encouraged to ask for the support and education that they need. This group supplies a no-pressure environment for reflecting upon and talking about professional development in a positive manner. Typical topics for these campus gatherings include licensure, negotiating the professional role, professional behavior in working with a supervisor, using resiliency skills for secondary traumatic stress, overcoming "reality shock," and building a professional support system. The positive peer support obtained in this group cannot be overstated. Using principles of trauma-informed care to guide this process, the group provides safety, peer support, empowerment, and collaboration not only about case material but also about development of their own heartiness and resilience in doing the work. As they mature in their professional lives and by the end of the first year post graduation, students learn to provide mentoring to others and learn trauma-informed principles to providing task and field instruction to the next generation of workers. The synergy in evidence is at once remarkable and encouraging as participants do, in fact, grow into task-instructors and field-instructors, with abiding ties to the university, who help train other cohorts of new workers as agents of change in child welfare. While this author uses a face-to-face approach for this activity, she is experimenting with less constrained technological means of connection, such as private Facebook groups and Skype or similar connections. When university faculty provide a means by which they can remain in contact with graduates, they can provide needed support and help with professional development, especially during the first year of practice. This transition-to-work group concept, which spans the university-agency divide, could eventually be expanded, under the rubric of university partnership programs, to cover all Title IV-E and National Child Welfare Workforce Institute graduates as these university partnership programs also span the university-agency divide.

Agencies also have a responsibility to ensure that new workers transition competently and resiliently and in ways that exhibit a trauma informed approach not only by realizing that trauma is implicit but recognizing that children, families, and workers are all traumatized in the process. By having policies in place that take the trauma principles into account, and encouraging workers to use reflective practice, good peer support, and supportive clinical supervision, agencies are discouraging re-traumatization (SAMSHA.gov). First, agencies must attain and maintain a safe organizational climate in which all of its workers can grow and develop. Providing a phased-in new-worker experience can alleviate some of the "reality shock" that occurs with suddenly having a full caseload. By funding and training good mentors and peer coaches, agencies demonstrate their commitment to good transitions for new workers. Investing in training and providing policies which support resiliency, encouraging work life-balance, and using of healthy coping mechanisms allow new workers to start off on the right foot and experienced workers to thrive in a supportive environment with good work habits for growth and professional development.

Investing in training for clinical supervision is also key to the success of new and experienced workers alike. When supervisors establish and maintain a supportive

and professional relationship with their new workers, they are investing in the professional development of that worker. A good supervisor can encourage, cajole, provide positive feedback, and help a worker plan for the future. By providing and encouraging healthy coping strategies, well-trained supervisors effectively dedicate themselves to preserving the integrity of the agency by ensuring the wholeness and resiliency of that agency's workforce. So, in short, having a dependable and supportive supervisor is one of the keys to holding on to workers and keeping the agency fully operational.

Supportive Supervision and Mentoring

Supervision involves the creation of a formal relationship between a worker and a supervisor, the person designated to lead or head a team of workers. Supervisors are the key members of the management team who set the principles of a trauma-informed approach into motion. These hard working individuals provide safe and encouraging environments which reframe negative events and emotions while providing a reality check on the situation at hand. Supervisors are key collaborators in the care of children and families and provide not only education in the moment but ongoing training to both the individual and the team as a whole.

Training and developing these supervisory professionals is multifaceted. The job of the supervisor requires clinical knowledge and skill and leadership and managerial knowledge, as well. Within the trauma-informed framework, supervisors must develop skills in listening, positive reframing, managing and containing emotional reactions to case scenarios, and encouraging esprit de corps among the team. Yet, supervisory training may be lacking in these skills. First, supervisors should want to supervise rather than this being the only job in which a worker can move into in the child welfare agency. Too often supervisors move from being a case manager into management because there are no higher level practice jobs within an agency. The supervisor must cultivate an interest in management, mentoring, and be able to envision the big picture both above and below them on the organizational chart. Supervisors need to have an adequate educational background, the MSW degree, for example, which provides them with the basic skill set in practice. They also need to learn to model trauma-informed practice, use the SAMSHA trauma principles in their everyday approach to the job, and model their own self-care program to their teams. Further, using strengths based language and avoiding negative languages constructions (can't or won't, for example) can help supervisors to set the climate for a positive work environment. While there are models for supervisory training such as NCWWI's Leadership Academy for Supervisors (NCWWI.org), they do not specifically focus on trauma-informed supervision. (Chapter 22 in this volume introduces a trauma-informed supervision model, titled "Indirect Trauma-Informed Supervision" (ITIS), which describes supervision at different stages in a worker's development as well as identifying components of a supervisory model. The reader is referred to that chapter for a more detailed discussion of supervision).

Key to helping workers though is attending to trauma and being a "trauma champion" on the team in order to mentor and enhance the worker-supervisor relationship (Harris & Fallot, 2001). Further, training for supervisors must include learning to use cognitive behavioral techniques that enhance resilience for workers. These techniques, particularly identifying and monitoring reactivity to stress and then reframing the situation, are key to helping supervisors learn to work with their teams. Ultimately, reflective, clinical supervision must become part of supervisor training in child welfare agencies if we are to truly have trauma-informed care for the child welfare system.

Within the actual important reflective supervisory relationship, the supervisor and worker create a space for the oversight of work. Yet, also within this relationship, the two can create a much deeper communication by means of developing collaborative work around the clinical aspects of providing casework to clients. This deeper relationship allows for the supervisor to assess, make recommendations, attend to the worker's emotional reactions and professional needs, and provide a pathway for the worker's development (Shulman, 1982). In child welfare, a highly important component of this relationship concerns gauging the level of secondary traumatic stress and assisting the worker in a manner that ensures resilience. This deeper relationship can grow into a mentor relationship through which the supervisor becomes a trusted ally of and champion for the worker throughout all levels of professional development. While Kram (1985) asserts that task supervision and psychosocial or clinical supervision are not mutually exclusive, the mentoring relationship may or may not grow out of the task or work supervisory relationship. Some workers are wary of building a mentoring relationship with supervisors due to trust and emotional safety, but others can and do build strong, safe relationships (Gayle, 2011). Nevertheless, supervisors should strive to provide good task supervision, and far more critical, clinical supervision with an eye toward trauma-informed supervision; workers who do not get the latter, however, must find it elsewhere because it lays the foundation to career enhancement and advancement.

Strategies for developing a strong working relationship with a supervisor include discussions around clear mutual expectations, perceptions of what good supervision and work look like, learning style and needs, previous traumatic stress, work-life balance needs, career goals, and needs and desires for future continuing education. Sometimes new workers do not have enough experience or have not reflected adequately on their professional direction; in those cases a supervisor plays a vital role in assessing strengths and learning needs that can assist new workers to identify goals and career paths. Supervisors are also key players in assigning new cases to workers; those cases, wisely chosen, enable workers to develop deepening clinical skills in various contexts. Good supervisors also develop workers for higher-level positions within an agency. They do this by providing more responsibility to workers or sending workers for specialized forms of training. It is through the deepening supervisory relationship that workers ultimately grow and move up the ranks. New and experienced workers alike must take that matter seriously.

Trauma-informed supervision also entails an ongoing assessment of the worker's response to cases, particularly complicated ones that involve severe trauma. Cases dealing with sexually-abused children or the death of a child tend to be the ones that have a higher incidence of secondary stress. They require heightened supervisory vigilance and even therapeutic measures: time off from the job; counseling via an Employee Assistance Programs; self-care strategies such as exercise, proper diet, mindfulness techniques, and reflective writing, among others (Pennebaker, Kiecolt-Glaser, & Glaser, 1988).

Child welfare literature continues to point out the importance of support from the supervisor and from peers (Madden, Scannapieco, & Painter, 2014; Zlotnik, DePanfilis, Daining, & Lane, 2003). Support derives from relationships that can be developed intentionally. These "communities of practice" not only aid in keeping workers on the job, but also provide a mechanism for their growth and development (Wenger, 1998). The supervisor is the key person who works to set up a dynamic, trauma-informed community of practice for the team. Within "communities of practice," workers develop or enhance their professional identities, learn new concepts, and ultimately make meaning out of the work they do (Wenger, 1998). The key words are "community" and "team"; supervisors must work hard to encourage a strong team approach. In that capacity, supervisors set expectations, provide leadership and education, ensure that a trauma-informed approach is being used with clients and model it for workers, as well as set a positive emotional tone by example and by encouraging team activities. Not all of these activities have to be serious. Some very successful supervisors work to set a fun tone to counterbalance the serious work agencies undertake. By way of example, weekly breakfasts, office-centered craft activities, and end-of-week reflective pep/support-sessions have proved successful. Supervisors can also encourage workers to work together on particularly stressful cases or encourage the team to support a member who is having a difficult time. Supervisor outlook and demeanor are important as well.

It is also the supervisor's role to assist workers who appear to be struggling with providing good assistance to children and families or their own secondary or post-traumatic stress. Sometimes, as it happens, the wisest advice the supervisor offers is that a worker should find a job that is less stressful. It is ultimately up to the worker to decide whether a work-situation is too stressful, but a supervisor can and should have a candid conversation with a worker and the two should intentionally reflect upon what the issues are and what potential remedies might be.

Reflective Practice

The last addition to the model of professional development for child welfare workers is the addition of reflective practice. Schools tend to do a great job in integrating students' thoughts and feelings about what they are learning and doing. While some agencies also do a good job at emotional integration, many clearly do not, and the

best index of that is the high turnover rate that continues to afflict child welfare agencies across the United States. It seems obvious, therefore, that agencies must begin to foster reflective practice, which is the integration of the situation at hand and the thoughts, feelings, perceptions, and theories that occur through the critical thinking process. While is important for students to integrate and develop a practice of reflection from the beginning of their education, it is also important to carry reflective practice forward as a daily practice-strategy. Critical in that regard is that beginning practitioners have to recognize vulnerabilities and strengths in themselves and their clients including the symptoms of trauma and signs of resilience. Becoming trauma-informed allows workers to view their clients through the trauma lens, which is key to adequate intervention. The trauma lens must also turn its focus inward; workers who do that will be in a better position to recognize "symptoms" in themselves requiring attention since secondary trauma often mimics the post-traumatic stress identified in clients (Figley, 1995). For example, workers who provide assessment or investigative services encounter many scenarios in which they and the children they are there to protect are in actual danger. Workers must first evaluate the situation for safety, protect the children, and devise strategies to ensure the continued safety of children. In the course of their work emotions ultimately surface not only about their own safety but about the scenarios in which children live. While the fight or flight response provides for assistance to survive frightening situations, the worker eventually has to be able to process the scenario and make meaning out of it. By using the trauma-informed principles of seeking peer support and collaboration, workers learn to share the burden of such emotionally charged work. Every practice experience provides an opportunity for reflection on not only trauma but also resiliency and strength and learning to reflect and then seek support from peers and supervisors is vital to providing trauma-informed care over the course of a career.

Agencies should encourage workers, in a formal way built into the workday, to take 15 or 20 min per-day to write reflectively on their thoughts, feelings, biases, and integration of theory with skill-building and to teach them to do this using strategies such as positive reframing. There are various methods or structures for reflective writings; noteworthy among them is the DEAL method (Ash, Clayton, & Moses, 2006; Lay & McGuire, 2010). DEAL is an acronym: under its terms, D means *describe* the experience, feeling, or question in detail (the who, what, when, where, and why); E means *examine* the situation or question in light of life experience (or past trauma) or other sources; and AL means *articulate learning* by asking four questions: "What did I learn? How did I learn it? How did it make me feel and how can I reframe that positively? What does it matter to me as a social worker? And what will I do in my future social work practice in light of this learning?" (Lay & McGuire, 2010, p. 550). Workers can use this model to begin their thinking about any aspect of social work practice. They could describe the issue, examine it carefully based on their own life experience, emotions, maturity, etc., and then articulate their learning in light of needs of the personal self and the professional self. This reflective exercise can then be used daily in practice throughout the career to center thinking on a particular issue or scenario particularly when they are

exposed to traumatic situations on the job. Reflections will change, of course, depending on "where" people are in their career, personal development, or maturity level, but the process can remain the same. A novice or advanced beginner might reflect on integrating trauma theory with other salient theories and practice or incorporating more contextual or situational knowledge—or even how to get all of the work done in any given day. However, a competent or proficient worker might reflect upon new and better ways to accomplish the work or help a family or the team to function more smoothly. The cumulative benefit of reflective writing and sharing in fact appears to decrease cellular-stress immune responses by allowing for the necessary processing of traumatic experiences into meaning-making and stress-reduction (Pennebaker, Kiecolt-Glaser, & Glaser, 1988). Building reflection into the supervisory session and making space for it at the agency level are important practices for helping workers to remain emotionally and behaviorally regulated and to remain healthy and satisfied workers who will be retained. Adopting team reflection time weekly can also provide a sound way of encouraging team-building and peer-support, as does sharing thoughts, ideas, and feelings about the tough emotional work that they do.

Resilience Training

Developing a resilient workforce entails commitment and work among all persons in an agency. The agency leadership must put into place policies, procedures, and training that encourage a trauma-informed climate for everyone. Recognizing that everyone in the agency has the potential to become traumatized is the first step to mitigation of the effects of trauma. The Resilience Alliance has developed a training guide to be used with child welfare organizations (Resilience Alliance, 2011). The essential principles, based in cognitive behavioral approaches, include team interventions to enhance mastery at both work skill and emotional regulation, providing opportunities for positive, strengths based collaboration including opportunities for peer learning of ways to master stress, recognition that at any given time a worker may be in stress or survival mode and will need support to regulate just as the children they work with need that support, and promoting opportunities for supervisors and workers alike to practice mindfulness, guided imagery, or breathing techniques for emotional and behavioral control (Resilience Alliance, 2011). By recognizing the inherent stress in the work and intentionally training on resilience techniques, agencies can provide a climate in which transfer of resilience learning can thrive. Workers themselves must take the time to use the techniques provided and become as strength based with the self as they are with their clients. Ultimately, developing as a professional involves not only learning how to do a job competently but also how to use professional behavior with clients and with the self. Child welfare work is really a vocation – a calling to care for children and families in need. This requires skills of resilience in order to do the best job for children and families.

Conclusion

This chapter examines professional development within a model developed by Dreyfus and Dreyfus (1986). However, their model provides only a skeleton of what professional development in child welfare looks like. While development occurs from novice to expert along some continuum particularly around varied experiences over time, it neglects the emotional and organizational components of being in the workforce, particularly one that has the ability to produce secondary traumatic stress in its workers. Therefore, this chapter proposed an organizational context that is trauma-informed at all levels from working with clients to caring for its workers. This context provides a supportive and educational new-worker experience, opportunities for growth over time, supportive and nurturing supervision and mentoring, a culture in which resilience techniques are embedded in practice, and an opportunity for reflective and meaningful practice. After all, social workers do the hard work of caring for children and families in child welfare, even at 2 in the morning because they care deeply about their clients and the reward of caring for these families over time with organizational supports in place can sustain a career over the course of a professional's lifetime.

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Chapter 21
Summary and Vision for the Future

Virginia C. Strand and Ginny Sprang

This book introduces a conceptual framework for envisioning how child welfare services could become more trauma informed as agencies pursue their mandate to provide services that assure safety, permanency, and well-being for children and families. Informed by phase oriented trauma theory, a foundation for effective intervention with traumatized children and their families, the framework provides an overarching structure for conceptualizing the delivery of direct practice services to clients and for reforming organizational culture in agencies. The framework is aligned with the three goals of child welfare intervention – safety, permanency, and well-being. The conceptualization presupposes a stage-oriented frame for both direct practice and the reform of agency culture.

In the introductory chapters, we also explore the intersection between culture, trauma, and child welfare. As noted in Chap. 4, there are at least four pathways that describe the link between culture/cultural identity, trauma, and child maltreatment. These include (1) the experience of immigrants and refugees, (2) historical trauma, (3) present-day trauma due to bias, prejudice, discrimination against targeted cultural groups, and (4) the consequences of institutional and societal oppression of cultural populations that results in their disproportionate presence of marginalized populations in communities fraught with the adverse social determinants of health. Significant effort is made to describe the application of cultural and linguistic competence within child welfare services as a tool to address repercussions of culture-related trauma, and to follow this thread in subsequent chapters.

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While most child welfare systems are not trauma-informed as of this writing, the chapters in this volume illustrate what is *possible*, without any effort to assert that these initiatives reflect the primary mode of practice at this stage. What we do believe is essential is that a phase-oriented approach to both the delivery of services and organizational reform is both useful and necessary. Preliminary efforts at evaluation of all the practices introduced are promising in their support for effectiveness.

Trauma-Informed Direct Practice with Children and Families

As one envisions direct practice with children and families, the arm of child welfare designed to assure safety is child protective services. Chapter 5 describes trauma-informed engagement, emphasizing that this practice must reflect the inherent imbalance in power between caseworkers and clients, and identifying strategies to reframe client presentations to effect a more empathic and genuine connection between worker and client. Chapter 6 introduces an evidence-based trauma treatment – Trauma System Therapy – that focuses on stabilization of the child and family as a prerequisite for further mental health intervention. It is often implemented in coordination with child welfare, and this chapter discusses the implementation in a suburban/rural county as well as in an urban child welfare setting, both of which are successful in early child welfare system intervention for safety, coordinated with ongoing mental health services.

Permanency goals for children, conceptualized here as the development or enhancement of a permanent caregiving relationship, are met either through preventive services, when children at risk of placement remain with their family of origin, or through foster care, when children have been removed due to unsafe conditions in the birth family home. It is the job of the child welfare system to help a child and family move toward a permanent relationship characterized by the safety and stabilization necessary for ongoing growth and development.

Referral for and evaluation of a need for effective intervention depends on careful assessment. Chapter 7 presents a standardized trauma assessment instrument used widely in child welfare agencies currently – the Child and Adolescent Needs and Strengths (CANS). This instrument addresses some of the existing challenges of assessment within child welfare through supporting clinical decision making, including level of care and placement decisions, linking the findings of the assessment directly to individualized service and treatment plans, engaging family members in the assessment process, and facilitating the planning and evaluation of service systems (Lyons, 2009). It emphasizes the importance of caseworker training for use of the CANS, and notes that when completing the CANS-Trauma with children and families, it is important for caseworkers to be trained and supported in attuning to their own potential secondary traumatic stress reactions and related self-care strategies to support them in their work.

Chapter 8, by contrast, suggests avenues for child welfare agencies to partner with community agencies for support in the assessment process. This chapter describes a collaboration between a flagship university and child protection system in a mostly rural and significantly under-resourced state. It emphasizes the use of trauma assessment for decision making.

Chapter 9 reflects on the provision of an evidence-based trauma treatment – Child Parent Psychotherapy (CPP) – with families in preventive services. CPP is indicated for infants and young children who have experienced at least one traumatic event, such as maltreatment, and/or are experiencing mental health, attachment, or behavioral problems, including posttraumatic stress disorder (PTSD). Caregivers are included in the treatment, which is focused on the dyad (Lieberman, Ghosh Ippen, & Van Horn, 2015). In CPP, the main symptoms arising from the trauma are treated by establishing safety and consistency in the therapy, fostering accurate identification and perceptions of safety by the child and caregiver, highlighting the need for safe behavior, identifying factors that interfere with the caregiver's ability to provide for the child's well-being, and helping establish the caregiver as a protective, benevolent, legitimate authority in the child's life. Treatment is coordinated with the preventive services caseworker.

Chapters in the next section focused on achieving permanency for children in the foster care system. This rests on the child developing a sustaining, nurturing, and supportive relationship with either a birth parent or alternative caregiver (foster or adoptive parent). A critical need has been for training of foster care, or resource parents, in managing traumatized children in an effort to avoid placement disruption, support positive attachment, and enable the effective treatment of the trauma. Chapter 10 provides information about a widely available training curriculum for resource parents. The goal of the training is to supports parents as they learn to "recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers." Preliminary evaluation finding suggest that it is effective in changing knowledge and beliefs. A second chapter discusses the critical need to work with birth parents while children are in care, emphasizing that parents are often dealing with their own trauma histories, and offering pathways for strengthening parents' recovery as they commit to reunification for their children in foster care.

In the last chapter on direct practice, we turn to an intervention with pre-adoptive families. An ambitious cross-system collaboration is described, which was designed to support the child and family by providing trauma-informed and trauma-responsive training, coaching, and related services to (a) foster and pre-adoptive caregivers, (b) the child welfare workforce, and (c) the mental health workforce. Preliminary results show some positive trends in improving several areas including workforce improvements as well as improvements in the knowledge, skills, and self-efficacy of pre-adoptive parents.

Collectively, these chapters illustrate innovative and often evidence-based intervention efforts to attend to a child's physical and psychological safety, permanency by building a strong child-caregiver relationship, and overall child and family well-being.

Developing a Trauma-Informed Organizational Culture

We began this section of the book with a discussion of implementation science principles. While client oriented evidence-based trauma treatments have incorporated many of the design features of implementation science, organizational culture reform has been less identified with this approach. In Chap. 13, we feature not only one particular implementation framework, but also connect the reader to an important resource – the California Evidence-based Clearing House for Child Welfare – which now offers a guide to selecting and implementing evidence-based practice in child welfare.

A major assumption underling the chapters in Part III is that the route to becoming a trauma-informed child welfare agency lies in adopting a phase-oriented approach to organizational culture reform. This necessitates the development of a safe and stable working environment as outlined in Chap. 3. While we were not able to identify many efforts to implement the macro strategies described in that chapter, we did find initiatives illustrating a range of macro and micro organizational strategies to achieve that objective. Chapter 14 discusses efforts in two jurisdictions – one rural and one urban – to implement and sustain trauma-informed child welfare systems.

The next two chapters identify two different assessment tools designed to assist an agency in identifying areas of strengths and challenges in preparing for trauma-informed organizational culture and practices. First is for assessing organizational readiness to implement trauma-informed practice, and the second to evaluate the degree to which an organization is informed and able to respond to the impact of secondary traumatic stress in the workplace. The organizational readiness instrument described in Chap. 15 is best used in a time series design to measure organizational readiness over time. One of the strengths of the measure is that it is aligned with the implementation components of the NIRN framework (Fixsen et al., 2009) and tracks the degree by which staff considers leadership, training, and support for new trauma practices and the availability of a facilitative administrative structure supportive. The Secondary Traumatic Stress measure described in Chap. 16 facilitates the application of specific competencies that would advance the well-being and effectiveness of child welfare organizations, and that are consistent with the trauma competencies endorsed by the Council on Social Work Education, and the American Psychological Association (Cook & Newman, 2014).

Micro strategies for organizational stabilization are addressed by Chaps. 17 and 18. Chapter 17 discusses trauma informed recruitment and selection strategies, devoting special attention to the utility of trauma course work in the educational background of recruits for child welfare practice. Additional strategies identified and discussed include realistic job previews, behavioral interviewing, and hiring a proportion of supervisor and management positions from outside the organization for public child welfare. Chapter 18 reviews a highly effective tool for educating child welfare professionals on the impact of child traumatic stress among children

and families, as well as teaching strategies for using trauma-informed child welfare practice to enhance the safety, permanency, and well-being of children and families involved in the child welfare system. The *Child Welfare Trauma Training Toolkit* (CWTTT) has been used extensively across the country, and evaluation initiatives in Florida, Oklahoma, and Rhode Island. Findings suggest that firstly, child welfare systems should consider a thoughtful implementation structure that includes training, follow-up coaching and consultation, and the use of champions who spread this practice among their peers. Secondly, training on the broad concepts and information is not enough. The individuals doing this work are hungry for concrete practice changes that they can make each day in their work that make a difference. While some time can be focused on presenting information and concepts, it is critical to drill down to specific practice changes that can be made at each level of the organization to better facilitate its capacity to become trauma-informed. Thirdly, all efforts need to occur across multiple levels of the organization. Readily available through the NCTSN, this is a highly valuable resource.

Strategies for assuring retention or the "permanent" attachment of the workforce to the organization are discussed in Chaps. 19 and 20. Chapter 19 describes an innovative approach to supervision that is trauma sensitive. The approach is one in which the supervisor recognizes the effect that trauma work has upon workers; proactively employs specific methods of anticipating and monitoring the signs of strain in workers; and guides the use of protective strategies. Chapter 20 expands on the notion of supervision to specify components of trauma-informed professional development, with special attention to transition to work.

Collectively, the chapters in this book examine child welfare practice through a multifactorial lens, examining the core components of interventions, approaches and partnerships from a trauma-focused perspective. These strategies have been used to address some of the common problems facing child welfare organizations, including family engagement, birth parent trauma, achieving cultural competence, screening and assessment, supervision, staff recruitment and training, secondary traumatic stress, and professional development. It is notable that the innovations highlighted in this text have been applied to a range of problems impacting workers, foster parents, biological parents, administration, supervisors, and key stakeholders. These discussions highlight the cross-systems interface challenges associated with this work and the range of solutions that have been developed to address these contemporary challenges. Because innovations are not equally and evenly distributed, available or possible across regions, child welfare agencies must make parsimonious choices about what initiatives they can pursue. The organization of these approaches within the broader context of safety, permanency and well-being helps guide the selection and sequencing of potential strategies. The description of each approach is accompanied by the existing evidence to support the approach, creating a compendium of empirical and evaluation data that can be used by child welfare leadership to make determinations about the goodness of fit between the practice and the potential setting.

Challenges

Despite the progress made in the areas highlighted in these chapters, there are a number of current or emerging issues that still need to be addressed in a meaningful way. It does appear that the child welfare system, broadly defined to include both the public and contract not-for-profit agencies, is making strides in incorporating trauma assessments for clients and is providing evidence-based trauma treatment. These services are documented in Part II. What looms as a critical remaining issue, however, is the need is for public child welfare agencies to establish physical and psychological safety for their workforce. If we are correct in our presumption that this needs to occur before other organizational strategies to achieve a trauma sensitive work culture can succeed, then absent this, organizations will continue to churn, the next child fatality will throw an organization backwards, and isolated efforts to achieve trauma sensitive organizations will not be able to be sustained in the long term.

A second emerging challenge is the dissemination of knowledge about the implementation of innovations or empirically supported practice in order to achieve sustainability. Child welfare leaders need to educate themselves about the developments in successful implementation. For example, child welfare, like many systems, needs to move away from a reliance on didactic training to introduce new practices. We now know that coaching and supervision in any new practice is necessary for its successful implantation. Also, implementation is an iterative process that depends on the development and the use of decision-support data systems. While child welfare has remarkably been at the forefront in systematizing management information systems at both state and federal levels, staff is not as sophisticated as they need to be in accessing and using their data for both program and system improvement. This will become an increasing challenge as the demand for proof of successful and measurable client outcomes grows.

A third challenge is the ongoing struggle to incorporate cultural and linguistic competencies into child welfare practice. Increasing awareness about the impact of historical trauma and present day bias is just a beginning. Staff at all levels need ongoing support for identifying and realigning attitudes that promote both personal and community cultural awareness. Skills to develop authentic relationships, engage in culture related conversations, mobilize strengths, and manage conflicts need to be cultivated, as well as the ability to work with interpreters and translators and adapt communication to address low literacy. Subsequent chapters are successful in integrating a discussion of the manner in which they have promoted cultural competency with varying degrees of success.

A fourth challenge involves the important role for child welfare in meeting the urgent need of trafficked victims. Recently, the Preventing Sex Trafficking and Strengthening Families Act, signed into law in 2014 mandates title IV-E agencies develop policies and procedures to identify, document and determine appropriate services for children who are involved in sex trafficking, at an elevated risk of becoming sexually exploited, and who are under the protection of the child welfare

system. Among the many requirements of this act, child welfare agencies are challenged to develop and enact protocols to locate sex trafficking victims who may be missing from foster care, and prevent future runaway behavior. However, the current range of potential strategies for addressing this problem is inadequate. Specialized placements for sex trafficking victims are limited, and the science to support best practices for safely treating this population is in its infancy. The practice of court-ordered placements in locked units is controversial and may be experienced as traumatic and harmful by youth (Wayman, 2013). This approach also stands in contrast to the current movement away from criminalizing youth victims of sex trafficking by involuntarily detaining them.

In fact the Victims of Trafficking and Violence Protection Act (2000), also referred to as the first modern day anti-slavery law (Ryf, 2002), states that children or youth under age 18 cannot consent to involvement in sex trafficking activities, so there is no legal mandate to establish force, fraud, or coercion (as is necessary in labor trafficking) or track them into detention. This law reclassifies these youth as sex trafficking victims instead of criminals or delinquents. Many states have adopted "safe harbor" laws which emphasize decriminalization, diverting victims from delinquency proceedings toward supportive and rehabilitative services, and in some cases identifying child welfare as the service system designated to intervene, protect and provide assistance to the child, even if a parent is not identified as the trafficker. This represents an unfunded mandate in many states, and creates a challenge to child welfare agencies who may not have the resources or expertise to provide such a response. Emerging literature suggests that many of these victims suffer from traumatic stress conditions, and have a particular typology of symptoms or treatment needs that should be addressed, however these studies are preliminary and need to be replicated (Cole, Sprang, Lee & Cohen, 2016; Hossain, Zimmerman, Abas, Light & Watts, 2010). Even so, decades of trauma research suggests that trauma-informed approaches are the framework most likely to be effective in guiding the development and adaptation of interventions to address this growing problem in child welfare practice because they target the source of the distress and can neutralize the power differential that characterizes the victim-perpetrator experience. As described in *The Role of Cultural Competence in Trauma-Informed Agencies and Services* (Chap. 4), child welfare workers work within a hierarchy that may unintentionally recreate these experiences for victims, a problem that must be overcome to provide adequate protection and care.

Finally, child welfare workers can be simultaneously exposed to direct and indirect exposure to traumatic experiences, and are at higher risk of developing secondary traumatic stress than workers in other professions (Sprang, Craig, & Clark, 2011). For example, the trauma-informed assessment approach discussed in Chap. 7 requires providers to discuss trauma experiences and reactions with families, an activity that necessitates solicitation of traumatic material that may be distressing to workers. In fact, the scope of work expected of most investigative workers requires this type of event review, an act that would likely be distressing to most, and one that can occur in the context of threatening or dangerous interactions. These experiences

can negatively impact a worker's ability to provide services, develop and sustain personal and professional relationships, and can lead to attrition, loss of productivity, and decreased quality of life (Showalter, 2010). Thus, it is extremely important for caseworkers to be trained and supported in attending to their own potential secondary traumatic stress reactions and to have access to strategies to support them in their work.

Chapter 18 speaks specifically to staff training strategies that can be useful in preventing and addressing secondary traumatic stress in the workforce. Given the high rates of turnover in child welfare agencies, this remains an ongoing challenge (Landsman, 2007). In Chaps. 9 and 16, the authors urge child welfare organizations to create a wider milieu where STS is openly acknowledged, discussed, and dealt with by all members of the system. To do this requires a willingness to fully embrace a trauma-informed approach to child welfare practice, for no agency can be truly trauma-responsive if it does not attend to the secondary trauma experiences of its workers.

In summary, the chapters of this book outline a range of trauma-informed strategies that child welfare agencies can enact to create a trauma-responsive culture and better meet their goals in the areas of safety, permanency and well-being. This requires increased cross-system collaboration, attendance to new legislative mandates, and a willingness to attend to the parallel process of workforce development and protection so that trauma-exposed workers can effectively manage traumatized children and families. A trauma-informed approach to child welfare practice provides the framework for successfully addressing these challenges.

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