Improving Access to Evidence-Based Trauma Focused Treatment for Children in the Child Welfare System

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CT Department of Children and Families

26th Annual Children’s Mental Health Research and Policy Conference  
March 3 - 6, 2013
ACF Grant (2011)

- $3.2 million, 5 year grant awarded to improve trauma-focused care for children in the child welfare system

- Workforce development (trauma-informed care)

- Universal trauma screening & linkages to assessment/EBTs
  - Screening: by DCF staff
  - Assessment & Treatment: by Community Providers

- Installation of trauma-focused EBTs in community providers
  - Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
  - Child & Family Traumatic Stress Intervention (CFTSI)

- System Assessment & Planning Year

Funding for the Connecticut Collaborative on Effective Practices for Trauma (CONCEPT) was provided by the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #0169
Overview

- Statewide Trauma Focused Cognitive Behavioral Therapy (TF-CBT) Dissemination
- Readiness & capacity assessment of trauma-informed care
- Trauma screening in child welfare
Connecticut

- History of in-home evidence-based practices
- Growing awareness about child traumatic stress
- Desire among key stakeholders to create a trauma-informed system of care
- Desire to implement evidence-based practices in outpatient community-based settings
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

- Developed by Cohen, Mannarino, & Deblinger
- Evidence-Based Treatment: 8+ studies
- Manualized & flexible

Target population
- Children/adolescents 3-18 suffering from traumatic stress
- Goals: Improve child (& parent) symptoms by helping them manage powerful emotions related to traumatic event(s)

Caregiver involvement in treatment

Greater improvements in:
- Child PTSD, depression, anxiety, shame, behavior problems
- Parent distress, support, parenting practices, depression
The Challenge

How do you bring an effective treatment from the research setting to a diverse, statewide system of care?
I'm back from training.

I got a big binder.

The training is already forgotten, but the binder will last forever.

A living monument to temporary knowledge!
The Learning Collaborative

- The Learning Collaborative approach is an **implementation and quality improvement model**
- Based on the Breakthrough Series Collaborative developed by the Institute for Healthcare Improvement (IHI)
- Diverse implementation teams from each agency
- Intensive training/consultation process (9-12 months)
- Use of data & implementation science
# Typical Traditional Training vs. Learning Collaborative

<table>
<thead>
<tr>
<th></th>
<th>Typical Traditional Training</th>
<th>Learning Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration</strong></td>
<td>1, 2, 3 days</td>
<td>12-18 months</td>
</tr>
<tr>
<td><strong>#Trainings</strong></td>
<td>Usually one</td>
<td>3-4 over the year</td>
</tr>
<tr>
<td><strong>Who?</strong></td>
<td>A few staff from many places</td>
<td>Teams from 5-6 sites</td>
</tr>
<tr>
<td><strong>Clinicians</strong></td>
<td>Clinicians</td>
<td>Clinicians, supervisors, sr. leaders, parents, others</td>
</tr>
<tr>
<td><strong>Tracks for dif. Roles</strong></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td>Nothing or a few phone calls</td>
<td>Regular calls, intranet &amp; weekly TA</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>Didactic</td>
<td>Interactive/adult-learning</td>
</tr>
<tr>
<td><strong>Data</strong></td>
<td>None or limited</td>
<td>Used at all levels; metrics</td>
</tr>
<tr>
<td><strong>Quality Improvement</strong></td>
<td>Rarely</td>
<td>Model for Improvement</td>
</tr>
<tr>
<td><strong>Motto</strong></td>
<td>“The training is already forgotten,</td>
<td>“Sharing relentlessly and</td>
</tr>
<tr>
<td></td>
<td>”</td>
<td></td>
</tr>
</tbody>
</table>

Note: Regular calls, intranet & weekly TA and Model for Improvement indicate regular check-ins, support, and ongoing evaluation to ensure continuous improvement and success.
CT TF-CBT Learning Collaborative

• Three Learning Collaboratives (one year each)

• 16 community agencies trained

• **Goals:**
  
  • **Increase availability** of trauma focused EBT
  
  • **Embed TF-CBT teams** within each agency
  
  • Build a **sustainable network** of TF-CBT providers
Data

• **Monthly implementation data** collected from each clinician through online surveys ("Metrics")

• **Child outcome data** collected for clinical purposes by each clinician, and entered in online scoring system
  - Trauma History Screen (trauma history)
  - UCLA PTSD-RI (PTSD sxs)
  - Short Mood & Feelings Questionnaire (depression sxs)
  - Completed every 3 months during treatment

• Primary use of data was for quality improvement
Resistance to Data & Standardized Assessments

- CT Setting: community mental health centers
- Therapists had little or no experience with data
- Anxiety about data
- Perception that data will not be useful for their practice
- Perception that data will be a burden
- “Data is just for research”
- Lack of time
- Data historically goes into a “Black Hole” or has been a one-way process
Strategies to Promote Data Use

- Require minimal data use
- Keep it simple
- Comprehensive training/practice early
- Site-based data person/coordinator
- Make it useful for staff
- Data should be incorporated into everything
  - Case discussion
  - Consultation with agency
  - Training on clinical skills
- Make it sustainable (cost, time, utility)
## Monthly Metric Form

10. Please choose the response that best describes your skill and understanding in implementing each of the specified components of TF-CBT this month.

<table>
<thead>
<tr>
<th></th>
<th>Did not use</th>
<th>Minimal</th>
<th>Minimal to Moderate</th>
<th>Moderate</th>
<th>Moderate to Advanced</th>
<th>Advanced</th>
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<td>📍</td>
</tr>
<tr>
<td>Parenting Skills</td>
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<td>📍</td>
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<td>Relaxation</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
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<tr>
<td>Affective Expression &amp; Regulation</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
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<tr>
<td>Cognitive Coping &amp; Processing</td>
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<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
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<tr>
<td>Trauma Narrative</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
</tr>
<tr>
<td>In Vivo Exposure</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
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<tr>
<td>Conjoint Parent-Child Treatment</td>
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<td>📍</td>
<td>📍</td>
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<tr>
<td>Enhanced Safety Skills</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
</tr>
<tr>
<td>Using standardized measures for assessment &amp; measuring progress</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
<td>📍</td>
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<tr>
<td>Sharing results of assessment measures with child/caregiver</td>
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<td>📍</td>
<td>📍</td>
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## Monthly Metric Report

### Comfort/Skill with TF-CBT Components - All Sites

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<th>Skill/Comfort</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
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<td>2.8</td>
<td>3.2</td>
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<td>3.7</td>
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<td>3.9</td>
<td>3.9</td>
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<td>Parenting Skills</td>
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<td>2.3</td>
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<td>4.0</td>
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<tr>
<td>Relaxation</td>
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<td>3.6</td>
<td>3.8</td>
<td>3.8</td>
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<tr>
<td>Affective Expression</td>
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<td>3.3</td>
<td>3.3</td>
<td>3.4</td>
<td>3.7</td>
<td>3.7</td>
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<tr>
<td>Cognitive Coping</td>
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<td>1.2</td>
<td>1.8</td>
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<td>2.9</td>
<td>3.3</td>
<td>3.5</td>
<td>3.5</td>
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<tr>
<td>Trauma Narrative</td>
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<td>0.5</td>
<td>0.9</td>
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<td>2.5</td>
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<td>3.2</td>
<td>3.2</td>
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<tr>
<td>In Vivo Exposure</td>
<td>0.7</td>
<td>0.4</td>
<td>0.9</td>
<td>2.3</td>
<td>2.6</td>
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<td>Conjoint Sessions</td>
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<td>Enhancing Safety</td>
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<td>Using measures</td>
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<td>2.8</td>
<td>2.1</td>
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<td>3.3</td>
<td>3.5</td>
<td>3.6</td>
<td>3.6</td>
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<td></td>
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<td>Sharing data</td>
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Web-Based Assessment Scoring

**Assessment Summary**

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<tr>
<th>Enter Client ID Number:</th>
<th>86661</th>
<th>Gender:</th>
<th>F</th>
<th>Age:</th>
<th>15</th>
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<tbody>
<tr>
<td>(At Baseline)</td>
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**UCLA PTSD-RI Raw Scores - Child Report**

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<thead>
<tr>
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<tbody>
<tr>
<td>Overall Severity</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Re-Experiencing</td>
<td>53</td>
<td>40</td>
<td>19</td>
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<tr>
<td>Avoidance</td>
<td>20</td>
<td>18</td>
<td>12</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Arousal</td>
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<td>7</td>
<td>3</td>
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<td>NA</td>
<td>NA</td>
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<td>SMFQ Total Scores - Child Report</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>12</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Completed?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>NA</td>
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<tr>
<td>Total Score</td>
<td>16</td>
<td>11</td>
<td>0</td>
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</table>

**UCLA PTSD-RI Raw Scores - Caregiver Report**

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Severity</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Re-Experiencing</td>
<td>54</td>
<td>44</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Avoidance</td>
<td>18</td>
<td>17</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Arousal</td>
<td>19</td>
<td>14</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>SMFQ Total Scores - Caregiver Report</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>16</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Completed?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Total Score</td>
<td>16</td>
<td>11</td>
<td>0</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
Staff trained

<table>
<thead>
<tr>
<th>Role</th>
<th>Trained in LC</th>
<th>Trained after LC</th>
<th>Active as of Feb. 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician</td>
<td>78</td>
<td>360</td>
<td>181</td>
</tr>
<tr>
<td>Supervisor</td>
<td>33</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Sr. Leader</td>
<td>24</td>
<td>6</td>
<td>29</td>
</tr>
</tbody>
</table>

- Staff turnover a universal concern
  - Median LOS on team is about 1 year
- Additional staff trained after LC through 2 day trainings
- Many clinicians who leave take jobs at other clinical settings
Clinicians’ Attitudes about EBTs Improved

- Evidence-based Practice Attitude Scale (EBPAS)*
- N=80 (clinicians & supervisors)
- Pre- and Post- training year

Results:
- Use of EBPs if required: $ns$
- Appeal of EBPs: $p = .003$
- Openness to EBPs: $p = .017$
- Divergence to clinical practice $ns$
- Total Score: $p = .005$

*Aarons, 2004*
Children served

- 2,369 children began TF-CBT as of September 2012

- Disposition for closed cases as of September 2012
  - 38% completed TF-CBT successfully
  - 41% received partial treatment
  - 6% transferred to higher LOC
  - 14% Unknown/other
Demographics

- Average age = 11.5 years old (range from 3 – 21)
- 60% female

Living situation:
- 65% with one or both biological parents
- 19% in a foster or adoptive home
- 17% in other settings/unknown

- 14% African American; 27% Latino; 46% Caucasian
- 32% have DCF involvement (mostly protective/committed)

- Most common “worst” traumatic events were sexual abuse, physical abuse/injury, death of a loved one, and separation from caregiver

- Children report mean of 7.8 different types of trauma exposure
<table>
<thead>
<tr>
<th>Role</th>
<th>Completers N=532</th>
<th>Noncompleters N=545</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>11.2</td>
<td>12.0</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Family Income (likert scale)</td>
<td>3.2</td>
<td>2.9</td>
<td>.019</td>
</tr>
<tr>
<td>PTSD Symptoms (UCLA PTSD-RI)</td>
<td>31.0</td>
<td>30.2</td>
<td>.320</td>
</tr>
<tr>
<td>Depression Symptoms (SMFQ)</td>
<td>8.6</td>
<td>9.5</td>
<td>.040</td>
</tr>
<tr>
<td># of Trauma Exposures</td>
<td>7.7</td>
<td>7.9</td>
<td>.271</td>
</tr>
</tbody>
</table>
TF-CBT Completers

- N=391 had pre-post assessments
- Completed cases average 23 sessions
- Parent/caregiver involvement for 93% of completers
Outcomes (N=391)

- Remission of likely PTSD diagnosis in 82% of children with likely PTSD diagnosis at baseline who completed treatment (based on UCLA PTSD-RI Severity)
Additional Benefits Observed

- Reduced no-show rate
- Increased staff morale
- Shorter length of stay in treatment
- Improved staff attitudes about EBTs
Sustaining TF-CBT

- DCF has provided ongoing support to sustain and expand TF-CBT

**Training**
- TF-CBT Two-day training for new staff
- Annual statewide conference
- Consultation calls/webinars with TF-CBT trainer

**Data Reporting**
- Statewide roster of trained staff
- Monthly QA data ("metrics")
- Assessment measure scoring/reporting

**Quality Improvement**
- Part-time statewide coordinator
- Site-based consultation with TF-CBT teams
- Quarterly performance plans
- Performance incentives
- Senior Leader meetings
Sustainment

- All agencies continue to provide TF-CBT
- All agencies continue to collect/report data
- All agencies use assessment measures
- Senior Leaders continue to meet
- Growth of TF-CBT teams despite turnover
- Variability in capacity/sustainability at agencies
Challenges

- Extra cost/time to utilize EBTs
- Challenges of using EBTs in community clinics
- Building & maintaining supervision capacity
- Staff turnover
- Measuring fidelity
- Cost/availability of ongoing training
Recommendations

- Learning collaborative model has been highly successful in disseminating TF-CBT across the state
- Agencies need ongoing training, quality assurance and support to sustain evidence-based models
- Centralizing and standardizing QA is cost-effective as EBTs scale up
- Use of data to drive clinical decision making and monitor outcomes should be utilized system-wide
- Systematic use of outcome and metric data can be applied to other behavioral health programs and services
Acknowledgements

- Bob Franks (CHDI)
- Bert Plant (DCF)
- Marilyn Cloud (DCF)
- Carrie Epstein (Yale Child Study Center)
- Carla Stover (Yale Child Study Center)
- Merva Jackson
- Doriana Vicedomini
- Alice Forester (Clifford Beers Clinic)
Universal Trauma Screening in Child Welfare:

The Connecticut Collaborative on Effective Practices for Trauma (CONCEPT)
Connecticut DCF System

• Consolidated children’s agency with 5 mandates
  - child protection
  - juvenile justice
  - behavioral health
  - substance abuse
  - prevention

• Structure
  • 4 facilities (residential, hospital, JJ facility)
  • 15 area offices in 6 regions
  • central office

• Average number of staff: 3,500

• Serve 36,000 children and 16,000 families across programs & mandates at any point in time
Background

- Past efforts to build a trauma-informed system of care
  - Statewide trauma summit in 2007
  - Trauma agenda

- Current components of trauma-informed system of care
  - Trauma-informed care (2011)
  - NCTSN Child Welfare Trauma Training Toolkit
  - TF-CBT available at 16+ clinics
  - Enhanced Care Clinics
  - Federal trauma grant (ACF - 2012)

- However, minimal awareness and utilization of TF-CBT by DCF staff

- 5-year, $3.2 million grant awarded from ACF in 2011 to improve access to trauma-focused EBTs for children in the CW system
DCF’s Ongoing Trauma Work

- Policy & Trauma Informed Practice Guide
- Foundational trauma training (NCTSN toolkit)
- Dissemination of trauma-focused EBTs
- Ongoing QA for EBT providers, including linking with DCF staff
- DCF Trauma Champions
- DCF Health & Wellness support teams
- Trauma Screening
Goals of Screening

- Identify children who may be suffering from traumatic stress
- Connect them with trauma-focused assessment/EBTs
- Integrate trauma-focused treatment into CPS case planning
System Assessment & Planning

- Understand the current systems
- Get input from all stakeholders
- Increase awareness – “this is coming”
- Gain buy-in and identify champions
- Develop implementation plan
System Assessment & Planning: Questions to Ask

- How and where does trauma fit with other screening, assessment, and evaluation procedures?
- How does it fit with standard CPS practice, and other initiatives/priorities?
- Who needs to be on board, and which systems need to be involved?
- How will the screening data be used, by whom?
- What services are available for children who screen “positive”?
- What other agency/state/federal practices, policies, laws, mandates, or lawsuits must be considered?
System Assessment & Planning: Feedback

- Tremendous interest in trauma
- No formal screening
- Little awareness about trauma-focused EBTs
- Integrate with CPS practice; make it easy and helpful
- Make it mandatory or it won’t get done
- Maintain ongoing communication about progress
Concerns about Screening

- Project fatigue ("one more thing")
- Keep it BRIEF
- CPS workers are not clinicians
- Demonstrate value to CPS workers in their work
- Secondary traumatic stress
Other Considerations for Screening

- Linking screening tools to available treatments

- Integrating with other initiatives/priorities
  - CPS Practice Model
  - EBT Learning Collaboratives
  - General mental health screening
  - Substance abuse screening
  - DV & human trafficking
  - Health & wellness community of practice

- How the screening results will be used
Systems Effected by Trauma Screening

- Programs
- Community Treatment Providers
- Central Office
- Policy
- Congregate Care Facilities
- EAP

- Information Systems

- Training Academy

- 15 Area Offices
  - Investigations
  - Differential Response
  - Adolescent Services
  - Foster Care & other units
  - Managers & supervisors

- Quality Assurance
Implementation Plan

- Standardized screening tool that integrates child, parent, and CPS worker reports
- Embedded within SACWIS system
- Pre-service & in-service training
- Policy changes to support/require screening
- Quality Assurance
- Sustainability
- Anticipated rollout in Fall 2013
What Screening Tool to Use?

- Decision to develop a custom screening tool

- Existing tools were too lengthy (typically clinical assessment measures)

- No off the shelf tool would satisfy all needs
  - No cost
  - Identify children for available EBTs (acute CFTSI model)
  - Administration by non-clinical child welfare staff
  - Reflects upcoming DSM-V changes
  - Integrate with/include common mental health concerns associated with trauma & substance abuse
Connecticut Trauma Screen

- **Structure**
  - 9 trauma history items
  - 10 PTSD items
  - 6 common other MH items
  - 1 substance abuse item

- Child version (age 7+) and caregiver version (age 4+)

- Interview format

- 10-20 minutes to complete

- Several small pilots have been completed
Screening Process

- Required for every child receiving DCF ongoing services (and all children in the home)
  - Investigations – at worker’s discretion

- Required re-screening every 6 months (with case plan review)

- Worker integrates child report, caregiver report, & record review/collateral info and enters into SACWIS

- Recommendation for type of assessment referral is made, with local EBT providers listed

- Standardized mental health referral form is generated using results of the screening

- Mental health assessment/treatment needs are pre-populated into DCF case plan

- Data available to all workers with access to the case
Training

- Train-the-Trainer approach with DCF Training Academy

- Two days of training:
  - Child trauma 101 for non-clinicians (NCTSN Toolkit)
  - CT Trauma Screen and referral process, local EBTs
  - Integrating into CPS case planning
  - Ongoing communication about children in treatment
  - Secondary traumatic stress

- Mandatory for all workers & supervisors

- Managers/supervisors will be trained first
Policy

- Develop a standardized tool to review relevant child welfare policies from the perspective of a “trauma lens”
- Develop a Trauma-Informed Policy/Practice Guide
- Review individual policies and practice guides to determine inclusion of a “trauma-informed” approach and make recommendations for modifications, as necessary
Challenges

- Complexity of the system
- Competing initiatives, priorities, & agendas
- Project fatigue
- Time & resources
- Data system time/cost
- Communication challenges
- Availability/sustainment of EBTs
  - History between providers & DCF
Recommendations

- Take time to understand the system
- Develop an inclusive structure and process (in/outside DCF)
- Manage “other” agendas and avoid “drift”
- Communication plan
- Engage the experts in each area of work
- Use staff/consultants/workgroups effectively
- Identify and develop “champions”
- Document list of key decisions/approvals
Acknowledgements

- Connecticut DCF Leadership

- CONCEPT Core Team
  - Kim Campbell
  - Marilyn Cloud
  - Christian Connell
  - Cindy Crusto
  - Robert Franks
  - Jodi Hill-Lily
  - Jason Lang
  - Bob McKeagney
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