A Grassroots Prototype for Trauma-Informed Child Welfare System Change

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The development of trauma-informed child welfare systems (TICWSs) that advance individual agency practice to target transformation of the system as a whole has been conceptualized but not documented. A grassroots effort to build a TICWS with key participants (e.g., Department of Human Services, Community Mental Health, Family Court, schools) in nine Michigan communities provides a field tested model for implementation. This article described what emerged as the core elements for a TICWS, which includes (1) development and support of a project champion, (2) trauma identification, (3) comprehensive assessment of traumatic impact, (4) evidence based trauma treatment, (5) establishing a common trauma language, and (6) trauma-informed decision-making. Several new instruments for assessing a TICWS are identified. Lessons learned are highlighted for consideration of communities seeking to develop TICWSs.

The conceptualization of trauma-informed child welfare systems (TICWSs) is a relatively recent phenomenon, with models forming through work with the homeless and adult mental health. Bloom and Farragher (2010) developed the Sanctuary Model, a trauma-informed agency model, designed to identify and respond to traumatic stress at the child, family, and agency level. The Sanctuary Model's evolution from adult psychiatric hospital settings (Bloom & Farragher, 2010) to children's residential campuses suggests that "systems frequently recapitulate the very experiences that have proven to be so toxic for the people we are supposed to treat." This compromises service delivery, trauma recovery, and the health of those working within the system.

TICWSs that transcend individual agency practice and target transformation of all key child welfare agency partners have been conceptualized within the National Child Traumatic Stress Network (NCTSN) since the formation of the NCTSN's System's Integration Committee in 2003. Some NCTSN sites are now piloting models for TICWS development and implementation, including Conradi and Wilson (2010), who provide a definition and framework for TICWSs. However, documentation of TICWS change model development has not yet occurred.

Models for child welfare system change (Glisson, 2002) have been theorized, piloted, implemented and researched to address issues such as assessing child safety, the overrepresentation of minorities, and foster care recidivism, as well as agency issues such as climate and culture. The focus of previous research has not been on system change, but rather on key areas of programmatic need within child welfare. The seminal work by Fixsen and Blase (2011) on the process of changing systems, details necessary components for changing professional and agency practice. They state, "An intervention is one thing. Implementation is another," which expresses the necessity of adopting an implementation model consistent with adult learning principles to increase the likelihood for sustained system change. Good ideas and attendance at trainings are unlikely to produce practice change unless implementation

plans include extensive ongoing coaching and consultation (Fixsen & Blase, 2011).

To date, the integration of child welfare programmatic research (content) with the tenets of lasting system change (process) has not been researched in the movement to create TICWSs. To address this gap, since 2008 the Southwest Michigan Children's Trauma Assessment Center (CTAC), a current SAMHSA funded NCTSN site, has developed and field-tested a TICWSs model in several Michigan communities. The primary purpose of CTAC's TICWS Change Initiative is to develop a framework and protocol for implementing TICWSs at the local community level in a "bottom-up" or grassroots approach.

Purpose

The current study documents the CTAC model of developing and sustaining TICWS change. The primary project goals were to (1) determine prerequisites for TICWS implementation at the local level, (2) identify system areas and methods necessary for TICWS capacity building, and (3) initiate and sustain the processes necessary for system integration of trauma language, identification, assessment, treatment, and decision-making across all systems involved in child welfare. Primary community partners were Department of Human Services (DHS), Community Mental Health (CMH), Family Court, and Intermediate School District (ISD). In Michigan, the DHS is a centralized system with policy dictated by state officials, CMH is a decentralized system with limited state control, the Family Court is under local county control, and the ISD is decentralized but under state mandates for education.

Methods

This is a preexperimental descriptive study of the development and implementation of a model for TICWS change. Evaluation methods were primarily qualitative and exploratory in nature, with the purpose

to field test the process of integrating trauma-informed knowledge, skills, and practices into systems.

Participants

The sample of project participants was comprised of professionals from agencies involved with child welfare from nine Michigan counties. Counties were selected to participate based on their pre-existing strategic partnership with CTAC and/or investment in trauma-informed change by local leadership. All nine counties that participated in the project are racially homogeneous, being primarily white (all over 96% white, with the exception of Lake County at 87%), and poor rural counties, ranging from 15 to 23.4% poverty (with the exception of Livingston County at 6.6% poverty).

Project Implementation

The field test implementation was a reciprocal process between CTAC and each of the counties. Figure 1 represents the typical flow of reciprocal interactions.

Figure 1
TICWS Partnership Process

CTAC Initiated Actions	Community Response Actions
1. CTAC provides trauma trainings statewide, which a community member or members attend.	2. An individual or group of individuals become interested and want more for their community; they see the value and relevancy for their community. "Champion" emerges.
3. CTAC willingness to engage in conversation and potential investment in the county to develop TICWSs.	4. Champion must gain support of local leadership to meet with CTAC, and be open to listen to the possibilities.
5. CTAC meets with local leadership to assess the capacity of the community take on the initiative.	6. Leadership discusses its ability and desire to commit to the project.
7. CTAC makes a commitment to the community based on the four key agency leaders being on board, and based on readiness.	8. Leaders/champion plan the initial kickoff of the initiative, which is to be community-wide.
9. Together, CTAC and the leadership committee identify specific areas to target to become more trauma-informed through using training, consultations, assessment capacity, and treatment capacity. The order of implementing components is community-dependent and driven by joint decision-making between CTAC and the leadership team.	

Measures

Based on community input, the CTAC developed two trauma-informed instruments: the Trauma-Informed System Change Instrument ([TISCI] Richardson, Coryn, Henry, Black-Pond, & Unrau, 2010) and the Trauma Screening Checklist ([TSC] Henry, Black-Pond, Richardson, & Vandervort, 2010a, 2010b) for purposes of meeting the communities' need to operationalize trauma, infuse a common trauma-informed language, and document TICWS change.

The TISCI was used in data collection to determine the current state of trauma-informed practices and the staff readiness to change, as well as to document the extent to which local communities had become trauma-informed. The TSC was used to identify children with trauma to provide actual numbers of potential children needing trauma-informed intervention in local communities. Both instruments are described in Table 1. Additionally, eight interviews of key personnel and secondary data (court neglect/abuse file) reviews (53 files representing 112 children from seven of the nine counties) were conducted at the start of the project and after one year to help determine the extent to which systems were trauma-informed.

Results

The combination of qualitative and quantitative findings provides evidence to support a framework for the development of TICWSs.

The TISCI was administered to professionals, paraprofessionals, and resource parents (biological, foster, adoptive, and kinship parents) across the nine communities ($N = 631$) during the first three years of the project. Baseline results were tallied at the time of completion to provide feedback to participants about their perception of trauma-informed practice and policy. Providing immediate feedback of the baseline scores to participants underscored the need for trauma-informed change in their community. In addition, the TISCI was used as a measure of change across systems over time. On a Likert scale of 1 to 5, with 1 being "not at all" and 5 being "completely true"—baseline scores for communities on average fell at a 2.4 for

Table 1
CTAC-Developed Instruments for the Project

Instrument	Informant	Description	Use	Psychometric Support
TISCI (2010)	Community participants across roles and agencies	A 19-item instrument measuring TICWSs at the agency and individual levels. Each level fits a two factor model, with both models showing strong factorial validity, to measure the areas of agency policy and agency practice, as well as individual integration and individual openness.	Developed to gauge the extent to which a community perceives itself as trauma-informed, as well as to measure change. Use by professionals across systems and agencies.	Factorial validity has been established, indicating a two factor model with excellent fit indices. Chronbach's alpha was 0.867 and 0.875 for the two factors.
TSC (2010) Two versions: 0–5 years 6–17 years	Resource parents, teachers, therapists, caseworkers	An instrument designed to screen for the presence of the impact of trauma in community children. Identifies the number of types of maltreatment events suspected, and types of behavior, mood issues, and academic concerns, with multiple response sets within each area of concern.	Used as initial screen to connect a child's exposure to potentially traumatic events with behavioral, mood, and academic concerns. Can be used for treatment planning or in aggregate form to raise awareness of the impact of trauma on a community's youth.	Psychometric study for establishing reliability and validity is not yet completed.

policy and 2.7 for agency practice regarding the extent to which their child welfare systems are trauma-informed.

Posttest results after one year revealed a statistically significant ($p < 0.05$) increase in the extent that policy had become more trauma-informed-increasing from 2.4 to 2.8 ($t = -2.046, df = 31, p < 0.049$). Agency practice likewise showed statistically significant improvement, increasing from 2.7 to 3.0 ($t = -2.063, df = 32, p < 0.048$). Although this improvement is encouraging, results highlight the difficulty of changing entire systems to a trauma-informed paradigm.

Key Areas for TICWS Implementation

Following the two counties' participation and subsequent CTAC evaluation in Year 1, six key areas for implementation emerged as critical in the development of a TICWS:

Development of Champion

Each community started with a local champion and/or group of champions committed to changing the child welfare system to be trauma-informed. Champions were identified through their own interest and initiative to mobilize resources and bring together community members central to system change. Their efforts were simultaneously supported by CTAC participation in leadership meetings, reinforcing interest and momentum for change. The motivation for champions varied from their previous trauma knowledge through trauma trainings, previous interactions with CTAC, and/or frustration with the current system's failures to meet the needs of children.

Local champions surfaced from different professional positions and roles. There was not one professional role that surfaced as necessary to lead the community toward system change. Champions included a Family Court judge, CMH children's director, a special education consultant, a DHS director, a DHS supervisor, and a juvenile justice probation officer.

Screening and Identification of Trauma in Children

Community identification of children who potentially have been traumatized within child serving systems is important to highlight

the correlation between trauma and challenging/concerning behaviors. Since the TSC was developed, 964 screens have been anonymously collected for children ages 0 to 17, primarily through DHS workers, resource parents, and school personnel. Of the 803 screens completed for the 6- to 17-year-old age range, children were recorded as having an overall average of 3.69 (3 to 4) types of maltreatment experiences, 2.31 (2 to 3) types of behavior concerns, 1.07 (at least 1) type(s) of mood issues, and 1.55 (1 to 2) types of academic concerns.

The participating communities used their screening results to raise awareness of the prevalence of children who have been traumatized and its impact in their community. Two project communities have used their screening results to secure funding from local foundations for the development of trauma assessment centers, which are now operational. Beyond the nine project counties, approximately a third of Michigan local CMH agencies have adopted the TSC for screening children at intake. One mental health agency has compiled 4,500 screens, with the vast majority of the children having at least two potentially traumatic events.

Comprehensive Assessment of the Impact of Trauma

To date, CTAC has trained three teams of professionals (out of the nine communities) in a transdisciplinary neurodevelopmental assessment protocol similar to that provided at CTAC (Henry et al., 2011). The teams are comprised of professionals from mental health, occupational therapy, speech/language, and the medical field. This type of comprehensive assessment is preferable for children experiencing *complex trauma,* which is a term used by some experts to describe both exposure to chronic trauma—usually caused by adults entrusted with the child's care, such as parents or caregivers—and the immediate and long-term impact of such exposure on the child (Henry, Sloane, & Black-Pond, 2007; van der Kolk, 2005). Children who have experienced complex trauma have endured multiple interpersonal traumatic events from a very young age. This is the more common experience of children in the child welfare system. As each county has approached this component differently based on its avail-

able resources, the following three assessment training strategies have been implemented:

1. **A multidisciplinary team composed of personnel from collaborating agencies:** A memorandum of understanding allowed for shared resources (multiple disciplines), including professionals from CMH and the ISD. Two assessment teams and a community protocol for triaging referrals were developed, and continue to provide assessments for children who have been traumatized.
2. **A same-discipline (mental health) assessment team:** A team of trained therapists to assess for trauma was developed. For those children assessed as having potential sensory, speech/language, and other special needs, referrals are routinely made to other community professionals not involved in the assessment team.
3. **Training individual therapists in trauma assessment:** This strategy is preferred by more rural communities with fewer available resources and is currently being introduced to communities. It includes training individual therapists in assessing and screening children across multiple domains of developmental functioning and trauma symptomology.

Regardless of the assessment model used, the communities struggled with engagement of physicians. In spite of the efforts of the CTAC physician to engage and educate physicians, lack of interest and commitment of time from the medical community has been a barrier to implementation across sites.

Development of a Cadre of Community Therapists (Public and Private) for Provision of Evidence-Based Trauma Treatment

Developing resources for provision of evidence-based trauma treatment was a primary goal in all nine communities, and a cadre of therapists (both CMH and private) was trained in all nine counties. In Year 1 of the grant, 29 clinicians from three county systems were trained in Trauma-Focused Cognitive Behavioral Therapy ([TF-CBT] Cohen, Mannarino, & Deblinger, 2006) and/or Real Life Heroes (Kagan, 2004), 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. During Year 3 of the grant, a second TF-CBT training was provided for 22 therapists in a northern Michigan county, with 19 clinicians continuing with follow-up consultation. Real Life Heroes was not offered during the third year. 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. These phases of treatment included psychoeducation, self-regulation skill building, trauma processing, and safety planning (trigger management). During 2010 over 230 children received TF-CBT from project trained therapists.

Establishment of Common Language Using Trauma-Informed Instruments to Understand and Describe Children who Have Been Traumatized

The champions for each project site identified the need for community (professionals' and caregivers') education on the harmful impact of trauma. To respond to this need, a series of trainings on specific topics and ongoing consultation were developed. Specific trauma trainings (Table 2) were provided to courts, schools, DHS, CMH, medical personnel, and caregivers to infuse trauma into agency and interagency discussion of children.

To further infuse trauma language CTAC developed a trauma-informed Court Report Checklist ([CRC] Henry et al., 2010a). This instrument was created in response to a community Family Court judge's request for information on the child's trauma history, the impact of the trauma on the child's functioning, and trauma-informed services available/being provided the child. These concerns were confirmed by a file review, as only 3 of the 53 Family Court files reviewed mentioned trauma and/or associated the child's behavior and emotional concerns with the impact of trauma. The CRC combines the screening capacity of the TSC with a section on trauma-informed components of treatment, and was developed to supplement the DHS worker's report to the court. Currently, five of the nine DHS and Family Courts use the CRC at disposition and review hearings

Table 2

Specific Training and Consultations for Establishing Common Trauma Language and Understanding for Communication Across Systems and Agency/Interagency Decision-Making

Training	Audience and Frequency	Purpose
Community kickoff	Broad-based community representation, ranging from administration to paraprofessionals and caregivers, including a range of school, court, DHS, mental health, law enforcement, parents, resource parents and medical personnel. One time event.	The acknowledgment of the need for a multidiscipline approach to child trauma across systems is modeled through this training, with CTAC team members representing mental health, occupational therapy, speech and language, medical, legal professions giving an overview of the impact of trauma from their field's perspective, and how this integrates with the whole. Primarily serves the purpose of building community awareness of the problem of traumatic impact to children, and why it is important to address for the community. Serves as a concrete marker as a starting point for the initiative.
DHS	Foster care, child protective services, adoption, prevention, permanency planning staff, and supervisors. Two to three sessions of training/ consultation over the course of a year.	1. Essential elements training: Initially used the NCTSN nine "essential elements." After the first two counties, limited the elements to the five most relevant to their work to better engage the audience. To facilitate operationalizing trauma-informed practice infuses trauma into DHS staff current decision-making processes. 2. Trauma-informed removal: Operationalizing in very concrete steps how to view removals through a trauma lens with use of specific examples. 3. Secondary trauma: Given the trainings already provided, secondary trauma is integrated and weaved throughout the other two trainings, with focus on the impact of secondary trauma on decision-making and view of casework.

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Table 2 Cont.

Training	Audience and Frequency	Purpose
School training	As part of a menu of professional development options for teachers and school counselors. Once or twice per community for interested school districts.	To operationalize trauma-informed practice in the schools. Provide concrete tools and education on how the impact of trauma manifests in the school setting.
Resource parent training	For resource parents, biological parents, occasionally with the inclusion of child welfare staff. A train the trainer module that s promotes sustainability in training resource parents on responding to children who have been traumatized.	Sharing the common language of understanding of trauma and concrete strategies for resource/biological parents of children who have been traumatized using the NCTSN resource parent training product.
Legal training	For attorneys and judges working with child welfare cases. A series of three training.	To share a common language with legal personnel and to help them understand the relevance of an understanding of trauma to their role and responsibility. Adoption of the caseworker "essential elements" for attorneys developed and trained by CTAC's attorney consultant on trauma-informed legal practice.
TF-CBT training and consultation RLH training and consultation	For therapists and mental health supervisors. Following a learning collaborative model: Two day initial training, with four-month follow-up and final session (TF-CBT only), and monthly consultation phone conferences.	Providing capacity with local mental health clinicians to use evidence based trauma- informed therapy.
Medical training	Two methods for primary care doctors and pediatricians: 1. Meetings with groups of physicians 2. Meeting individually with physicians that local professionals have referred as being receptive to trauma-informed change	Neither method has been effective in gaining support beyond agreement with the philosophy to the point of actually changing practice.

in all Family Court proceedings. The Trauma-Informed Therapist Report ([TITR] Henry et al., 2010b) was subsequently developed as a method for therapists to inform caseworkers and the Family Court of progress in trauma-informed assessment and treatment. The core phases of trauma treatment (Layne, Ghosh-Ippen, Strand, Stuber, Abramovitz, Reyes, Jackson, Ross, Curtis, Lipscomb, & Pynoos, 2011)—psychoeducation, affect regulation skill building, trauma processing, and managing triggers—are contained within the template. A cohort of therapists within each community has been trained in TF-CBT with the expectation that they will complete the TITR. In a current review, two years following implementation of the CRC in the first pilot community, 100% of the cases had a CRC submitted by the DHS worker to the judge prior to court hearings. Feedback from the Family Court judge indicated that the CRC provided important trauma information to the judge for decision-making.

Use of Trauma Knowledge in Decision-Making for Children

The two key areas of trauma-informed decision-making were legal/judicial decision making and child welfare decision making. For the legal decision-making process, a document highlighting the Essential Elements for attorneys (see Table 2) was developed. This was a series of key questions on trauma history, trauma symptomology, and trauma services, for attorneys to ask at Family Court hearings to provide trauma information in judicial decision-making.

Trauma-informed child welfare decision-making emerged as one of the greatest needs and most significant challenges within pilot communities. The system pressures and the nature of child welfare work impeded the ability of DHS workers to try new ways of practice. Trainings were developed and initiated by CTAC to address the issues of secondary traumatic stress and decision making regarding removal of children from biological parents and placement changes. The Trauma-Informed Removal Training (Henry & Richardson, 2011) provided a trauma-informed framework for the removal and/or placement change thought processes that typically go into child protective services decision-making. The training empowers workers on how to minimize the trauma of removal through development of a

trauma-informed removal plan for all children prior to their removal from biological parents.

Discussion

The results of this project provide a framework and protocol for developing a TICWS model that can be implemented in local communities. Several building blocks consistently emerged within each of the nine study communities that appear critical for initiating and maintaining TICWSs.

First, each community needed a local champion to keep the project going. The role diversity of champions reveals that a variety of professionals can become local champions, yet they must enlist the commitment of primary child welfare leaders to convene and motivate other community members to participate and take ownership of building TICWSs. If one or more agencies passively participates and/or resists implementing trauma-informed change, the possibility for systemic change is significantly reduced. There also needs to be trauma-informed agency change within each of the agencies within the child welfare system. Each of the nine county child welfare systems had varying levels of system change; but those counties that demonstrated the most change were more collaborative. In the most successful collaboration leaders attended meetings and trainings, were willing to develop and implement new ideas, committed agency resources to transagency trauma-informed processes, and took ownership of the trauma-informed child welfare initiative directing CTAC as to what they needed most from the partnership.

Second, the introduction and use of trauma-informed instruments and tools facilitated increased use of trauma language and added discussion of traumatic impact into decision-making across agencies. The CTAC-developed instruments (identified previously) provided a mechanism for workers, legal officials, and therapists to identify trauma and traumatic stress, understand child trauma recovery, and more effectively and collaboratively communicate and make decisions for children who had been traumatized. Having system-wide documentation of trauma to infuse into the daily system lexicon for case

discussion and decision-making is essential, whatever the instrumentation, as evidenced by one county that went from no discussion in court reports of traumatic impact on children to all court reports containing such information.

Third, consistent with Fixsen and Blase's (2011) implementation model, the greater the intensity and length of consultation beyond initial trainings, the more likely that participants adopted new trauma practices and built trauma-informed capacity. At the start of the project, CTAC planned to provide ongoing consultation for a 9- to 12-month period to participating communities. However, this period of time proved inadequate to support system change. Ongoing CTAC support to communities was extended for the length of the grant (4 years), which meant that initial participating counties received up to 3.5 years of training and consultation. TICWS change has been slower than expected with the primary barriers being (1) the challenge of changing traditional paradigms for professionals from event-focused only (child maltreatment), to simultaneously considering the traumatic impact to the child; (2) the difficulty integrating a new trauma framework and evidence-based modalities into multiple agencies; (3) the lack of sustained consultation provided to child welfare workers, school staff, and court personnel; and (4) significant child welfare worker turnover, which resulted in a majority of new staff within all the communities without trauma training. The individual and cumulative effect of these barriers might have been significantly reduced if the intensity of consultation was more intense (frequent) and accessible at a local/agency level. Such consultation, consistent with Fixsen and Blase's research, would provide the hands-on support necessary for changing practice and enhancing larger system change. CTAC, because of limited personnel resources, was unable to consistently attend community leadership meetings within each community and increase consultation, which minimized CTAC's ability to provide trauma expertise, direction, and feedback during the initial and ongoing stages of TICWS development. Depending on the champion/champions power and influence within each community, the impact of CTAC's absence was minimized by the champion's ability to motivate and infuse energy into leadership

participants. Without an active champion and/or CTAC's active participation, community leadership teams lost momentum.

The suspected effects of secondary trauma and/or job burnout, especially with the child welfare staff, on their implementation of new trauma-informed practices were not anticipated. A majority of staff communicated that they were in "survival mode" and had little energy to use new forms to document trauma and/or to implement trauma-informed casework practices. The DHS training was retooled so instead of promoting new trauma-informed practices, child welfare worker training began with discussion of secondary trauma. This change in the training increased staff consideration and responsiveness of how trauma could be infused into their practices.

If trauma is going to be integrated into practice and decision-making, the authors would recommend that child welfare agencies hire "resident trauma experts" to provide in-house trauma-informed consultation to operationalize trauma-informed casework. Resident trauma experts would need to be employees of the local offices who receive more specialized trauma training and also have reduced work load to be available for case conferences and staff meetings to draw attention to how trauma can be integrated into service planning and implementation.

Building trauma-informed capacity within the child welfare system to better address the psychological needs of children who have experienced maltreatment was the primary goal of all nine counties to varying degrees. All nine counties increased their capacity to provide trauma-informed services to children and their families. Yet, despite capacity building, integration of trauma across agencies within the child welfare systems (legal, mental health, child welfare, and education) was slow, limited, and continuously challenging. The mandates for each system are different, so that a focus on the trauma needs of the child often was secondary to maintaining agency mandates and boundaries. These are traditional challenges that are not unique to the development of TICWSs, yet the lack of "real" collaboration inhibits the potential integration of trauma into guiding system planning, service provision, and decision-making.

Conclusions

The nine communities participating in the TICWS project were predominantly rural, with small populations, and the child welfare systems had relatively few players with only one family court judge presiding within each community. The generalizability of this TICWS change model to larger communities is compromised by this limitation. Change in a large community requires commitment from a greater number of key leaders within each agency. Discord between leaders can seriously impede any systemic effort to build and integrate a TICWS across agencies. Given these inherent challenges, larger counties would likely demand increased intensity of training and consultation along with greater emphasis on training internal "experts" and an extended time commitment given the greater number of players and agencies.

The desired outcomes of TICWSs are rooted in the federal standards of "safety, well-being, and permanency." This TICWS project is a first step in developing a comprehensive TICWS model as the antecedent to actual improved child outcomes. The driving assumption is that TICWSs produce better outcomes for children and families including reduced placement changes, increased permanency, and overall improvement in child functioning at home, school, and the community. Due to the limited funding, measurement of these child outcomes did not occur, which is a limitation of the project. As TICWS models develop across the country, measurement of the previously defined child outcomes is essential to provide the statistical evidence to affirm the value of TICWSs in producing positive child outcomes.

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