Building Trauma-Informed Child Welfare Systems

July 2013
Introduction

This report was written in response to a request from Christine Norbut, Senior Director of Strategic Consulting for Casey Family Programs, in her work with the State of Wisconsin. As part of their Fostering Futures Blueprint, Wisconsin is seeking information on building trauma-informed child welfare systems. In particular, Wisconsin is looking for information on ways to operationalize trauma-informed care in locally-based systems, as well as examples of other jurisdictions that have made progress in operationalizing trauma-informed care.

This report summarizes of the state of the child welfare field in operationalizing trauma-informed care, and includes three sections: (1) Context and definition; (2) Prerequisites for successful implementation of trauma-informed care; and (3) Barriers to successful implementation. The report also includes the following appendicies: (A) Matrix summarizing national examples of trauma-informed care activities; (B) Additional technical assistance resources; and (C) List of acronyms. Jurisdictions included in the matrix do not necessarily represent the “best” trauma-informed child welfare jurisdictions, but instead have made progress towards operationalizing trauma-informed care and can serve as relevant examples for Wisconsin to draw upon.

Information in this report was gathered from a review of the peer-reviewed literature, online search of publicly available information about trauma-informed activities in jurisdictions, and conversations with experts in trauma-informed care.

1. Context and Definition

Children involved in the child welfare system have been, by definition, exposed to traumatic situations. In the course of their child welfare involvement, system-imposed stressors, such as removal from the home, can compound pre-existing stressors and re-traumatize children who already carry significant burdens. These two sources of stress can interact and amplify each other, whereby untreated stress reactions can lead to placement disruptions, which only intensify the problematic reactions and behaviors (Conradi et al., 2011). As child welfare systems better adapt to meet the needs of children’s trauma histories, new strategies can mitigate rather than exacerbate these traumas.

One definition of a Trauma-Informed Child Welfare System (TICWS) which has been advanced by the Chadwick Trauma-Informed Systems Project (CTISP),\(^1\) in conjunction with the National Child Traumatic Stress Network (NCTSN),\(^2\) has gained momentum:

> A trauma-informed child welfare system is one in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, families, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery (Wilson, 2013).

As Charles E. Wilson\(^3\) explains, key phrases within this definition deserve specific attention: (1) the definition focuses not only on child trauma victims, but also their caregivers and the child welfare workforce that seeks to help them, as these groups are also affected by primary and secondary traumatic experiences; and (2) the definition emphasizes that simply having

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\(^{1}\) For more information, see: [http://www.chadwickcenter.org/CTISP/ctisp.htm](http://www.chadwickcenter.org/CTISP/ctisp.htm)

\(^{2}\) For more information, see: [http://www.nctsn.org/](http://www.nctsn.org/)

\(^{3}\) Charles E. Wilson is the Executive Director at the Chadwick Center for Children and Families, Rady Children's Hospital San Diego
Knowledge about trauma is not sufficient, but asserts that systems must also make use of that knowledge and integrate it into everyday practice with children and families (Wilson, 2013).

Elaborating upon this definition, the NCTSN Child Welfare Committee articulated the “Essential Elements of a Trauma-Informed Child Welfare System,” including:

1. **Maximize Physical and Psychological Safety for the Child and Family**
   A trauma-informed system recognizes that psychological safety is important to the child’s long-term recovery, as social and emotional well-being has direct implications for physical safety and permanence. Psychological safety is a sense of safety or the ability to feel safe within one’s self, and to feel safe from external harm, which is critical for functioning as well as physical and emotional growth.

2. **Identify Trauma-Related Needs of Children and Families**
   Trauma screening helps identify potential triggers and creates a guide for direct trauma-informed case planning. Those who screen positive for trauma receive a thorough assessment by a trained mental health provider, which will guide subsequent intervention efforts.

3. **Enhancing Child Well-Being and Resiliency**
   A child’s recovery from trauma often requires the right treatment delivered by a skilled therapist who helps the child reduce overwhelming emotion related to the trauma, cope with trauma triggers, and make new meaning of their trauma history. But, to fully address the trauma, the child also needs the support of caring adults in their life. Case planning also focuses on helping children to build their relational capacity, in order to build supportive relationships that can last across the lifespan and enhance natural resilience.

4. **Enhancing Family Well-Being and Resiliency**
   Providing trauma-informed education and services to birth parents and resource parents enhances their protective capacities, thereby increasing the well-being, safety, permanency, and resiliency of the child.

5. **Enhancing Family Well-Being and Resiliency of Those Working in the System**
   Adding to the stressors of working within the child welfare system, many workers experience secondary traumatic stress reactions, which are physical and emotional stress responses to working with a highly traumatized population. A trauma-informed system acknowledges the impact of primary and secondary trauma on the workforce and develops organizational strategies to enhance their resilience.

6. **Partnering with Youth and Families**
   Providing youth and families with a voice and choices in their care plays a pivotal role in helping them to tap into their own resilience and reclaim the power that was taken away from them during the trauma.

7. **Partnering with System Agencies**
   No one agency can function alone, and in trauma-informed systems child welfare reaches out and coordinates with other systems so that they also view the child and family through a trauma lens, and work with them accordingly. Such coordination is necessary to prevent one part of the system undoing the helpful trauma-informed work of another part of the system (NCTSN Child Welfare Committee, as discussed in Wilson, 2013).

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2. Prerequisites for Successful TIC Implementation

According to the research literature and conversations conducted with experts in trauma-informed care\(^5\) numerous system features\(^6\) must be in place to achieve successful Trauma-Informed Care (TIC) implementation:

1. Development of Champions / Securing Buy-In from Leadership Down to Frontline Workers

A champion or group of champions committed to transforming the child welfare system into becoming trauma-informed can facilitate the necessary process of securing buy-in from agency leadership down to line workers (Henry et al., 2011; Conradi and Wilson conversation). By developing champions to energetically speak up for TIC, and giving them venues to communicate their priorities early and often within the process, they will have more opportunities to spread the word about TIC (Conradi and Wilson conversation). Champions are identified through their own interest and initiative to mobilize resources and bring together community members central to systems change (Henry et al., 2011). Local champions often surface from different professional positions and roles (Henry et al., 2011). For example, from the Southwest Michigan Children’s Trauma Assessment Centers (CTAC)\(^7\) nine-county demonstration project, champions included a Family Court Judge, Community Mental Health children's director, a special education consultant, a Department of Human Services (DHS) director, a DHS supervisor, and a juvenile justice probation officer (Henry et al., 2011).

Conradi and Wilson highlighted the importance of creating culture change towards an understanding of TIC. As a result, the messages that leadership sends throughout the agency (both intended and unintended) are critically important in supporting a change of culture. While the buy-in and expressed commitment to TIC from leadership is a basic pre-requisite to initiating implementation, the buy-in of middle managers and supervisors can be essential to sustaining the implementation process over time (Kramer et al., 2013; Conradi and Wilson conversation). Because frontline workers frequently turn over within child welfare, training supervisors and developing their buy-in can be a more efficient strategy than focusing entirely upon line workers. Without securing the buy-in of managers and supervisors, the vision of the leadership can get lost on the workers. In that way, managers and supervisors serve a type of translation function to communicate priorities and knowledge to line staff (Conradi and Wilson conversation).

2. Staff Development and Knowledge/ Skill-Building

Before TIC can be implemented, it must first be understood. Staff can benefit from various strategies for training at multiple levels and in numerous ways (Conradi et al., 2011). Conradi and Wilson discussed that one-time trainings are inadequate for full skill transfer of TIC content. Instead, they recommended that initial day-long trainings be followed up with successive trainings, and that material be integrated into daily casework through ongoing coaching and staff support. Additionally, Conradi and Wilson recommended including supervisors in trainings, and leveraging supervisors to reinforce and build TIC skills into everyday practice (Kramer et al., 2013).

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\(^{5}\) Lisa Conradi and Charles Wilson from the Chadwick Center for Children and Families, Rady Children’s Hospital San Diego

\(^{6}\) The below categories of prerequisites expand upon the framework of prerequisites for TICWS implementation at the local level developed by Henry and colleagues (2011).

\(^{7}\) The Southwest Michigan CTAC demonstration included nine predominantly rural, small population counties, with primarily Caucasian populations. These child welfare systems had relatively few players, often with just one family court judge within each community. The study authors suggested that the small, local systems facilitated an easier implementation process than would be experienced in larger systems, where commitment would be required from a greater number of key leaders within each agency. As a result, implementation in larger communities would likely require increased intensity of training and consultation, greater emphasis upon “resident experts,” and an extended time commitment given the greater number of players and agencies (Henry et al., 2011).
A comprehensive strategy for TIC staff development can be built upon existing curricula, including the Child Welfare Trauma Training Toolkit (CWT TT)\(^8\) (Conradi and Wilson conversation). The CWT TT curriculum is built around the “Essential Elements of a Child Welfare System” (above) and, in addition to teaching basic knowledge, skills, and values about working with children in child welfare, it teaches strategies for using trauma-informed child welfare practice to enhance the safety, permanency, and well-being of children and families who are involved in the child welfare system. Several states, including Oklahoma and Texas, are using the CWT TT to train all child welfare workers and supervisors on a statewide basis (Hendricks, 2013), and Kramer and colleagues (2013) documented how the CWT TT was customized and integrated into a statewide trauma-informed training program in Arkansas.

3. System Development and Readiness for Change

Another source of training and system development includes the Trauma-Informed Child Welfare Practice Toolkit (TICWPT),\(^9\) developed by CTISP, which was designed to assist individuals and systems in their efforts to create a more trauma-informed child welfare system. The TICWPT includes five documents that are designed to provide guidance, support, and practical suggestions that can be utilized across service systems:

   A tool for administrators across child welfare who are interested in making their systems more trauma-informed.

b. Desk Guide on Trauma-Informed Mental Health for Child Welfare\(^{11}\)
   Designed to assist child welfare workers and supervisors in understanding mental health services available in child welfare.

c. Desk Guide on Trauma-Informed Child Welfare for Child Mental Health Practitioners\(^{12}\)
   Designed to assist mental health professionals in increasing their knowledge of the policies, practices, and culture of the child welfare system.

d. Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model\(^{13}\)
   A resource for child welfare agencies as they strive to update or articulate their current practice model.

e. Trauma System Readiness Tool (TSRT)\(^{14}\)
   This self-report measure was designed for child welfare systems to use as they assess the trauma-informed nature of their own system. The TSRT was designed to be administered to multiple informants across all levels of the organization, including caseworkers, supervisors, managers, and administrators. It can be completed across regions within a state or county. Results from the TSRT provide cross-informant data to each system detailing how front-line case workers’ responses from the survey are similar or different from those of supervisors and administrators.

Tools to assess system readiness for the implementation of TIC can provide valuable information about strengths and gaps within the system, as well as provide useful information in

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\(^9\) For more information, see: [http://www.chadwickcenter.org/CTISP/images/TICWPracticeToolkit.pdf](http://www.chadwickcenter.org/CTISP/images/TICWPracticeToolkit.pdf)


\(^14\) Available at: [http://surveygizmolibrary.s3.amazonaws.com/library/113599/TraumaSystemReadinessTool2.pdf](http://surveygizmolibrary.s3.amazonaws.com/library/113599/TraumaSystemReadinessTool2.pdf)
developing a baseline. Also, see the Trauma-Informed System Change Instrument (TISCI),\(^{15}\) which can be used to determine the current state of trauma-informed practices and staff readiness for change (as used in Henry et al., 2011). Conradi and Wilson suggested that agencies must be ready for change to achieve successful implementation, and that those agencies that have successfully negotiated organizational change in the past, or those with histories of innovation, will be more likely to succeed in operationalizing TIC. Implementation can begin in those communities first, building momentum to expand into new territory from there.

One limitation of the CTAC demonstration was that due to limited funding, measurement of child outcomes was not conducted, and therefore they could not demonstrate results upon those outcomes. Agencies should consider developing measures and including other evaluation activities as a part of implementation plans (Henry et al., 2011). To develop implementation strategies and support broader implementation processes, Conradi and Wilson recommend utilizing the materials and technical assistance of the National Implementation Research Network (NIRN).\(^{16}\) Additionally, numerous new federal funding opportunities are currently available for developing trauma-informed systems in child welfare.\(^{17}\)

4. **Development of Processes for Trauma Screening and Assessment for Case Planning**

Trauma screening tools typically seek to evaluate the presence of two critical elements: (1) exposure to potentially traumatic events; and (2) signs of traumatic stress symptoms/ reactions (Conradi & Kisiel, 2013). As part of a needs assessment, screening results can be used to raise awareness around the prevalence of children who have been traumatized and its impact in their community (Henry et al., 2011). Additionally, screening results can help programs to secure funding from local foundations for the development of system components such as trauma assessment centers (Henry et al., 2011).

The initial assessment benefits from gathering comprehensive information from a variety of sources, including birthparents, foster parents, and youth (Conradi et al., 2011), as well as from assessing multiple domains of developmental functioning (mental health, biological health, functional/ occupational, and speech/ language) and trauma symptomology (Henry et al., 2011). Relevant instruments in trauma assessments include:

a. **Trauma Symptom Checklist for Children (TSCC)**\(^{18}\)
   
   The TSCC evaluates post-traumatic symptomatology in children and adolescents, including the effects of child abuse (sexual, physical, and psychological) and neglect, other interpersonal violence, witnessing trauma to others, major accidents, and disasters.

b. **Trauma Screening Checklist (TSC)**\(^{19}\)
   
   The TSC was developed as part of the Southwest Michigan CTAC demonstration to assess for traumatic experiences and symptoms of traumatic response (Henry et al., 2011).

c. **Court Report Checklist (CRC)**\(^{20}\)

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\(^{15}\) Available at: [http://muskie.usm.maine.edu/helpkids/telefiles/011013tele/Trauma_Informed_System_Change_Instrument_2010_final_1%5B1%5D.pdf](http://muskie.usm.maine.edu/helpkids/telefiles/011013tele/Trauma_Informed_System_Change_Instrument_2010_final_1%5B1%5D.pdf)

\(^{16}\) For more information, see: [http://nirn.fpg.unc.edu/](http://nirn.fpg.unc.edu/)

\(^{17}\) For more information on new federal funding opportunities for developing trauma-informed child welfare systems, see: Casey Family Programs (2013). Funding for Trauma-Informed Care: Integrating screening and assessment practices into the routine provision of health care for foster children. *Casey Practice Digest*, 4, 14-16.

\(^{18}\) For more information, see: [http://www.johnbriere.com/tsc.htm](http://www.johnbriere.com/tsc.htm)


The CRC was created in response to a family court judge’s request for information on child trauma history, the impact of trauma on child functioning, and trauma-informed services available (Henry et al., 2011).

d. Trauma-Informed Therapist Report (TITR) (unpublished)

The TITR was developed as a method for therapists to inform caseworkers and the family court of progress in trauma-informed assessment and treatment (Henry et al., 2011).

For a review of trauma tools, see: Child and Adolescent Trauma Measures: A Review, which presents information on 35 instruments that assess exposure to trauma, symptoms of traumatic experiences, symptoms of PTSD, and multiple trauma symptoms. Also, see NCTSN’s Measures Review Database, which provides reviews of tools that measure children’s experiences of trauma, their reactions to it, and other mental health and trauma-related issues.

5. Development of Community Capacity / Cross-System Coordination and Collaboration

Once children are effectively identified and assessed for trauma, comprehensive treatment options must be available from skilled mental health providers in the community (Conradi et al., 2011). As a result, developing resources for provision of evidence-based trauma treatment and creating a cadre of therapists is an important planning goal for communities (Henry et al., 2011). Henry and colleagues detail CTAC’s training regimen:

In Year 1 of the grant, 29 clinicians from three county systems were trained in TF-CBT and/or Real Life Heroes, using a learning collaborative methodology. There was two-day training with a year-long consultation protocol including monthly phone consultation and quarterly in-person consultations…. In each community, additional training for clinicians and school social workers was provided to introduce phase-based and trauma-informed interventions appropriate in their setting (Henry et al., 2011, P. 177-178).

Conradi and Wilson emphasized the importance of developing broader understanding and using a shared language of TIC across service agencies and providers. To develop this understanding across agencies and roles, they recommend using the CWTIT. To respond to the need for shared language in CTAC, a series of trainings on specific topics and ongoing consultation were developed, including specific trauma trainings that were provided to courts, schools, DHS, CMH, medical personnel, and caregivers to infuse trauma into agency and interagency discussion of children (Henry et al., 2011). Conradi and Wilson recommend that mental health providers receive the same amount of training on TIC as child welfare workers, which can be challenging to achieve, yet can also be critical to changing the care that children and families receive. While the process of training judges on TIC was most challenging, once they are brought into the process they can become powerful champions, particularly among other judges (Conradi and Wilson conversation).

An early (2005) NCTSN report attempted to determine how various service systems communicate with each other about trauma and whether (alone or through interaction) they retraumatize children or promote healing following a traumatic event. Their study sought to identify gaps in communication among agencies and systems and to develop training materials to

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22 For more information, see: http://www.nctsn.org/resources/online-research/measures-review
improve collaboration around child trauma. Among the findings, the study found that regardless of the agency, respondents seldom received in-depth information about a child’s trauma history, most agencies did not conduct trauma assessments, and many respondents did not offer nor receive trainings related to trauma.

3. Barriers to Successful Implementation

In the course of implementing TIC, the research literature described numerous barriers to successful implementation. These barriers are organized below into the same categories used for the above section: “Prerequisites for Successful Implementation.” Also included below are strategies described in the research literature for overcoming some of these barriers.

1. Development of Champions / Securing Buy-In from Leadership Down to Frontline Workers

Barriers:
- Difficulty in changing traditional paradigms from event-focused only to simultaneously considering the traumatic impact upon children (Henry et al., 2011).
- Difficulty in obtaining high participation rates in training initiatives and buy-in from child welfare staff (Kramer et al., 2013).

Strategies:
- Utilize champions’ abilities to motivate and infuse energy into leadership and participants to achieve buy-in (Conradi et al., 2011).
- When initiatives are undertaken at the request of leadership, leadership can serve as key champions to leverage change (Kramer et al., 2013).
- Identify and map TI practices onto child welfare system priorities, as trauma will inevitably intersect with them in some way (Conradi et al., 2011).
- Actively partner with families and youth throughout the process, as they provide a critical perspective and have creative ideas for improving the system (Conradi et al., 2011).

2. Staff Development and Knowledge/ Skill-Building

Barriers:
- Lack of sustained consultation to child welfare workers, school staff, court personnel, and providers (Henry et al., 2011).

Strategies:
- Ensure that consultation is more intense (frequent) and accessible at the local (agency) level, and offered to all providers and agency staff who handle cases (Hendricks et al., 2011; Henry et al., 2011).
- Agencies need to hire “resident trauma experts,” located at the local-level, in order to provide in-house (Trauma-Informed) TI consultation to adequately operationalize TI casework (Henry et al., 2011).
- Securing leadership-level buy-in to the prioritization of supervisor-level training resulted in the decision to mandate attendance, which was critical to high levels of supervisor participation (Kramer et al., 2013).

3. System Development and Readiness for Change

Barriers:
- High rates of child welfare worker turnover (Henry et al., 2011).
- Heavy child welfare caseloads (Kramer et al., 2013).

• Difficulty managing the effects of secondary trauma/burnout amongst child welfare staff (Conradi & Kisiel, 2013; Hendricks et al., 2011; Henry et al., 2011).
• Lack of time to administer assessment tools (Conradi & Kisiel, 2013).
• “Initiative fatigue” (Conradi and Wilson conversation).
• Logistics and cost of a statewide implementation/lack of funding to fully support programs (Hendricks et al., 2011; Kramer et al., 2013).

**Strategies:**

• Increase staff support and interventions to address secondary traumatic stress (Hendricks et al., 2011).
• Redesigning training so that it begins with discussion and strategies for addressing secondary trauma, rather than starting with new trauma-informed practices. In CTAC, this change increased staff consideration and responsiveness for how trauma could be infused into their practices (Henry et al., 2011).
• Instead of adding onto initiative fatigue, weave new activities into existing protocols and initiatives. For example, San Diego County found creative ways to integrate a TI lens into Signs of Safety protocols (Conradi and Wilson conversation).
• Replace existing practices rather than add on new practices (Conradi et al., 2011).
• Statewide implementation should be paid for with sufficient state-level funding, to support a team to conduct trainings, etc. (Kramer et al., 2013).

4. **Development of Processes for Trauma Screening and Assessment for Case Planning**

**Barriers:**

• Lack of training on administration of screening tools (Conradi & Kisiel, 2013).
• Lack of training to effectively use assessment information for case planning (Conradi & Kisiel, 2013).

**Strategies:**

• Integrate some trauma assessment questions into existing assessment protocols (Conradi & Kisiel, 2013).
• Implement structured screening tools/processes at each site to assist workers in making appropriate referrals (Hendricks et al., 2011)

5. **Development of Community Capacity / Cross-System Coordination and Collaboration**

**Barriers:**

• Inconsistent access to trauma-focused mental health treatment (Hendricks et al., 2011)
• Integration of a TI framework into multiple agencies can be slow, limited, and continuously challenging—the result of different mandates in different systems (Henry et al., 2011).
• The lack of “real” collaboration inhibits the potential integration of trauma into system planning, service provision, and decision-making (Henry et al., 2011).

**Strategies:**

• Implementation of a robust training regimen, including cross-training of staff from different agencies (See the CTAC training example above) (Henry et al., 2011).
• Create opportunities for building relationships and developing broader understanding of TI, such as using a shared language across service agencies and providers, and relying upon existing curricula such as the CWTIT (Conradi and Wilson conversation; Hendricks et al., 2011; Henry et al., 2011).
Appendix A: Matrix Summarizing National Examples of Trauma-Informed Care Activities

Lisa Conradi and Charles Wilson explained that no jurisdiction has comprehensively implemented a complete TICWS; many are advancing, yet none have fully arrived. Within jurisdictions, there are pockets of excellence and innovation, but jurisdictions are still working on the spread of these practices.

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<td>Arkansas</td>
<td>In 2012, Kramer, Sigal and colleagues evaluated initial stages of a statewide trauma-informed training program for Arkansas DCFS supervisors, which demonstrated significant improvements in participants' knowledge of trauma. Implementation of TI practices also increased significantly. Researchers attribute success to high participation and top leadership buy-in (For more information on AR's statewide training initiative, see Kramer (2013) in references section below). They also acknowledge the importance of training supervisors prior to training frontline workers.</td>
<td>Benjamin Sigel, Psychiatric Research Institute, University of Arkansas Medical Sciences Phone: (501) 364-1592 Email: <a href="mailto:basigel@uams.edu">basigel@uams.edu</a></td>
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<td>Recently, the Arkansas Network for Early Stress and Trauma (NEST) received a four-year grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to provide evidenced-based services for children exposed to trauma. NEST is a collaborative effort between University of Arkansas Medical Sciences (UAMS), Mid-South Health Systems of Jonesboro, and the Ozark Guidance Center.</td>
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<td>California (LA County and San Diego County)</td>
<td>In 2010, both LA County and San Diego County became part of the TICWP Breakthrough Series Collaborative (BSC) funded by NCTSN and SAMHSA to use trauma-informed practices to improve foster care placement stability (For more information on the TICWP BSC, see Conradi et al. (2011) in references section below). Practice teams tested screening tools and ways of connecting birth and foster parents, provided TI psycho-education to caregivers, and developed TI trainings for child welfare staff. Each of the TICWP BSC teams is comprised of a public child welfare agency and a mental health organization providing evidence-based, trauma-focused treatment in the community. Teams include administrators, managers, supervisors, frontline workers, and therapists from both the child welfare and mental health systems, as well as birth parents, foster parents, and alumni of care. California offers two major trauma clinics—one at UCLA and one at the Chadwick Center of Rady Children's Hospital in San Diego.</td>
<td>Charles Wilson, Executive Director, Chadwick Center Phone: (858) 966-5814 Email: <a href="mailto:cwilson@rchsd.org">cwilson@rchsd.org</a></td>
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<td>In 2012, San Diego County became one of three national laboratory sites for the implementation of the Chadwick Trauma-Informed Systems Project (CTISP), which was established to: provide leadership in identifying effective treatments and developing specialized service delivery models to children in the public child welfare system; to</td>
<td>Lisa Conradi, Project Director of CTISP Email: <a href="mailto:lconradi@rhsd.org">lconradi@rhsd.org</a></td>
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<td>Debra Zanders-Willis, Director, Child Welfare Services, San Diego County Email: <a href="mailto:debra.zanders-willis@sdcounty.org">debra.zanders-willis@sdcounty.org</a></td>
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Connecticut | Drawing upon a learning collaborative model to build TIC, the Connecticut DCF used the CWTTT for training, and implemented Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). DCF also recently identified TIC as one of the Department’s five guiding principles. In 2011, DCF was awarded a 5-year federal Administration on Children, Youth, and Families (ACYF) discretionary grant to improve services to children and youth with complex trauma called the Connecticut Collaborative on Effective Practices for Trauma (CONCEPT). The project seeks to create a more trauma-informed workforce and institutionalize universal trauma screening, assessment, and referrals for trauma-focused services, as well as increase collaboration with community service providers. CONCEPT is implementing TF-CBT and the Child and Family Traumatic Stress Intervention (CFTSI) in DCF facilities and community provider agencies. Additionally, the project is focusing on infrastructure development and the modification of policies to support screening, assessment, and referrals. Proposed in April 2013 and supported by the Governor, the “Three Branch Institute on Child Social and Emotional Well-Being” is a statewide effort to coordinate TIC across systems. A six member team will develop and implement a plan of action for improving well-being outcomes of children in foster care. Members of the executive branch, legislative branch, and the judiciary branch comprise the team, which is led by Joette Katz, DCF Commissioner. | Jason Lang, leading the ACYF grant project in CT Email: jalang@uchc.edu Bob Franks, Trauma Focused Learning Collaboratives Email: rfranks@uchc.edu Joette Katz, Commissioner Connecticut DCF Phone: (860) 550-6300 Email: Jk.dcf@ct.gov
Massachusetts | Massachusetts was one of the TICWP Breakthrough Series Collaborative sites funded by SAMSHA and NCTSN in 2010 to develop child trauma informed child welfare practices to increase foster care placement stability (For more information on MA’s BSC experience, see Barto (2013), and Conradi (2011) in references section below). In 2011, the Massachusetts DCF was awarded a 5-year ACYF discretionary grant to improve services to children and youth with complex trauma. In addition to the MA Child Trauma Project, NCTSN has a number of members/projects in Massachusetts including: the Trauma Center at Justice Resource Center which has collaborated to develop the New England Trauma Services Network, the Latino Child Trauma Stress Initiative, and | Beth Barto, day to day Manager on Massachusetts ACYF grant project Email: BBarto@luk.org Suzanne Hannigan, Project Director, MA System of Care Expansion Email:
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| **Project BRIGHT.** | The University of Massachusetts Medical School Child Trauma Training Center (CTTC) is being developed by the Department of Psychiatry to improve identification of trauma, to increase trauma-sensitive care, and to increase access to evidence-based, trauma-focused treatment for at-risk and underserved children and youth aged 6–18 in central and western Massachusetts—including court-involved youth and youth in military families. During the grant period CTTC anticipates: 1) training 1,800 child-serving professionals in trauma-sensitive care; 2) reaching approximately 20,000 children/youth with trauma-informed services; and 3) providing TF-CBT to 900 children/youth. | suzanne.hannigan@state.ma.us  
Phone: (508) 616 2531  
Jessica Griffin, Director of Department of Psychiatry, UMass  
Phone: 508-856-8829  
Email: jessica.griffin@umassmed.edu |
| **Michigan** | Building on the work of an existing NCTSN site, the Southwest Michigan Child Trauma Assessment Centers (CTAC) initiative, now in its third year and currently operating in nine counties, has partnered with key local leadership within the Department of Human Services, community mental health, family court, and intermediate school districts to create a trauma-informed child welfare system (For more information on the CTAC demonstration, see Henry et al. (2011) in references section below). Several new trauma-informed instruments were developed by CTAC, including a validated Trauma-Informed Organizational Survey, Trauma-Informed Court Report, and Trauma-Informed Therapist Report. Beginning in 2012, the Detroit Trauma-Informed Project (D-TIP) at CTAC is supporting further development of a collaborative continuum of trauma-informed services in Detroit. Working with traumatized urban youth and their families within the child welfare and juvenile justice systems, the project seeks to increase child and familial resiliency by identifying and addressing trauma from a multisystem perspective. | Jim Henry, Director of Southwest Michigan CTAC, Western Michigan University, Lead on Michigan's work and consultant on Trauma-Informed Child Welfare,  
Email: james.henry@wmich.edu |
| **New Hampshire** | New Hampshire was one of the TICWP Breakthrough Series Collaborative (BSC) sites funded by SAMSHA and NCTSN in 2010 to develop TI child welfare practices to increase foster care placement stability (For more information on the TICWP BSC, see Conradi et al. (2011) in references section below). Building on this collaborative, New Hampshire was also one of three national laboratory sites for implementation of the Chadwick Trauma-Informed Systems Project (CTISP), seeking to test trauma treatments and develop specialized service delivery models to serve victims involved with the public child welfare system. | Kay Jankowski, Dartmouth Trauma Interventions Center  
Leading the ACYF grant project in New Hampshire,  
Phone: (603) 653-0738  
Email: kaj.jankowski@dartmouth.edu |
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<th>Jurisdiction</th>
<th>Project Description</th>
<th>Contact</th>
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</table>
| New Hampshire | New Hampshire initiated the Bridge Project to integrate trauma treatment services across several state systems that serve New Hampshire youth and families who have been exposed to abuse, neglect, violence, or trauma. The Bridge Project targets 3 care systems of key importance to abused and at risk children:  
  • Child protective services (NH Division for Children, Youth & Families (DCYF))  
  • Juvenile justice (also part of NH Division for Children, Youth & Families)  
  • Judicial branch (NH Family Court Division).  
  New Hampshire was awarded a 5 year grant from ACYF (Oct. 2012 – Sept. 2017), seeking to: implement screening and assessment for children and youth; integrate data into case planning and review processes; institute psychotropic medication monitoring and clinical guidelines to increase safe prescribing practices; increase access to evidence-based treatments to meet the mental health needs of DCYF involved children and families; and identify and de-scale services that are found not to be effective. | Lisa Conradi, Project Director of CTISP in NH Email: lconradi@rhsd.org |
| North Carolina | North Carolina was one of the TICWP Breakthrough Series Collaborative (BSC) sites funded by SAMSHA and NCTSN in 2010 to develop TI child welfare practices to increase foster care placement stability (For more information on the TICWP BSC, see Conradi et al. (2011) in references section below). North Carolina DSS has worked with the North Carolina Child Treatment Center to train clinicians in 100 counties on TF-CBT and offer this as a treatment option.  
  In 2011 North Carolina was awarded a 5-year ACYF discretionary grant to improve services to children and youth with complex trauma through Project Broadcast, which serves young children (ages 0 to 5) and youth (ages 13 to 18) disproportionately represented in child welfare. Project Broadcast seeks to provide training, support, and infrastructure to mental health professionals, and project goals include: coordinate system-level changes across the system of care in the nine demonstration counties; develop TI child welfare workforces and systems across the nine counties; increase local capacity and access to trauma-specific evidence-based mental health treatments; and develop a plan to incorporate these practices statewide. | Jeanne Preisler, Project Broadcast, day to day Manager of North Carolina’s ACYF grant, Email: Jeanne.Preisler@dhhs.nc.gov |
| Oklahoma | Oklahoma was one of the TICWP Breakthrough Series Collaborative (BSC) sites funded by SAMSHA and NCTSN in 2010 to develop TI child welfare practices to increase foster care placement stability (For more information on the TICWP BSC, see Conradi et al. | Annette Burleigh, Leading TIC efforts in OK Email: |
Through its BSC involvement, Oklahoma became one of three national laboratory sites for the implementation of the Chadwick Trauma-Informed Systems Project (CTISP), which seeks to: enhance system-wide capacity to become trauma informed and trauma focused; build resilience of children and reduce repeat exposures to identified traumas; partner with Mental Health providers to support birth parents toward trauma recovery; and support staff and resource families with identifying and addressing secondary trauma effects.

Appendix B: Additional Technical Assistance Resources
The following sources of TA were identified by Lisa Conradi and Charles Wilson as potential sources of TA for Wisconsin's Fostering Futures Blueprint efforts.

<table>
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<tr>
<th>Resource</th>
<th>Description of TA they can provide</th>
<th>Contact Information</th>
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</table>
| National Center for Child Traumatic Stress (NCTSN) | NCTSN is currently seeking to identify communities that are interested in putting TIC into practice, and will provide TA, in exchange for program data. | NCCTS — University of California, Los Angeles  
Phone: (310) 235-2633  
For email requests, use the contact form: [http://www.nctsn.org/contact](http://www.nctsn.org/contact)  
Website: [http://www.nctsn.org/](http://www.nctsn.org/) |
| Ambit Network, University of Minnesota       | Ambit Network's aim is to make high quality care more accessible for traumatized children and families. Ambit is a leader in helping communities use research-based prevention and intervention techniques to increase children's ability to deal with trauma. In order to achieve these goals, Ambit partners with a variety of nonprofit, government, and community agencies to help them improve the care they offer to traumatized youth and families. | University of Minnesota  
Phone: 612-625-1900  
Email: fsosinfo@umn.edu  
Website: [http://www.cehd.umn.edu/fsos/projects/ambit/default.asp](http://www.cehd.umn.edu/fsos/projects/ambit/default.asp) |
| Eugene Griffin at Northwestern University     | Dr. Griffin has worked extensively with TIC, particularly TIC assessment processes. | Northwestern University  
Phone: 312-503-1375  
Email: e- |
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<tr>
<th>Resource</th>
<th>Description of TA they can provide</th>
<th>Contact Information</th>
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<td>National Implementation Research Network (NIRN)</td>
<td>The mission of NIRN is to contribute to the best practices and science of implementation, organization change, and system reinvention to improve outcomes across the spectrum of human services. Goals include: to advance the science of implementation across human service domains; and to inform policies that promote implementation science and best practices in human services.</td>
<td><a href="mailto:griffin@northwestern.edu">griffin@northwestern.edu</a> Website: <a href="http://psychiatry.northwestern.edu/faculty_member/eugene-griffin/">http://psychiatry.northwestern.edu/faculty_member/eugene-griffin/</a></td>
</tr>
<tr>
<td>University of North Carolina Email: <a href="mailto:nirn@unc.edu">nirn@unc.edu</a> Website: <a href="http://nirn.fpg.unc.edu/">http://nirn.fpg.unc.edu/</a></td>
<td></td>
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</tbody>
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**Appendix C: List of Acronyms**

| The federal Administration on Children, Youth, and Families | ACYF |
| Breakthrough Series Collaborative | BSC |
| Chadwick Trauma-Informed Systems Project | CTISP |
| Child Welfare Trauma Training Toolkit | CWTTT |
| Court Report Checklist | CRC |
| Michigan Department of Human Services | DHS |
| National Child Traumatic Stress Network | NCTSN |
| National Implementation Research Network | NIRN |
| Southwest Michigan Children’s Trauma Assessment Centers | CTAC |
| The federal Substance Abuse and Mental Health Services Administration | SAMHSA |
| Trauma-Focused Cognitive Behavioral Therapy | TF-CBT |
| Trauma-Informed | TI |
| Trauma-Informed Care | TIC |
| Trauma-Informed Child Welfare Practice | TICWP |
| Trauma-Informed Child Welfare Practice Toolkit | TICWPT |
| Trauma-Informed Child Welfare System | TICWS |
| Trauma-Informed System Change Instrument | TISCI |
| Trauma-Informed Therapist Report | TITR |
| Trauma Screening Checklist | TSC |
| Trauma Symptom Checklist for Children | TSCC |
| Trauma System Readiness Tool | TSRT |
References


Casey Family Programs (2013). Funding for Trauma-Informed Care: Integrating screening and assessment practices into the routine provision of health care for foster children. *Casey Practice Digest*, 4, 14-16.


