# Trauma-Informed Innovative Practices

Insights From Children's Bureau Discretionary Grantees on Addressing Trauma in Child Welfare

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## Disclaimer

The views expressed in this publication do not necessarily reflect the views or policies of the Children's Bureau, the Administration for Children and Families, or the U.S. Department of Health and Human Services. For more information, please visit the Children's Bureau website at https://www.acf.hhs.gov/cb.

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# Introduction

Trauma exposure has significant short- and long-term consequences for children in the child welfare system, affecting their physical, social, emotional, and spiritual well-being (Child Welfare Information Gateway, 2015). To address the growing body of evidence on its negative impact, the federal government passed several legislative changes[1] that "reflect heightened interest and concern . . . about the need to address the far-reaching effects of trauma and its associated, often devastating, mental health consequences" (U.S. Department of Human Services, 2013). Between 2011 and 2013, the Children's Bureau released three discretionary funding opportunities to support state and local jurisdictions to identify children impacted by trauma, address their unique needs, and link them with behavioral and mental health services (see sidebar). All three funding opportunities were designed to help grantees develop a full continuum of trauma-informed supports. The Children's Bureau also encouraged grantees to build cross-system collaboration and develop rigorous implementation and outcome evaluations to build evidence of promising practices. The 2013 funding opportunity required a targeted focus on supporting and improving outcomes for children in foster care who may become available for adoption.

> **Trauma-Focused Child Welfare Funding Opportunities Announcements (FOA) (2011–2013)**
>
> 2011: Integrating Trauma-Informed and Trauma-Focused Practice in Child Protective Service Delivery (HHS-2011-ACF-ACYF-CO-0169)
>
> 2012: Initiative to Improve Access to Needs-Driven, Evidence Based/Evidence-Informed Mental and Behavioral Health Services in Child Welfare (HHS-2012-ACF-ACYF-CO-0279)
>
> 2013: Promoting Well-Being and Adoption After Trauma (HHS-2013-ACF-ACYF-CO-0637)

## Purpose of This Report

The report highlights selected innovations, successes, and lessons learned across three clusters of trauma grantees to inform future trauma-informed initiatives. The 20 funded grantees included state and local child welfare agencies, universities, and community providers. Exhibit 1 presents the

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[1] Related legislation includes the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351) and the Child and Family Services Improvement and Innovation Act of 2011 (Pub. L. 112-34).

complete list of grantees by cluster, including their location, lead organization, and project name. Links to online project pages are provided when available.

## Exhibit 1. Trauma Grantees

| Home state | Project funded agency |
|---|---|
| **2011 grantees** | |
| Denver County, Colorado | **Integrating Trauma-Informed and Trauma-Focused Practice into Child Protective Services**<br>Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, University of Colorado-Denver School of Medicine |
| Connecticut | **[Connecticut Collaborative on Effective Practices for Trauma (CONCEPT)](#)**<br>State of Connecticut Department of Children and Families (DCF) |
| Massachusetts | **Massachusetts Child Trauma Project**<br>Massachusetts Department of Children & Families |
| Montana | **Transforming Tribal Child Protective Services (TTCPS) Project**<br>The University of Montana School of Social Work |
| North Carolina | **[Project Broadcast](#)**<br>North Carolina Department of Health and Human Services' Division of Social Services |
| **2012 grantees** | |
| California | **[California Screening, Assessment, and Treatment (CASAT) Initiative](#)**<br>Rady Children's Hospital |
| District of Columbia | **[Trauma-Informed Practice: Cutting-Edge Treatment of Child Victims of Abuse and Neglect](#)**<br>District of Columbia Child and Family Services Agency |
| Louisiana | **[Louisiana Child Welfare Trauma Project](#)**<br>Tulane University |
| Michigan | **[Genesee County Appropriate Screening and Assessment Project](#)**<br>Children's Trauma Assessment Center, Western Michigan University |
| New Hampshire | **[Partners for Change Project (NH Children's Behavioral Health)](#)**<br>Dartmouth Trauma Interventions Research Center, Trustees of Dartmouth College |
| New York City | **Project Atlas**<br>Child Study Center, New York University School of Medicine |

| Home state | Project funded agency |
|---|---|
| Ohio | **GatewayCALL** <br><br> Franklin County Children Services |
| Oklahoma | **Oklahoma Trauma Assessment and Service Center Collaborative** <br><br> Oklahoma Department of Human Services |
| Washington | **Creating Connections: Creating Mental Health Connections for Children and Youth in Foster Care** <br><br> University of Washington |
| **2013 grantees** | |
| Kansas | **Kansas Assessment Permanency Project (KAPP)** <br><br> University of Kansas School of Social Work |
| Kentucky | **Project SAFESPACE** <br><br> University of Louisville Research Foundation, Inc. |
| New Hampshire | **New Hampshire Adoption Preparation and Preservation Project** <br><br> New Hampshire Division for Children, Youth and Families, Adoptions |
| Rhode Island | **Adopt Well-Being Rhode Island Initiative (AWBRI)** <br><br> Rhode Island Department of Children, Youth and Families |
| Tennessee | **Trauma/Resilience and Network/System Transformation (TRANSform)** <br><br> Harmony Family Center, Inc. |
| Vermont | **Placement Stability Project (PSP)** <br><br> The University of Vermont and State Agriculture College |

**Note:** For convenience and brevity, grantees are identified throughout the remainder of this report by location and year of funding, e.g., California (2012). Project names are also noted when applicable.

Information is organized by five core components. Across the three FOAs (see sidebar on page 2), the Children's Bureau identified the following components as essential to establishing trauma-informed organizations: universal screening, functional assessment, child- and system-level monitoring, service array expansion, and data-driven implementation. The report then presents information across two components applied by most grantees but not explicitly stated as core components in the FOAs: cross-system trauma-informed care training[2] and workforce support

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[2] While training was not identified as a specific component to be included in grant activities, the FOAs recognized the importance of training and encouraged grantees to develop cross-system, trauma-informed training components.

around secondary traumatic stress. It concludes with a list of achievements identified across grantee efforts.

# Information Sources

The following includes synthesized information gathered from a variety of sources:[3]

- Semiannual progress reports submitted to the Children's Bureau

- Final grant reports submitted to the Children's Bureau (Final reports include detailed descriptions of grant activities and findings from process, outcome, and cost evaluations.)

- 2017 Trauma-Informed Care Cross-Cluster Survey completed by 17 of the 20 grantees[4]

- Documentation from the 2018 annual meeting of the trauma grantees, in which participating grantees self-identified innovative practices

- Summary matrix developed in 2019 documenting the characteristics of grantee activities by core components (Material for the matrix was derived from the grantee progress reports, final reports, and follow-up correspondence with grantees as needed.)[5]

The authors reviewed all these source documents, identifying those that included descriptions of the five highlighted components. They also conducted a telephone interview with a former federal project officer from one of the trauma clusters, eliciting feedback on her thoughts about innovations and how to highlight individual grantees.

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[3] Information contained in this report was extracted from these sources, sometimes verbatim and others summarized.
[4] Throughout, percentages reported about survey data are based on the total of 17 responding grantees.
[5] Some of the data items in the trauma matrix are not always available for all 20 grantees. When data from the matrix are presented, percentages of total grantees are not included, and the total number may not add up to 20.

# Core Components

All grantees spent the first year of the 5- to 7-year[6] award period assessing where trauma-informed approaches were most needed in their communities and how to implement processes, practices, and services to create a trauma-informed child welfare system. Efforts in the remaining years encompassed a wide variety of strategies, including integrating a trauma approach into child welfare practices, improving referrals to appropriate trauma-based services, increasing knowledge and capacity of the child welfare workforce and community partners, using data to inform decisions, and building evidence about effective trauma practices.

Despite a wide range of project scopes and strategies, all grantees were encouraged to follow a set of common core components. This section describes the five core programmatic components envisioned by the Children's Bureau and presents common grantee activities and selected examples of innovative practices within these components.[7] Exhibit 2 provides a visual description of how the five components are related: universal screening, functional assessment, and service array can be viewed as a sequential case flow process and monitoring and data-driven implementation inform all three aspects of this case flow.

**Exhibit 2. Core Components of Trauma Grants**



Case- and System-Level Monitoring

Universal Screening → Functional Assessment → Service Array

Data-Driven Implementation
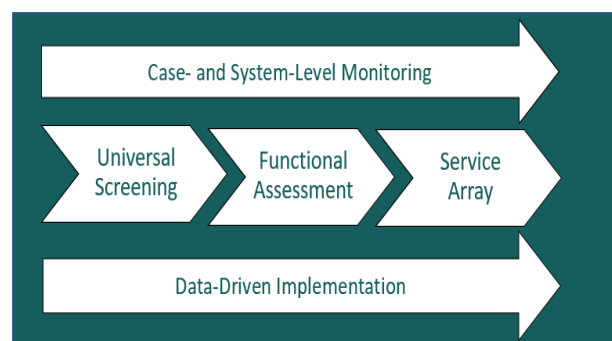
# Universal Screening for Child Trauma

Screening for trauma helps identify individuals who could benefit from trauma-specific supports and services. To promote this aim, the Children's Bureau expected grantees to implement a universal screening process for children and youth involved in the child welfare system. Ongoing and age-

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[6] Multiple grantees received no-cost extensions of 1 or 2 years to complete grant activities.
[7] The five core components highlighted reflect common threads across grantee clusters. They do not present a comprehensive look at all innovative strategies and interventions.

appropriate universal screening using reliable and valid tools identified the prevalence of developmental, mental, and behavioral health risks; trauma-related symptoms; and functional impairment. The intention of the screening process was not diagnostic. Rather, it identified individual mental and behavioral health needs and, if appropriate, prompted a comprehensive functional assessment at the child and family levels.[8]

# Grantee Activities

**Target population**. Most grantees developed a universal screening process for children placed in out-of-home care, while a small number conducted screening on all children with open child welfare cases. Several grantees changed their target populations over the course of the grant, with some being expanded (e.g., from screening only children in placement settings to all children with open child welfare cases) and others limiting universal screening to children in out-of-home placements. Several, including all 2013 grantees, expanded trauma screening processes to include children with the goal of adoption.

**Screening instruments.** Grantees used a broad range of tools and instruments to screen children (see sidebar), sometimes integrating multiple instruments into a single screening package and at times applying instruments to inform screening and assessment simultaneously.

**Screening process.** Typically, child welfare case workers completed the screening instruments, although some sites assigned the responsibility to behavioral health clinicians or specialized workers. The screenings were usually completed within 30 days, with timeframes varying from 10 days to 6 months.

## Screening Instruments Used by Grantees

Ages and Stages Questionnaire (ASQ)

Child and Adolescent Needs and Strengths (CANS)

Child Behavioral Health Screener

Child PTSD Symptom Scale

Child Stress Disorder Checklist

Child Trauma Screening Questionnaire (CTSQ)

Child Welfare Trauma Referral Tool

Childhood Traumatic Events Scale (CTES)

Global Appraisal of Individual Needs (GAIN)

Mood and Feelings Questionnaire

Pediatric Symptom Checklist

Screen for Child Anxiety Related Emotional Disorders (SCARED)

Southwest Michigan Children's Trauma Assessment Center (CTAC) Trauma Screening Checklist

Strengths and Difficulties Questionnaire (SDQ)

Trauma and Behavioral Health Screen

Upsetting Events Survey, modified from Traumatic Life Events Questionnaire

Young Child PTSD Checklist

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[8] While funding was intended to promote the development of a universal screening process that informed a subsequent functional assessment, several grantees implemented tools that informed both processes.

**Statewide rollout.** Ten of 17 grantees responding to the 2017 survey indicated they intended to implement a statewide trauma screening. Five reported successful statewide implementation by the end of the project, while several others expanded trauma screenings to large proportions of the state.

**Screening data.** Six grantees integrated screening data into their Statewide Automated Child Welfare Information Systems (SACWIS) or Comprehensive Child Welfare Information Systems (CCWIS). Eight developed databases specifically for this purpose. Three integrated screening into another existing system (e.g., Results Oriented Management [ROM] or other stand-alone data systems), while three did not enter screening data into any data system.

Some of the challenges related to screening included sustaining the process after the grant ended, concerns about labeling children and sharing data with mental health providers without appropriate consent, additional workloads for child welfare caseworkers, and limited availability of trauma-informed services and supports in response to service needs identified through screenings.

## Selected Grantee Highlights

**California (2012).** For the CASAT Initiative, Rady Children's Hospital and its collaborators developed and implemented a trauma-informed screening process at the county level. The project team originally adopted the Screen for Child Anxiety Related Emotional Disorders (SCARED) and the Strengths and Difficulties Questionnaire (SDQ) screening instruments. After identifying several administrative barriers and challenges to sustainability, the team developed a statewide survey to identify which screening approaches were implemented and to gauge administrator attitudes about screening implementation efforts. Findings from the survey contributed to the passage of state legislation[9] mandating trauma-related screenings as part of Early and Periodic Screening, Diagnosis, and Treatment programs.

**Connecticut (2011).** Members of the CONCEPT project team developed, piloted, and validated the Child Trauma Screening Tool, a brief (10-item) measure. The tool is now used to screen all children aged 3 and older in the care of the state child welfare system. As of 2018, almost 1,600 children ages 6+ in child welfare placements were screened for trauma exposure. The tool has also been contractually embedded into the comprehensive Multidisciplinary Evaluation (MDE) process. MDE includes assessment of physical, dental, developmental, educational, behavioral, and emotional well-being, as well as child traumatic stress components, and is completed by contracted providers within 30 days of a child's placement into care.

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[9] California AB-340 Early and Periodic Screening, Diagnosis, and Treatment Program: trauma screening. (2017-2018)

# Functional Assessment

Functional assessments help providers determine individual strengths and needs, make a referral to treatment services that address the needs, and monitor progress over time. The Children's Bureau encouraged grantees to strive for high-quality, in-depth assessments conducted by qualified mental health professionals with expertise in child development. Grantees were expected to use reliable, valid functional assessment tools and ensure assessments were trauma informed, developmentally and age appropriate, and culturally sensitive. If properly implemented, results could inform case planning with a functional outcomes orientation. For example, periodic assessments could measure improvement in social and emotional functioning and well-being before, during, and after the receipt of mental and behavioral health interventions.

## Grantee Activities

**Functional assessment process.** Seven grantees reported functional assessments were conducted by behavioral health clinicians, while six grantees assigned the task to child welfare case managers. The others completed assessments as part of a collaborative teaming process or determined who would conduct them on a case-by-case basis. Assessments usually took place every 6 months, with some assessments repeated every 90 days. Some grantees also allowed the assessment process to be triggered at the discretion of caseworkers or by other critical incidents (e.g., a child's removal from home, holding a multidisciplinary team meeting).

**Assessment instruments.** Grantees used a range of common assessment tools to conduct functional assessments (see sidebar). Instrument selection varied, based on who completed the

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**Assessment Instruments Used by Grantees**

Ages and Stages Questionnaire (ASQ)

Alabama Parenting Questionnaire (APQ)

Brief Child Abuse Potential Inventory (B-CAP)

Center for Epidemiologic Studies-Depression Scale (CES-D)

Child and Adolescent Functional Assessment Scale (CAFAS)

Child Behavior Checklist (CBCL)

Child and Adolescent Needs and Strengths (CANS) trauma module

Child PTSD Symptom Scale (CPSS)

Child Stress Disorders Checklist (CSDC)

Functional Status Scale (FSS)

Parenting Stress Index (PSI)

Pediatric Symptom Checklist (PSC)

PTSD Symptom Scale Interview (PSS-I)

Short Mood and Feelings Questionnaire (SMFQ)

Strengths and Difficulties Questionnaire (SDQ)

Trauma History Screen (THS)

Trauma Symptom Checklist for Children (TSCC)

Traumatic Events Screening Inventory (TESI)

Young Child PTSD Checklist (YCPC)

UCLA Child/Adolescent PTSD Reaction Index

assessment and level of clinical expertise (e.g., child welfare workers, behavioral health screeners and clinicians, collaborative teaming processes).

**Family assessment.** Eight grantees assessed caregivers and their children in care. Families were sometimes assessed using the family component in the Child and Adolescent Needs and Strengths (CANS) instrument. Other grantees used instruments such as the Parenting Stress Index and the Structured Analysis Family Assessment to assess the impact of trauma on the family unit.

**Assessment data.** Five grantees integrated assessment data into their SACWIS or CCWIS data systems; eight developed their own databases. Five integrated assessment data into another system (e.g., mental health data systems, ROM).

As grantees implemented functional assessments, they recognized the need to provide additional training and guidance to the child welfare workforce on interpreting gathered information and applying it to child/family case plans and service referrals.

## Selected Grantee Highlights

**Kansas (2013).** To support the use of screening and assessments in case planning, the KAPP project developed practice tips for frontline workers to use, adapt, and integrate into their case plans and daily work. Practice tips were connected to the scores of each tool and incorporated into agency information systems for seamless application in case planning. Frontline workers provided feedback after implementation, and some modifications were made.

**Michigan (2012).** The Michigan Department of Health and Human Services (DHHS) executed a large contract with Southwest Michigan Children's Trauma Assessment Center to ensure trauma assessments are readily available in every county and to create a continuum from trauma screening to assessment based on the center's model. The project's collaborative learning processes revealed that local community mental health providers could not conduct enough trauma assessments for all the children screened for trauma. DHHS recognized that if children are screened, it needed to be able to follow through with a trauma assessment. The allocated state contract funding enabled DHHS to provide the most vulnerable children with quality trauma assessment services to facilitate recovery.

**California (2012).** Members of the CASAT Initiative developed, designed, embedded, and rolled out a revised assessment process for all children and youth receiving behavioral health services in three pilot counties. The resulting Trauma Informed-Mental Health Assessment Process (TI-MHAP) included functional assessments and trauma-informed elements. It was also integrated into an electronic mental health documentation system. The CASAT project team created a resource guide based on the TI-MHAP pilot to support other county behavioral health systems seeking to better identify and treat the needs of children, youth, and families impacted by trauma.

# Child and System-Level Monitoring

While universal screenings and functional assessments help identify and measure trauma exposure, the provision of individualized trauma treatment requires human service systems to share client-level information about service needs and functional gains. To build comprehensive, reliable, and integrated trauma-informed systems, grantees were encouraged to monitor ongoing progress and develop data-driven tracking processes to assess progress toward functional and well-being outcomes at the child and system levels. Automated data systems and data exchanges allowed jurisdictions to integrate data from multiple sources and share information with all involved in case planning and service delivery.

## Grantee Activities

**Data-driven case planning and ongoing monitoring.** Fifteen of 17 grantees responding to the 2017 survey indicated data-driven case planning and ongoing progress monitoring as key project activities. At the child level, some grantees developed templates for progress reports and communication protocols between child welfare and behavioral health workers. Several sites also incorporated CANS assessment scores into data-driven decision making and used CANS language in progress reports and treatment plans. At a system level, behavioral health leadership used data from CANS assessments to examine specific treatment needs and change over time in regions across the state. One grantee highlighted how outcome data were successfully incorporated into state-funded contracting discussions.

**Database integration.** Nine grantees indicated database integration as a key project activity. Several grantees reported integrating screening and assessment data into SACWIS/CCWIS, which helped to better monitor progress at the client and system levels.

Grantees indicated plans to develop child and system-level monitoring were often less successful than those related to other core components. Challenges included limited case-level information sharing despite formal communication policies and procedures, inaccurate or incomplete data in existing systems, and lack of time to develop and implement ongoing monitoring systems during the grant period. Grantees also faced issues related to client consent and data sharing: the cost of enhancing and maintaining systems and roadblocks to matching across collaborative service systems.

## Selected Grantee Highlights

**Kentucky (2013).** Project SAFESPACE developed a technology-enhanced facilitation process for information sharing between child welfare and behavioral health providers. The project team incorporated standardized screeners into Kentucky's SACWIS, known as TWIST, which then lead to determining whether a referral to a behavioral health professional for a functional assessment was

warranted. When appropriate, the behavioral health provider completed the CANS assessment and entered data into KIDnet, a web-based application that scored the assessment and sent information back to TWIST. At the client level, KIDnet generated a report for the behavioral health provider and child welfare case worker highlighting areas of need, strengths, progress, diagnosis, treatments modalities, and intensity of service. CANS assessment reports indicated change over time in treatment domains and outcomes and also helped generate new treatment recommendations. TWIST could also automatically integrate data regarding out-of-home care to KIDnet, and the behavioral health clinicians could search and input CANS results. At a systems level, this web-based data exchange allowed for data-informed service array reconfiguration as part of a larger system of care redesign.

**Oklahoma (2012).** Oklahoma's Trauma Assessment and Service Center Collaborative project used the Child Behavioral Health Screener (CBHS) as a screening and functional assessment tool to identify behavioral needs of children within the state child welfare system. Monthly screenings were entered into Oklahoma's SACWIS, so child welfare staff could quickly score and interpret CBHS responses. This information was shared via an automated dashboard with a threshold to indicate when a referral should be made for a clinical assessment by a mental health provider. By conducting monthly screenings, child welfare staff were able to regularly monitor progress and discuss results with clients. CBHS data were available at the client and aggregate levels. The project team plans to compare CBHS data with Medicaid service utilization data to identify the services children were receiving and any changes made in services following a CBHS-based referral.

**Vermont (2013).** Vermont's PSP developed *iTIPS for Tuning In,* a smartphone application (app) designed to give foster and kinship caregivers access to concrete, trauma-informed parenting strategies for youth in their care. Designed for caregivers using Resource Parent Curriculum, the app allowed users to watch videos, view parenting scenarios, access tips on self-care, complete weekly assessments of child behavior, and monitor the child's progress. An accompanying research study suggested the technology-enhanced program supports increases parenting skills and self-efficacy, with mixed evidence on changes in child outcomes. Caregivers also believed the app reinforced program content. PSP hopes to create a new version for birth parents.

# Expanding the Service Array

Developing a trauma-informed continuum of care requires the availability of and access to effective mental and behavioral health interventions. Grantees were encouraged to develop a strategy for ensuring access to timely, appropriate, and evidence-based or evidence-informed treatments that fit the changing needs and characteristics of children and families in the child welfare system. Related activities included reconfiguring the service array by assessing the existing trauma-based interventions and expanding capacity to address service gaps, while also scaling down services not

supported by the evidence and/or not meeting the assessed needs of the target population. The Children's Bureau also expected grantees to explore strategies to access Medicaid funding where possible to support reimbursement for mental and behavioral health treatments.

## Grantee Activities

**Expanded Service Array.** Among the 17 grantees who completed the 2017 survey, several service activities were identified as key grant components: service array reconfiguration (9 grantees), system-wide implementation of new types of evidence- based practices (8), testing EBP effectiveness (3), and testing EBP fidelity (i.e., dosage studies) (2).

Grantees incorporated several EBPs into their project efforts (see sidebar).

**Service delivery**. A few grantees implemented team-based models for supporting families.

- **Ohio (2012).** The GatewayCALL project colocated team members, including project managers, behavioral health clinicians, and internal evaluation teams at the child welfare agency.

- **District of Columbia (2012).** The project team procured onsite consultation and short-term mental health services within the child welfare agency, including services from a Medicaid provider.

- **Rhode Island (2013).** For its project, the Rhode Island Department of Children, Youth and Families implemented a home-based, trauma-informed team to follow a child and provide continuity of care.

**Learning collaboratives**. Eight grantees created learning collaboratives—phased, cohort-based approaches to provide training and peer learning supports—to strengthen the pool of trained clinicians who could provide trauma-informed, evidence-based practices in local communities (see description of North Carolina grantee's learning collaborative efforts in Amaya-Jackson et al., 2018). Some grantees viewed their learning collaboratives as successful. Others struggled with high clinician turnover, which offset gains in service availability and accessibility. In these situations, participating clinicians either did not complete the collaborative training or moved to agencies or positions not serving children and families from the grantee's child welfare agency.

> **Evidence-Based Practices/Trauma-informed Interventions Assessed Through Grantee Evaluations**
>
> Alternatives for Families-Cognitive Behavioral Therapy (AF-CBT)
>
> Attachment, Self-Regulation and Competency (ARC)
>
> Child and Family Traumatic Stress Intervention (CFTSI)
>
> Child-Parent Psychotherapy (CPP)
>
> Cognitive Behavioral Therapy for PTSD/Trauma (CBT)
>
> Parent-Child Interaction Therapy (PCIT)
>
> Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
>
> Trauma Systems Therapy (TST)

Although some grantees made progress in expanding trauma-informed services and supports, many had challenges in building capacity in local communities. In keeping with other efforts to enhance collaborative partnerships, grantees often needed to address the challenges and shortcomings of one service system to realize positive change in other systems. Within the mental health system, challenges included high rates of turnover among trained clinicians, keeping the mental health community aware of grant-supported trauma initiatives, and adapting evidence-based practices to meet the needs of child welfare populations.

## Grantee Highlights

**Massachusetts (2011).** The Massachusetts Child Trauma Project selected three treatments for dissemination: Trauma-Focused Cognitive-Behavioral Therapy; Child-Parent Psychotherapy; and Attachment, Self-Regulation and Competency. The UMass Child Trauma Training Center developed a statewide centralized referral line and maintained an active database of clinicians trained in trauma-informed evidence-based practices. Referrals steadily increased throughout and beyond the grant period as the centralized line became more well known. Child welfare staff received information about the line during trainings and via ongoing communication. The Massachusetts Department of Mental Health committed 7 additional years of funding for the centralized referral line and clinician database. The state also used learning communities, training, and dissemination to create buy-in and integrate these treatments into standard practice.

**Rhode Island (2013).** The AWBRI project implemented a Trauma Systems Therapy (TST) approach to supporting child welfare-involved children impacted by trauma. In partnership with the grantee, Family Services of Rhode Island (FSRI) created a TST continuum to increase consistency in providers and treatment modalities. For example, FSRI assigned two teams to each girl entering one of its residential treatment programs—a clinical team at the residential home and one to work with her and her family in the home and community. This approach encouraged continuity and continued family engagement. FSRI also trained staff in its family coaching and visitation programs to support the TST approach across program areas. The agency planned to expand the model into its treatment foster care program and to train foster parents in the TST curriculum.

**Tennessee (2013).** To help child welfare professionals support children entering foster care, the TRANSform project developed a product to help identify and address the trauma caused by out-of-home placements. This product includes a booklet for children to tell their stories and a toolkit for case workers and caregivers to help the children understand what happened to them. This product used the power of personal narrative to help heal and change the question from, What's wrong with you to what happened to you? The handbook offers guidance to help manage life transitions, while the toolkit provides a forum for children to share what they want others to know about their stories. Professionals, parents, and other caring adults can also learn how to develop positive relationships with children who have experienced trauma and help them face related challenges.

# Data-Driven Implementation

Data-driven implementation is the process of deciding a course of action to implement a new initiative or improve ongoing efforts based on aggregate data rather than intuitive presumptions (James Bell Associates, 2018). The Children's Bureau worked with grantees to ensure they applied data-driven decision making and implementation science principles during the first grant year to assess existing system readiness and fit with the planned implementation activities for the remaining grant years. These included efforts related to screening, assessment, outcomes-oriented case planning, progress monitoring, and evidence-based service selection.

## Grantee Activities

**Comprehensive organizational assessments at multiple points in time.** Grantees used assessments to build rigorous implementation strategies and support high-quality data collection and evaluations. Assessments examined key organizational and systemic factors that could facilitate or impede implementation and scale-up efforts. Grantees also used implementation science-based assessments to help interpret evaluation findings and explore what may have facilitated or impeded the achievement of outcomes.

**Continuous quality improvement methods.** Grantees applied methods, such as Plan-Do-Study-Act cycles, data dashboards, and other online applications to integrate cross-system information to review and report implementation and outcome evaluation data. They used these methods to provide useful and ongoing feedback to local stakeholders and the Children's Bureau. They also presented implementation and outcome findings at annual grantee meetings and described how data contributed to long-term decision making and sustainability of core project components.

## Selected Grantee Highlights

**North Carolina (2011).** Project Broadcast applied the National Implementation Research Network's framework to track implementation efforts and facilitate system improvements. Project partners adapted the Trauma System Readiness Tool (Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, 2013) and administered versions tailored to child welfare staff, resource parents, and mental health providers/system of care members in the nine participating counties. Data collected during the first grant year helped identify gaps and needs, while those collected during the final year examined system changes tied to project implementation. The team used Plan-Do-Study-Act cycles (Amaya-Jackson et al., 2018) to immediately identify implementation challenges, used small-tests-of-change to address these challenges, and developed strategies for sustainability. To support data-driven implementation and decision making, project partners developed a web-based clinical tool called the North Carolina Treatment Performance and Outcome System (NC-TOPPS). NC-TOPPS supports monitoring of workforce performance, clinical outcomes,

service utilization, and cost—thereby providing real-time information about how specific treatment models impact child and family outcomes. NC-TOPPS also helps trained clinicians implement trauma-informed, evidence-based treatment models with fidelity and gathers data to support the payment of enhanced Medicaid rates for these treatments.

**New Hampshire (2012 and 2013).** The New Hampshire Adoption Preparation and Preservation Project and a related project, Partners for Change, conducted comprehensive data collection and analysis to assess system and stakeholder implementation readiness and key facilitators and barriers over time. They also conducted focus groups, surveys, and key informant interviews with a range of stakeholders, including foster and adoptive parents, child welfare staff, and leaders of partner organizations. Near project end, leaders applied a well-known implementation science framework, the Consolidated Framework for Implementation Research (CFIR), to take stock of facilitators and barriers that may have influenced the outcomes and results of both projects. The CFIR captured domains about the intervention, individuals targeted for the intervention (i.e., child welfare workers and mental health providers), the process of rolling out and conducting implementation efforts, and two levels of context (i.e., external and internal to the state child welfare agency). This in-depth contextual analysis helped New Hampshire document its successes and explore the effects of office culture, work climate, workload characteristics, and events such as the opioid crisis on outcomes.

# Additional Components

Grantees primarily focused on the core components described earlier and specified in the Children's Bureau funding opportunity announcements. However, several grantees implemented two additional project components during their grant periods: cross-system, trauma-informed training, and workforce supports to address secondary traumatic stress.

# Cross-System Trauma-Informed Care Training

To encourage the adoption of trauma-informed best practices, grantees implemented broad and comprehensive training efforts to educate professionals across the system of care about the symptomatology and repercussions of exposure to trauma.

## Grantee Activities

**Trauma training topics.** According to the 2017 survey, all 17 surveyed grantees offered general training on trauma. Other common training topics included trauma screening (15 grantees), evidence-based practices (14), assessment (11), secondary traumatic stress training or organizational stress training (10), case planning (9), working with resource parents (8), data systems (8), and adoption (4).

**Training curricula.** The most commonly used curricula were the National Child Traumatic Stress Network (NCTSN), Child Welfare Trauma Training Toolkit (7 grantees) and Trauma Systems Therapy training (3). Grantees also customized their own curricula by incorporating elements from existing curricula, such as the Neurosequential Model of Therapeutics, and two from the NCTSN, Think Trauma: A Training for the Staff in Juvenile Justice Residential Settings and CORE Concepts for Understanding Stress Responses in Children and Families.

**Training participants.** All 17 surveyed grantees offered trauma-focused trainings to the child welfare workforce. Trainings also targeted other stakeholders, including organizational leadership (13 grantees), clinicians (11), resource parents (10), and other child-serving and family partners (3).

Grantees encountered challenges when implementing communitywide trainings to a wide spectrum of stakeholders. They accounted for varying levels of understanding of the importance of trauma, motivation to engage in training given competing priorities, and differences in terminology across service systems.

## Selected Grantee Highlights

**Washington (2012).** The Creating Connections project worked to create a common language among child welfare professionals, mental health professionals, and families to enhance engagement in effective services. Project team members trained more than 1,200 social workers on how to use assessment results in the case planning process. They also developed a specialized training for mental health professionals—Things I Wish My Therapist Knew About Foster Care: A Child Welfare Training for Mental Health Therapists. Approximately 200 mental health professionals attended this training, which included information about the child welfare system, mental health needs of children and youth in foster care, methods to increase collaboration with child welfare workers, and best practices for increasing caregiver and biological parent involvement in treatment.

**Denver County, Colorado (2011).** As part of the Denver Department of Human Services (DHHS) project, it created opportunities to continually and systematically train staff on trauma assessment and treatment planning. Training was provided to all DHHS child welfare, judicial system, and support staff—from top administrators to casework interns and security guards—to create a trauma-informed approach to every family interaction. Casework staff received additional coaching and consultation to reinforce knowledge transfer. Foster care and kinship providers also participated in trainings to understand the link between trauma and children's behavior, feelings, and attitudes.

**District of Columbia (2012).** The District of Columbia Child and Family Services Agency created an e-learning workshop that was delivered via a train-the-trainer model. The eight-module training delves into critical elements of trauma-informed care and related casework practices. Training content was tailored for the direct services agency staff. However, the 2,500+ participants reflected a diverse range of stakeholders, including social workers, foster parents, attorneys, guardians ad litem, judges, police officers, mental health professionals, teachers/school administrators, and afterschool service providers.

# Workforce Support/Secondary Traumatic Stress

Grantees recognized if they intended to implement a trauma-informed child welfare system, acknowledging and addressing the secondary traumatic stress experienced by the child welfare workforce is important. According to the National Center for Child Traumatic Stress (NCCTS), "secondary traumatic stress can be thought of as a form of occupational stress. It can be a cumulative response to working with many trauma survivors over an extended period, or it may result from reactions to a particular client's traumatic experience" (Siegfried, 2008). NCTSN published a resource that provides an overview of the impact of secondary trauma on the child welfare workforce and strategies for prevention of and interventions for secondary traumatic stress. According to this fact sheet, secondary traumatic stress not only negatively affects individual workers, but also impacts an organization's culture and ability to effectively help children and

families. Many of the trauma grantees developed trainings to specifically address the signs and symptoms of this vicarious exposure to trauma. Of the 17 grantees that responded to the 2017 survey, 9 developed or enhanced resources on secondary traumatic stress to strengthen employee resilience and mitigate the impact of constant exposure to the experiences of children and families. Several grantees also developed new and innovative efforts to address the impact at an organizational level.

## Selected Grantee Highlights

**Michigan (2012).** Through its contract with Michigan DHHS, the Western Michigan University's Children's Trauma Assessment Center piloted a program to address secondary traumatic stress in 13 counties. By the end of the project, the center was contracted to deliver trainings on office culture and climate and secondary traumatic stress in all DHHS offices. Other nonprofit child-serving agencies could also receive the training. Each office helped create its own plan to identify and address the stress, reflecting a broader, statewide commitment to building workforce resiliency. The center also developed worksheets for use with staff, supervisors, and managers.

**Massachusetts (2011).** The Massachusetts Child Trauma Project developed several creative approaches for addressing secondary trauma among staff. For instance, one leadership team within the project learning collaborative established a "self-care committee" and developed a staff secondary trauma screening survey. Survey results catalyzed several self-care offerings, including online wellness tools, a meditation group, and weekly yoga classes. One team watched a documentary on vicarious trauma featuring five professionals employed by a community service provider, while another team facilitated a wellness debriefing group.

# Trauma Innovation Achievements

This report highlights the trauma grantee achievements across core programmatic components emphasized by the Children's Bureau and implemented by several grantees. During a 2018 meeting organized by the Children's Bureau, the grantees summarized innovations and reflected on their accomplishments in the areas listed below.

**Development of trauma-related materials.** The extensive array of developed materials includes tools/measures, worksheets, toolkits, and curricula. Some materials were created to fill an existing gap in resources; others were adapted from trauma work in other fields.

**Development of technology.** Grantees embraced technology to accomplish diverse aims, such as building capacity to access trauma screening assessments and treatment data in existing or newly created data systems, building data-driven trauma systems, and creating online learning platforms for trauma trainings.

**Expansion of access to trauma-related services and supports.** Expansion activities included funding new services, training mental health professionals in evidence-informed practices, and co-locating mental health and child welfare staff. The expansion of services was realized in local counties, regions, and even across states.

**Targeted attention to supporting parents and youth.** Grantees found ways to help resource parents understand and address the symptoms of trauma, such as smartphone apps and training opportunities for foster and kinship parents. They also integrated parent and child voices into training materials designed for professionals.

**Implementation of systems-level change.** At the child welfare agency level, grantees modified policies and practices around screening and assessment processes to embed a trauma-informed approach. Grantees also secured state funding to sustain trauma-informed practices and activities beyond their funded grant periods. Examples include ongoing training, provision of evidence-based services, and maintenance of trauma-focused staff positions.

**Impact on children, families, and professionals**. The three funding opportunities supported the completion of thousands of screenings and assessments. Grant funds also made it possible to train thousands of child welfare, mental health, and other service professionals.

Grantees also described key factors that enabled or inhibited their ability to achieve their vision of a trauma-informed child welfare system. These are listed below.

**Collaboration across child-serving agencies and involvement of organizational leadership in championing a trauma-informed approach.** Grantees stressed the importance of creating a

shared vision and building the willingness and capacity to collaborate. Leaders who understand and champion grantee efforts facilitate collaboration. Related needs include developing personal relationships, building trust, and breaking up the traditional siloed approach to service delivery. Grantees also stressed the need to assess the current child welfare system for strengths and gaps and to find creative, collaborative ways to finance these services.

**Data integration**. Some grantees successfully created or enhanced data systems. As a result, screening, assessment, and service data could be shared among provider staff. However, some could not make such modifications due to technical and/or legal reasons. Grantees stressed the importance of allocating adequate monetary and staffing resources to integrate data systems and making them as mobile as possible (e.g., building capacity to enter trauma screen data into systems from out in the field).

**Availability of trauma-informed treatments.** Grantees were often successful in integrating trauma screening and assessment into child welfare practice; however, finding adequate and appropriate services in the community was typically more challenging. Trauma-informed services were often the last piece of the continuum to be addressed in projects and were frequently the most difficult to enhance.

**Staffing resources**. Grantees described the challenges of training the child workforce and putting new processes in place amidst staff turnover and heavy workloads. These also applied to mental health provider organizations.

**Adaptability and flexibility**. Grantees found they often needed to adapt existing resources for individual communities, accounting for factors such as local leadership and context, existing service arrays, and agency resources.

This report documents how federal child welfare discretionary grantees across the country integrated new and innovative trauma-focused initiatives into their child welfare systems and highlights the successes, challenges, and lessons learned. The grantees achieved remarkable progress in testing the building blocks of a trauma-informed system that will inform similar efforts in the future. With the recognition of the impact of trauma in the Children's Bureau vision for changing national child welfare practice and in recent federal legislation such as the Family First Prevention Services Act (2018) and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (2018), the experiences of these grantees has advanced the knowledge base on which to build comprehensive and collaborative trauma-informed systems of care.

# Additional Resources

## Contributions to Federal Resources

Grantees contributed to many federal publications and resources. Selected resources include—

[ACF Resource Guide to Trauma-Informed Human Services](#)

[ACF Resource Guide - Resources Specific to Child Welfare Agencies](#)

[Information Memorandum: Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services](#)

[SAMHSA Resources for Child Trauma-Informed Care](#)

[Child Welfare Information Gateway Issue Brief: Developing a Trauma-informed Child Welfare System](#)

## Grantee Products and Resources

Grantees also developed several resources, tools, and products and disseminated lessons learned during grant periods. Links to selected publicly available resources are listed below.

**Collaborative Grantee Peer Reviewed Articles**. Links to abstracts for a selection of published articles collaboratively developed by multiple grantees, are listed below.

Akin, B., Strolin-Goltzman, J., & Collins-Camargo, C. (2017). Successes and challenges in developing trauma-informed child welfare systems: A real-world case study of exploration and initial implementation. *Child and Youth Services Review, 82*, 42–52. https://doi.org/10.1016/j.childyouth.2017.09.007

Collins-Camargo, C., Strolin, J., & Akin, B. (2019). Use of technology to facilitate practice improvement in trauma-informed child welfare systems. *Child Welfare*, *97*(3), 85–108.

Lang, J. M., Ake., G., Barto, B., Caringi, J., Little, C., Baldwin, M. J., Sullivan, K., Tunno, A. M., Bodian, R., Joy Stewart, C., Stevens, K., & Connell, C. M. (2017). Trauma screening in child welfare: Lessons learned in five states. *Journal of Child and Adolescent Trauma, 10*, 405–416. https://doi.org/10.1007/s40653-017-0155-y

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

**Individual Grantee Peer Reviewed Articles**. Links to abstracts for a selection of published articles developed by individual grantees are listed below.[10]

Akin, B., Dunkerley, S., Brook, J., & Bruns, K. (2019). Driving organization and systems change toward trauma-responsive services in child welfare: Supervisor and administrator perspectives on initial implementation. *Journal of Public Child Welfare*. https://doi.org/10.1080/15548732.2019.1652720

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

Barto, B., Bartlett, J. D., Von Ende, A., Bodian, R., Noroña, C. R., Griffin, J., Fraser, J. G., Kinniburgh, K., Spinazzola, J., Montagna, C., & Todd, M. (2018). The impact of a statewide trauma-informed child welfare initiative on children's permanency and maltreatment outcomes. *Child Abuse & Neglect*, *81*, 149–160. https://doi.org/10.1016/j.chiabu.2018.04.023

Bunger, A. C., Doogan, N. J., & Cao, Y. (2014). Building service delivery networks: Partnership evolution among children's behavioral health agencies in response to new funding. *Journal of the Society for Social Work and Research*, *5*(4), 513–538. https://doi.org/10.1086/679224

Bunger, A. C., Cao, Y., Girth, A. M., Hoffman, J., & Robertson, H. A. (2016). Constraints and benefits of child welfare contracts with behavioral health providers: Conditions that shape service access. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*(5), 728–739. https://doi.org/10.1007/s10488-015-0686-1

Butcher, R., Jankowski, M. K., & Slade, E. (2020). The costs of implementing and sustaining a trauma and mental health screening tool in a state child welfare system. *Children and Youth Services Review*, *114*. https://doi.org/10.1016/j.childyouth.2020.105011

Collins-Camargo, C., & Antle, B. (2018). Child welfare supervision: Special issues related to trauma-informed care in a unique environment. *The Clinical Supervisor*, *37*(1), 64–82. https://doi.org/10.1080/07325223.2017.1382412

Crandal, B. R., Martin, J. K., Hazen, A. L., & Rolls Reutz, J. A. (2017). Identifying trauma-related and mental health needs: The implementation of screening in California's child welfare systems. *Advances in Social Work*, *18*(1), 335. https://doi.org/10.18060/21278

Crandal, B. R., Martin, J. K., Hazen, A. L., & Rolls Reutz, J. A. (2019). Measuring collaboration across children's behavioral health and child welfare systems. *Psychological Services*, *16*(1), 111–119. https://doi.org/10.1037/ser0000302.supp

Crandal, B., Rolls Reutz, J., Wilson, C., & Hazen, A. (2018). Leadership change within a system during an implementation effort: Considerations after implementing trauma-informed care in child welfare and behavioral health systems. *APSAC Advisor, 30*(3).

Fraser, J. G., Griffin, J. L., Barto, B. L., Lo, C., Wenz-Gross, M., Spinazzola, J., Bodian, R. A., Nisenbaum, J. M., & Bartlett, J. D. (2014). Implementation of a workforce initiative to

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[10] The list of articles was generated from grantee-provided information in final reports and may not include all published articles supported by these grants.

build trauma-informed child welfare practice and services: Findings from the Massachusetts Child Trauma Project. *Children and Youth Services Review*, *44*, 233–242. https://doi.org/10.1016/j.childyouth.2014.06.016

Hemenway, A., Krompf, A., Beaudry, J., Gillespie, C., Wilcox, C., Gillespie, C., Burns, D., Bessette, B., Cota, S., & Strolin-Goltzman, J. (2018). Placing strengths at the center: Implementing a trauma-informed, collaborative case planning process for children and youth in foster care using the Child and Adolescent Needs and Strengths (CANS) tool. *APSAC Advisor*, *30*(3).

Hoffman, J. A., Bunger, A. C., Robertson, H. A., Cao, Y., & West, K. Y. (2016). Child welfare caseworkers' perspectives on the challenges of addressing mental health problems in early childhood. *Children and Youth Services Review*, *65*, 148–155. http://dx.doi.org/10.1016/j.childyouth.2016.04.003

Jorgenson, J., Strolin-Goltzman, J., Bielawski-Branch, A., Beaudry, J., & Richard, J. (2017). An innovative model for supporting pre-adoptive placements: Screening, cross system collaboration, and trauma informed parent management training. In Strand & Sprang (Eds.) *Developing Trauma Informed Child Welfare Agencies and Services*. New York: Springer Publications.

Kerns, S. E. U., Pullmann, M. D., Putnam, B., Buher, A., Holland, S., Berliner, L., Silverman, E., Payton, L., Fourre, L., Shogren, D., & Trupin, E. W. (2014). Child welfare and mental health: Facilitators of and barriers to connecting children and youths in out-of-home care with effective mental health treatment. *Children and Youth Services Review*, *46*, 315–324. https://doi.org/10.1016/j.childyouth.2014.09.013

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

Leake, R., Wood, V. F., Bussey, M., & Strolin-Goltzman, J. (2019). Factors influencing caregiver strain among foster, kin, and adoptive parents, *Journal of Public Child Welfare*, *13*(3) 285–306. https://doi.org/10.1080/15548732.2019.1603131

Peisch, V., Sullivan, A. D., Breslend, N. L., Benoit, R., Sigmon, S. C., Forehand, G. L., Strolin-Goltzman, J., & Forehand, R. (2018). Parental opioid abuse: A review of child outcomes, parenting, and parenting interventions. *Journal of Child and Family Studies*, *27*(7), 2082–2099. https://doi.org/10.1007/s10826-018-1061-0

Pritikin, J. N., Hunter, M. D., von Oertzen, T., Brick, T. R., & Boker, S. M. (2017). Many-level multilevel structural equation modeling: An efficient evaluation strategy. *Structural Equation Modeling: A Multidisciplinary Journal*, *24*(5), 684–698. https://doi.org/10.1080/10705511.2017.1293542

Strolin-Goltzman, J., Breslend, N., Hemenway Deaver, A., Wood, V., Woodside-Jiron, H., & Krompf, A. (2020). Moving beyond self-care: Exploring the protective influence of interprofessional collaboration, leadership, and competency on secondary traumatic stress. *Traumatology*. https://doi.org/10.1037/trm0000244

Sullivan, A., Breslend, N., Strolin-Golzman, J., Brelawski-Branch, A., Jorgenson, J., Deaver, A., Forehand, G., & Forehand, R. (2019). Feasibility investigation: Leveraging smartphone technology in a trauma and behavior management-informed training for foster caregivers. *Children and Youth Services Review*, *101*, 363–371. https://doi.org/10.1016/j.childyouth.2019.03.051

Tullberg, E., Kerker, B., Muradwij, N., & Saxe, G. (2017). The Atlas Project: Integrating trauma-informed practice into child welfare and mental health settings. *Child Welfare*, *95*(6), 107–125.

Verbist, A., Antle, B. F., Winters, A. M., & Collins-Camargo, C. (2020). A review of treatment decision making models and factors in social work practice. *Families in Society*. https://doi.org/10.1177/1044389420921069

Winters, A. M., Collins-Camargo, C., Antle, B. F., & Verbist, A. N. (2020). Implementation of system-wide change in child welfare and behavioral health: The role of capacity, collaboration, and readiness for change. *Children and Youth Services Review, 108*. https://doi.org/10.1016/j.childyouth.2019.104580

Woodside-Jiron, H., Jorgenson. S., Strolin-Goltzman, J., & Jorgenson, J. (2019). "The glue that makes the glitter stick": Preliminary outcomes associated with a trauma-informed, resiliency-based, interprofessional graduate course for child welfare, mental health, and education, *Journal of Public Child Welfare*, *13*(3), 307–324. https://doi.org/10.1080/15548732.2019.1600630

**Grantee Developed Tools and Resources.** Links to a selected set of screening tools, guides, treatment protocols, and training resources are listed below.

Project Broadcast Trauma Screening Tool (Under Age 6)

Trauma and Behavior Health Screen (For child welfare caseworkers)

Trauma-Informed Mental Health Assessment Process - Guide

Youth PTSD Treatment (YPT): A cognitive behavioral therapy CBT) for post-traumatic stress disorder (PTSD) (For clinicians)

Things I Wished My Therapist Knew: A Child Welfare Training for Mental Health Therapists

Trauma Informed Parenting Skills (TIPS for Tuning In)

**Grantee Final Reports**. To access final reports and other resources produced under these funded grants, visit the CB Discretionary Grant Programs – Discretionary Grants Library.

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