Helping Kids in Foster Care Succeed: *Strategies for North Carolina to Strengthen Families and Save Money*

North Carolina Family Impact SEMINAR

Duke | CENTER for CHILD and FAMILY POLICY

Duke University 2015 Family Impact Seminar

Helping Kids in Foster Care Succeed:
Strategies for North Carolina to Strengthen Families and Save Money

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Acknowledgements

North Carolina Family Impact Seminar
Overview

Background and Purpose

North Carolina Family Impact Seminars (NCFIS) include seminars, briefing reports and follow-up activities designed for state policymakers, including legislators and legislative staff, the governor and executive branch staff, and state agency representatives. With publicly available materials following each seminar, NCFIS' reach extends to a wide range of organizations and individuals who are working on the topic addressed in North Carolina and beyond.

The seminars provide objective, nonpartisan, solution-based research on a topic of current concern to state policymakers. The seminars address how policies and practices affect children and families. Legislators and legislative staff guide topic selection based on their concerns and those of their colleagues and constituents, as well as their knowledge of what is likely to be addressed during current and future legislative sessions. The 2015 NCFIS focuses on several topics related to foster care, with an overarching theme of child and family well-being.

In two primary ways, NCFIS presents research, information and insight related to policy, practice and programs:

- The seminar at which experts present and interact with legislators, legislative staff, executive branch staff from the state and local level, and other stakeholders and
- The seminar briefing report and accompany materials, which feature the seminar topic

NCFIS provides a foundation for ongoing engagement and interaction among diverse sectors and perspectives. These include legislators and the experts who speak at the seminars; researchers, faculty and staff of Duke University's Center for Child and Family Policy, which houses and convenes NCFIS; and individuals and groups who have an interest in each seminar issue. Stakeholders include members of the executive branch, directors of state and local government agencies, leaders of nonprofit agencies, and researchers and scholars from Duke and other institutions of higher education. The Center for Child and Family Policy widely disseminates the briefing materials and makes them available online at www.childandfamilypolicy.duke.edu.

Jenni Owen
Director, North Carolina Family Impact Seminar

2015 North Carolina Family Impact Seminar

Helping Kids in Foster Care Succeed:
Strategies for North Carolina to Strengthen Families and Save Money

Executive Summary

The 2015 North Carolina Family Impact Seminar (NCFIS) focuses on a topic that is timely both nationally and in North Carolina. Ensuring that children and youth in foster care become healthy, educated, functioning adults is the subject of recent federal legislation,[1] as well as current state-level conversations. In addition, North Carolina legislators are considering working with the Pew-MacArthur Results First Initiative, which works with states to "implement an innovative cost-benefit analysis approach that helps them invest in policies and programs that are proven to work."[2]

The discussion around the need to ensure the well-being of children and youth in foster care involves state systems and private services providers, requires both legislative and executive action, and is non-partisan. We all want to ensure that children and youth in foster care – who have already been dealt a difficult hand – grow up to become contributing citizens. Current conversations tend to center not around *whether* to support children in foster care, but *how*. On one level, children and youth in foster care often have needs that are more complex than those of their peers who have not experienced foster care. This is in large part because of the trauma they have experienced and the treatment they need to adequately address that trauma. On another level, children in foster care want and need the same opportunities and experiences as other children. These include caring adults, structure and stability, and healthy spaces to take the developmentally-appropriate risks that are essential to growing up.

As Dr. Mark Testa points out in his 2015 NC Family Impact Seminar remarks and in this briefing document, ensuring the well-being of children in foster care is a complex, "wicked" problem. The research on well-being for this population – much of which is highlighted in this compilation – illuminates some critical realities:

- Well-being for children in foster care is less than optimal. Many children and youth in foster care are not thriving physically, mentally, emotionally and socially.
- Well-being matters. The physical, mental, emotional and social/relational health foundations laid in childhood help determine future success in life, and unaddressed childhood trauma weakens those foundations.
- While safety and stability are critical, they are not enough to ensure well-being. Children's mental and emotional health problems do not just go away with time; they must be identified and treated effectively.

[1] The *Preventing Sex Trafficking and Strengthening Families Act*, passed in September 2014, calls on states to improve normalcy for youth in foster care, among many other recommendations.
[2] More information about the Results First Initiative is available online at: http://www.pewtrusts.org/en/projects/pew-macarthur-results-first-initiative.

- Ignoring the social-emotional well-being of children and youth in foster care will cost society in the long run. Many adults who had adverse childhood experiences are more likely to have poor physical and mental health outcomes years later. Intervening early is less costly and more effective than waiting until adulthood.

The 2015 NC Family Impact Seminar speakers and the accompanying materials highlight these realities, intentionally featuring research, policy, and practice from multiple perspectives. They also present policy options for consideration by policymakers who are convinced of the need but may find themselves asking, "So what should we do?"

Senator Tamara Barringer opened the seminar by highlighting the importance of improving the well-being of youth in foster care. Seminar keynote speaker Testa highlighted the "grand challenges" of child welfare and called on policymakers to address them through a bipartisan process of evidence-based policymaking. A candid conversation between Nancy Carter, a longtime advocate for youth aging out of foster care, and Marcella Middleton, who aged out of the foster care system, gave us insight into the challenges children and youth deal with in foster care and their experiences when they leave the system to face life on their own. A panel discussion on the social-emotional health of children in foster care highlighted the research on why such a focus is critical, featured the investment approaches that The Duke Endowment is taking in this area, then focused on the evidence-based solutions that North Carolina is embracing, specifically Project Broadcast and Partnering For Excellence. The panel consisted of Dr. Katie Rosanbalm of the Duke Center for Child and Family Policy, Rhett Mabry of the Duke Endowment, Kevin Kelley from the NC Division of Social Services Child Welfare Section, and Jenny Cooper of Partnering For Excellence Initiative.

Some of the materials in this compilation are national and others are North Carolina-specific. They intentionally reflect the themes of the seminar presentations. Many tie directly to the seminar speakers' expertise and remarks. Others provide context, background and additional insight into the problems and possible solutions for addressing social-emotional well-being for children and youth in foster care.

There are no easy answers to "wicked" problems. However, the seminar speakers and accompanying materials demonstrate that there are many research-informed steps policymakers can take to help ensure the social-emotional health of children and youth in foster care. Legislators, state agencies, service providers, private funders, and foster and birth families can collaborate to:

- Train systems and individuals that work with children in foster care – be they social services, public health, public education, private service providers or foster families – in what to expect from children who have been through trauma, in order to best help them heal.
- Screen all children and youth entering foster care for trauma and behavioral health concerns and fully assess those children and youth who screen positive.
- Provide children and youth with appropriate evidence-informed treatment to address identified concerns.

- Measure and track well-being.
- Leverage protective factors to support recovery.
- Provide adequate oversight, planning and services to give youth aging out of foster care the best possible start to adulthood.
- Enhance stability and attachment to caregivers through permanency options like kinship care, guardianship, adoption and post-permanency supports that help ensure continued family functioning.

The 2015 North Carolina Family Impact Seminar educated and informed policymakers and other public and non-governmental stakeholders about some of the key considerations regarding ensuring social-emotional well-being for children and youth in the foster care system. There are other factors at play, and system transformation is not likely to be quick or smooth, but continued conversations about evidence-based policy options can yield better practice and policy decisions.

Overview of Child Welfare in North Carolina

Prepared by Harlene Gogan, Research Instructor, UNC-CH School of Social Work

In North Carolina, children are first and foremost protected from abuse and neglect and safely maintained in their homes whenever possible and appropriate. In calendar year 2014 there were 142,808 children with one or more reports of abuse or neglect. Of children reported, 23,883 were substantiated or found in need of services. Throughout all of 2014, 14,812 children spent time in foster care, leaving 9,889 children in foster care at the end of 2014. This is child welfare by the numbers in North Carolina. To describe the children we must dig deeper.

North Carolina has a federally mandated, state supervised, county administered social services system. This means the federal government authorizes national programs and a majority of the funding, and the state government provides oversight and support, but it is the 100 local social service agencies that deliver the services and benefits (excerpted from DSS website www.ncdhhs.gov/dss/about).

The Division of Social Services (DSS) provides training, technical assistance, and consultation to the local staff who work in programs for families and children including Child Welfare, Family Support, Work First, Child Support, and Food and Nutrition Services. (www.ncdhhs.gov/dss/about)

Child Protective Services

The Child Protective Services program strives to ensure safe, permanent, nurturing families for children by protecting them from abuse and neglect while attempting to preserve the family unit. Child Protective Services help prevent further harm to children from intentional physical or mental injury, sexual abuse, exploitation, or neglect by a person responsible for a child's health or welfare. Child Protective Services also helps protect dependent children who have no parent, guardian, or custodian to provide care and supervision, or whose parent, guardian or custodian is unable to provide care or supervision and lacks an appropriate alternative child care arrangement (excerpted from DSS website www.ncdhhs.gov/dss/cps/index.htm).

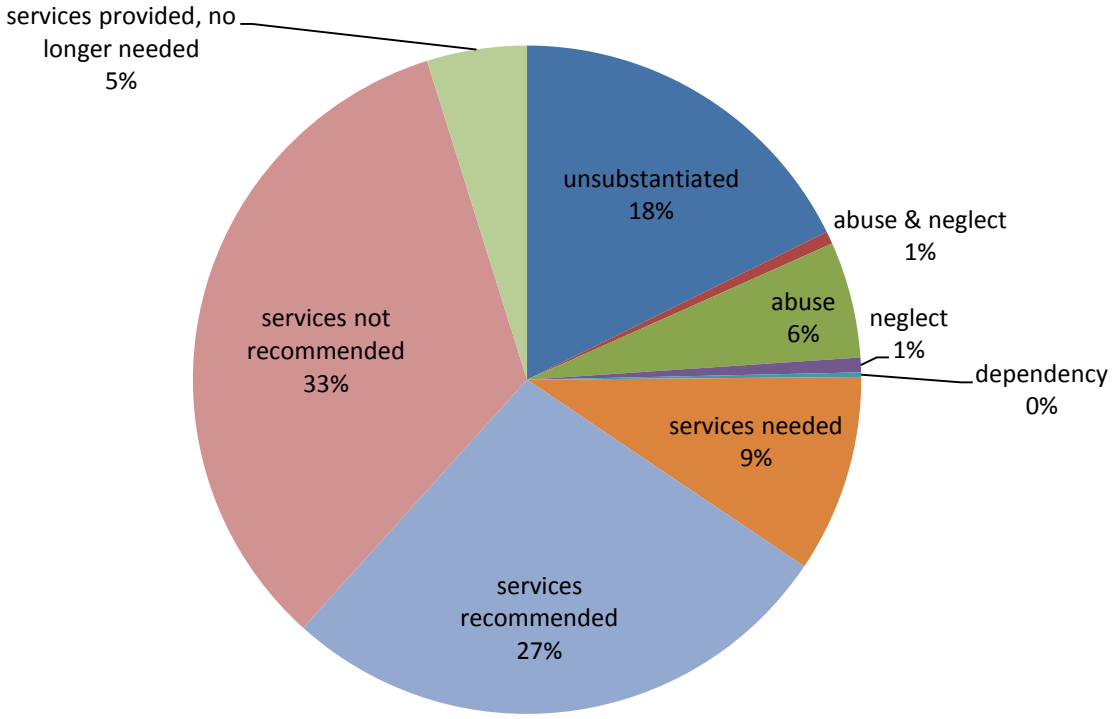
Social services staff accomplish these services through:

- Assessing suspected cases of abuse and neglect
- Assisting the family in diagnosing the problem
- Providing in-home counseling and supportive services to help children stay at home with their families
- Coordinating community and agency services for the family
- Petitioning the court for removal of the child, if necessary
- Providing public information about child abuse, neglect, and dependency (www.ncdhhs.gov/dss.cps/index.htm)

The first contact a child has with child welfare in North Carolina is via a report of abuse or neglect. This report could come from someone who cares about the welfare of the child: a neighbor, a teacher, or a police officer, for example. The Multiple Response System allows for a differentiated response to abuse (the traditional investigative track) and neglect (the family assessment track). The family assessment track allows and encourages the provision of services to families that would build on their strengths and eliminate the risk of harm to their children.

Of CPS reports screened in for evaluation, **Figure 1** shows the outcomes of the reports in calendar year 2014. As you can see from the Figure, only 17% of reports were substantiated (Investigative track) or found to need services (Family Assessment track).[1]

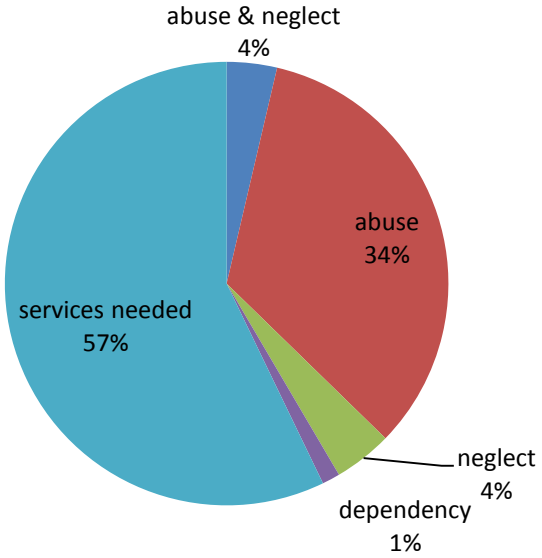
Figure 1: Maltreatment Reports Findings, 2014



[1]On the Family Assessment track, "Services Needed" is the finding when the safety issues and future risk of harm is so great that the agency must provide involuntary services to ensure the safety of the child. "Services Provided, no longer needed" is the finding when the safety of a child and future risk of harm were at some point in the assessment high enough to require involuntary services, but the successful provision of services during the assessment has mitigated the risk to a level in which involuntary services are no longer necessary to ensure the child's safety. "Services Recommended" is the finding when the safety of a child is not an issue and future risk of harm is not an issue, but the family would benefit from other non-safety-related services to improve child and family well-being. "Services not Recommended" is the finding when not only is the safety of a child not an issue and there is no concern for the future risk of harm to the child, but the family also has no need for other non-safety-related services. Source: NC DSS: http://info.dhhs.state.nc.us/olm/manuals/dss/csm-60/man/pdf%20docs/CS1408.pdf

Among those substantiated and in need of services, **Figure 2** shows the type of maltreatment. The most prevalent type of maltreatment is the 57% of children who are "in need of services," which is the maltreatment outcome of the family assessment track.

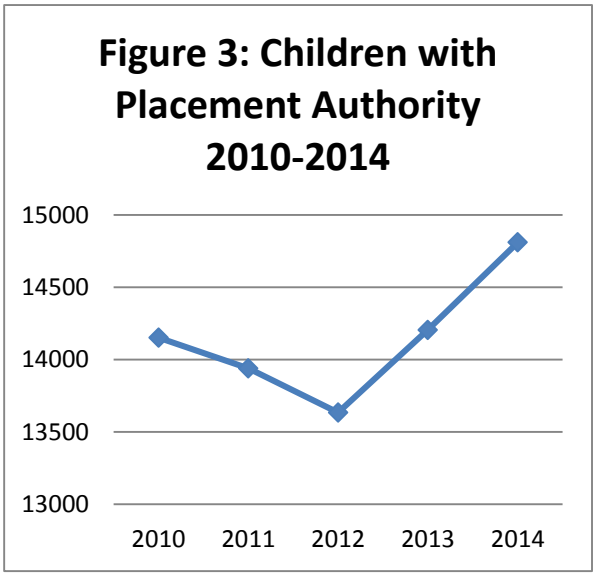
Figure 2: Type of Maltreatmentment for Those Maltreated, 2014

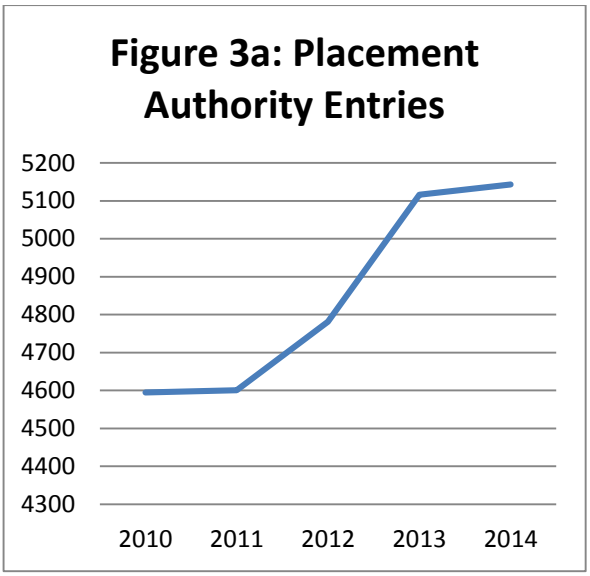


Child Placement Services for Children

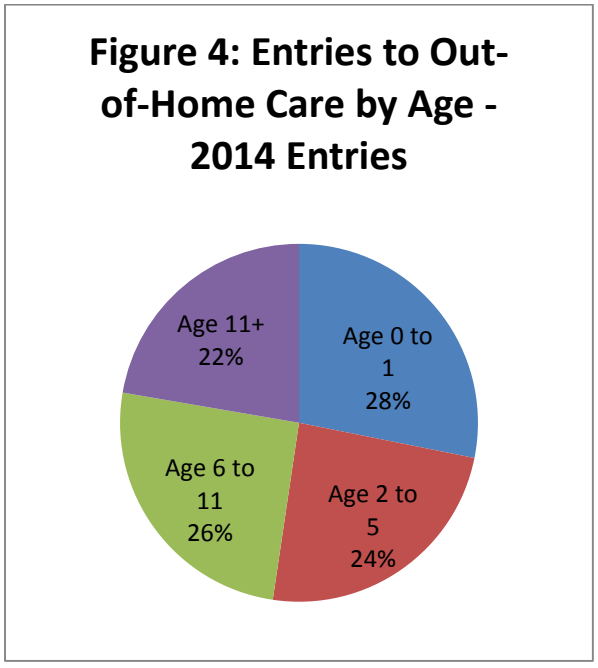
In the event that children cannot remain safely in their home, North Carolina is given placement authority for the child. **Figure 3** shows the number of children who have been in foster care at some point during the calendar year for 2010 to 2014. For a view of these children that is unbiased by children in care a long time, we look at entry cohorts, that is all children entering placement authority within a calendar year. **Figure 3a** shows the number of entering children in the past five calendar years.

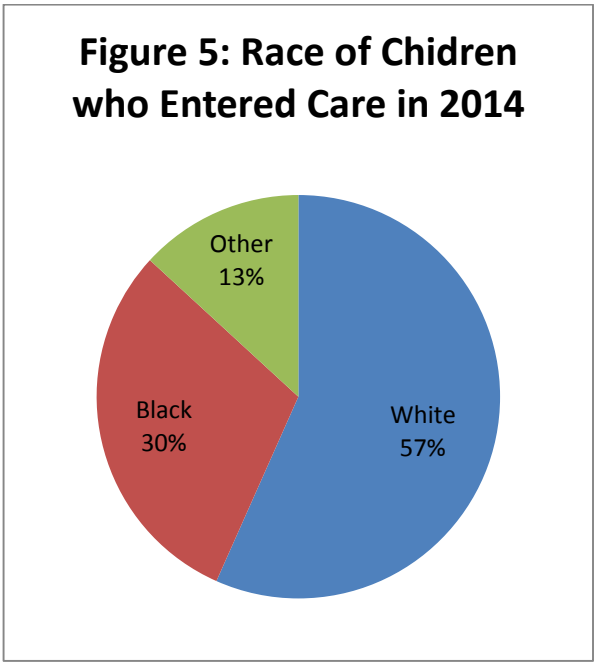
The Figures highlight that the number of children in care and the number of children entering care have increased in recent years.





Demographic characteristics of children in Foster Care are provided in **Figures 4 and 5.**





Each of North Carolina's 100 counties continues to strive towards obtaining permanency for foster children by providing Child Placement Services to children who need temporary homes. These services include:

- Providing temporary homes for children in DSS custody
- Supervising children in foster care
- Providing ongoing counseling and support services to help families and children reunite and stay together

- Providing extra counseling and support for families and foster parents of children who are ill, disabled or delinquent
- Petitioning the court for legal termination of parental rights
- Making recommendations for adoption for children unable to return home
- Recruiting, screening, training potential foster parents, performing home studies, performing local criminal background checks to ensure the safety of potential foster children placed in the home, and recommending licensure of the home. (www.ncdhhs.gov/dss/placement/index.htm)

While providing temporary homes for children, of utmost importance is to maintain children in as homelike an environment as possible, to reduce the trauma to the child and to maintain family connections when at all possible. **Figure 6** shows the initial countable placement types for the 2014 calendar cohort. **Figure 7** shows whether children in the 2014 entry cohort were ever placed with relatives, and **Figure 8** shows whether children in that cohort were ever placed in family settings.

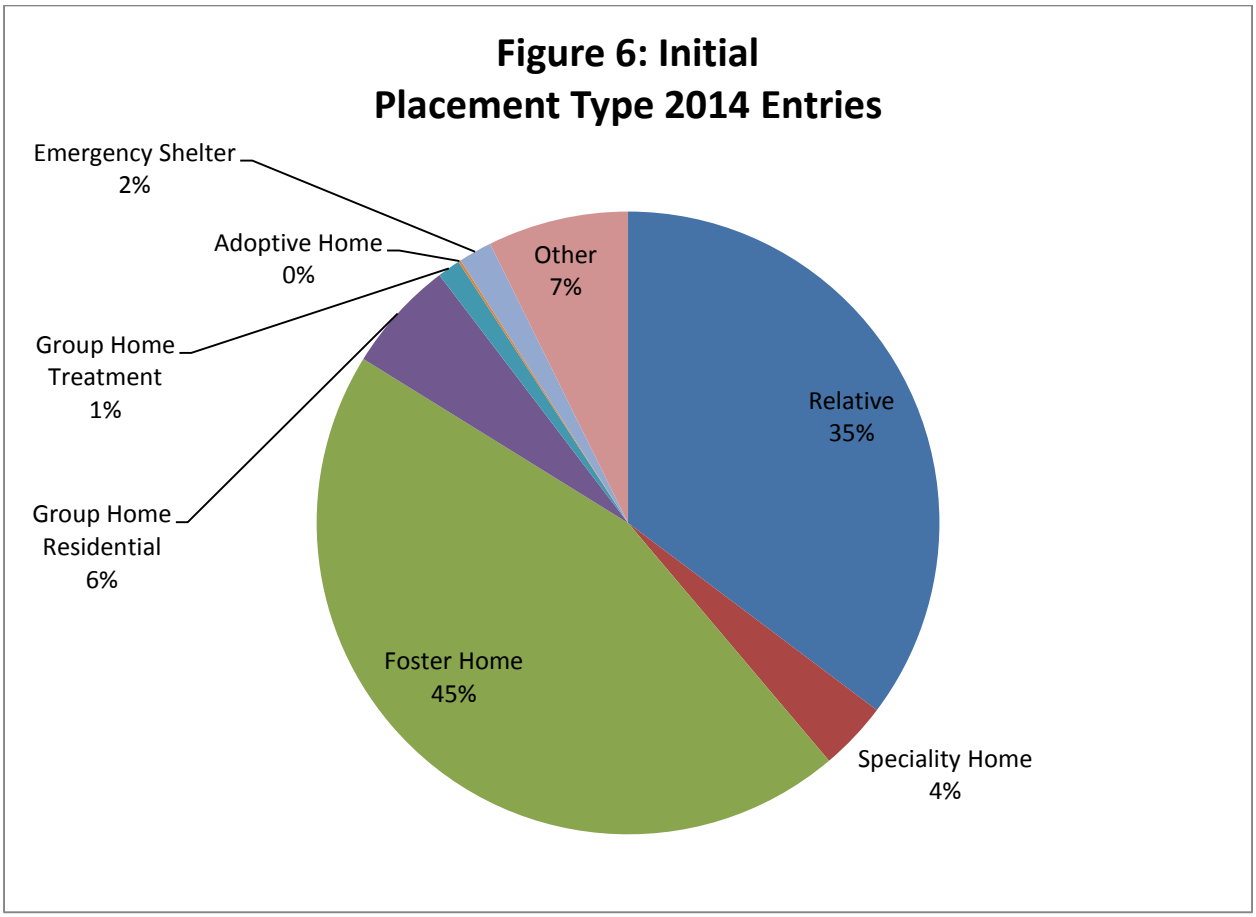


Figure 7: Out of Home Placements with Relatives - 2014 Entries

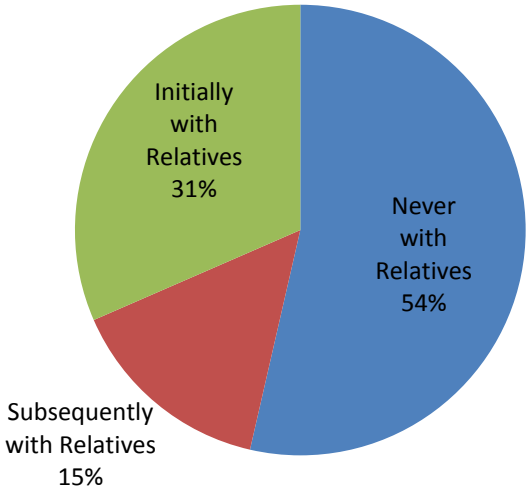
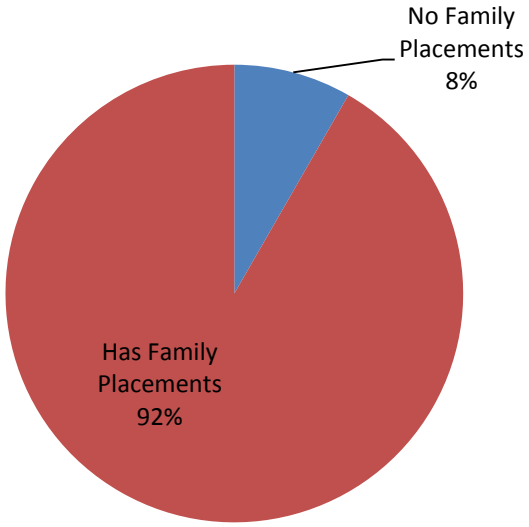


Figure 8: Children Ever in a Family Setting - 2014 Entries



Besides maintaining family relationships and connections, stability in living situations is a goal. **Figure 9** shows the number of placements for a child in the first year of foster care for the 2014 calendar cohort. Another goal of child welfare in North Carolina is to reduce the time a child is maintained in foster care. **Figure 10** shows the median length of time that North Carolina has had placement authority for children in foster care over time.

Figure 9: Number of Placements in the First Year - 2014 Entries

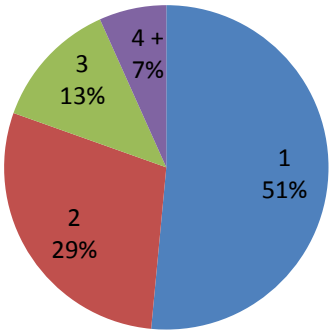
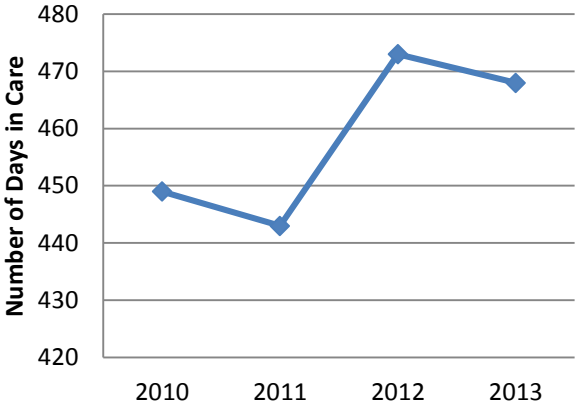
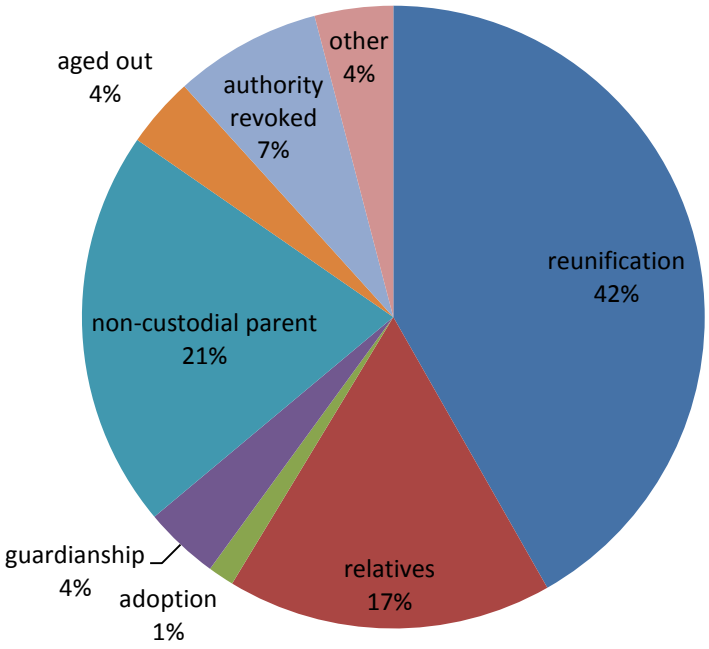


Figure 10: Median Length of Stay for Entry Cohorts (Calendar Year)

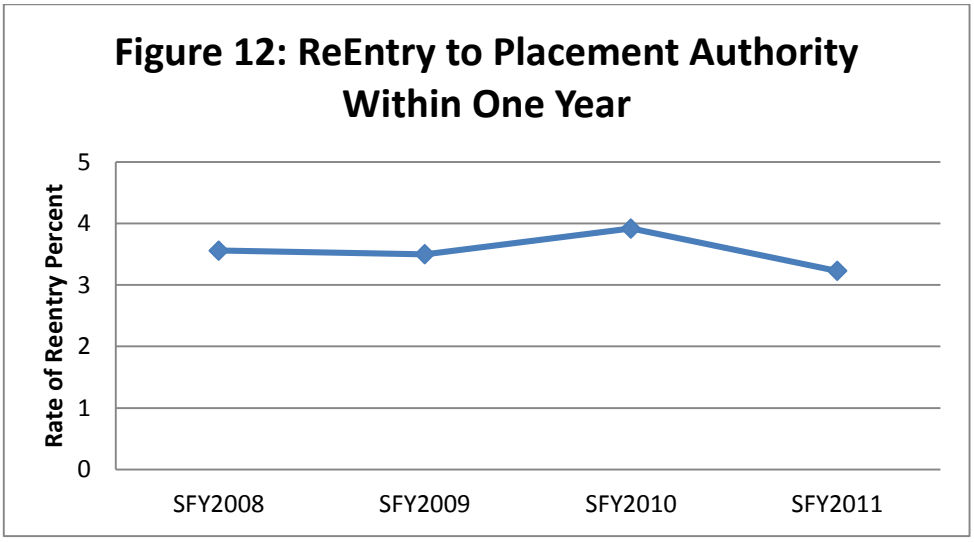


When foster care is necessary, it should be a safe, short and stable experience. Permanency planning establishes a goal of moving a child to a safe, permanent and nurturing setting with his or her own family, a relative or an adoptive family, as quickly as possible with court approval. At the end of 2014, 76.7% of the 2014 entry cohort remains in foster care. **Figure 11** shows the outcomes for children in the 2014 calendar cohort who have been moved to a permanent setting.

Figure 11: Outcomes for Children Who Entered Care in 2014



Reentry to foster care happens when a child is unable to be maintained safely in their permanent placement. North Carolina has a very low rate of reentry for children under age 18. **Figure 12** shows re-entry within a year of permanency for North Carolina. For reentry to occur, first a child must leave placement authority. So unlike the other figures that are for more recent periods, reentry rates are for state fiscal year cohorts 2008 - 2011.



Summary

In North Carolina, of children reported for abuse or neglect in 2014, 17% were found to have been maltreated (investigative track) or in need of services (family assessment track), and over half of these (57%) were in need of services (the maltreatment outcome from the family assessment track). Of the maltreated children, 21.5% (5,143) entered foster care in 2014. Of children entering foster care, 46% were initially or subsequently placed with a relative, and 8% were never placed in a family setting.

As of the end of 2014, 80% of children in foster care had one or two placements. Given that it has been less than a year for all but children who entered care on Jan 1, 2014, and 76.7% of children remain in foster care at the end of 2014, however, the number of placements is artificially low. For those children who have already left foster care after being in care for less than a year, 63% are back with a parent (reunified, or with the non-custodial parent) and an additional 17% are with a relative.

The median time in placement authority is long (440-475 days), but the reentry rate within a year of permanency is low (3-4%). While there are always improvements that can be made in North Carolina for children in need of protection or child welfare services, this report shows the child welfare system of North Carolina is caring for its children, keeping them safe, placing them with nurturing families and preserving the family connections, wherever possible.

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

FAQs on Foster Care
From the North Carolina Division of Social Services

What is Foster Care?

Foster care is a temporary living arrangement for abused, neglected, and dependent children who need a safe place to live when their parents or another relative cannot take care of them. Often their families face issues such as illness, alcohol or drug addiction, or homelessness.

When the county Department of Social Services (DSS) believes a child is not safe, and a judge agrees, DSS takes custody of that child and finds a foster home for him or her. Length of stay in foster care varies from a few days to much longer.

Foster families are recruited, trained, and licensed to care for abused and neglected children temporarily, while their parents work with social work professionals to resolve their family issues. Relatives may be licensed as foster parents.

The foster family, DSS and the birth family work together to return children to their own homes as quickly as possible. In cases where the child becomes free for adoption, foster parents may be considered as adoptive parents.

What Are the Different Types of Foster Care?

There are seven types of foster care placements. All of them except some kinship placements and all interstate placements are licensed by the State of North Carolina.

- **Kinship Care:** The court allows a child to live with his/her aunt, uncle, grandparents, or another relative.
- **Emergency Foster Care:** When DSS takes custody of children, they may spend a short time in emergency foster care, which may be a family home or a group home. Children can stay in these homes only for a short time.
- **Family Foster Care:** Children are taken care of by families trained and licensed to take care of children who have been separated from their own parents.
- **Group Homes/Residential Facilities:** Some children will be placed in group homes or residential facilities, depending on what best suits their needs. Here children will be taken care of by house parents or residential child care workers and may attend a school at the facility.
- **Treatment Programs:** Children with special physical or emotional needs that require professional treatment may live with other children receiving special care. This care is provided by specially trained residential child care workers.
- **Therapeutic Foster Care:** Some children need assistance with behavioral mental health or substance abuse problems, but do not need to be in a treatment program. In this case, a foster family is trained to provide specialized care to children with these special needs.

- **Interstate Foster Care Placements:** Sometimes, children may be placed in a foster care placement outside North Carolina. This usually happens when there are relatives living out of state who are willing and able to care for the children.

Who Are the Children?

Thousands of children in North Carolina enter the foster care system each year, and range in age from infants to 18 years old. All foster children have unique backgrounds, experiences, personalities, strengths and needs.

Some children in foster care require extensive care for physical or emotional handicaps and disabilities.

Some also require help with undisciplined and delinquent behaviors. Most foster children do not have a strong sense of belonging or self-worth. Many have been victims of physical or sexual abuse. All children who are in foster care require special care, support and nurturing.

Who Pays for the Child's Care?

Foster parents receive financial compensation from the placement agency for a child's room, board, and other living expenses. Sometimes there are supplemental payments for the care of children with special needs.

Although the amount of the financial compensation payments may vary from agency to agency and sometimes based on the individual needs of the foster child, the current (2015) state recommended rates are as follows:

- $475 for children ages 0 - 5
- $581 for children ages 6 - 12
- $634 for children ages 13 and over

Who Can Be a Foster Parent?

Foster parents must:

- Be at least 21 years old
- Have a stable home and income
- Be willing to be finger printed and have a criminal records check
- Maintain a drug free environment
- Complete all required training and be licensed by the state of North Carolina

North Carolina state law requires that all foster parents be licensed to care for children in their care. These licenses are issued by the N.C. Department of Health and Human Services. County Departments of Social Services and private child caring agencies are authorized to work with

potential foster parents to assist them with the licensing process and to provide supervision and support for the foster parents.

Potential foster parents receive 30 hours of training. The training covers topics such as child abuse and neglect, working with birth parents, and helping foster children deal with the issues they face. It also helps the potential foster parents think about how parenting another child may affect their family.

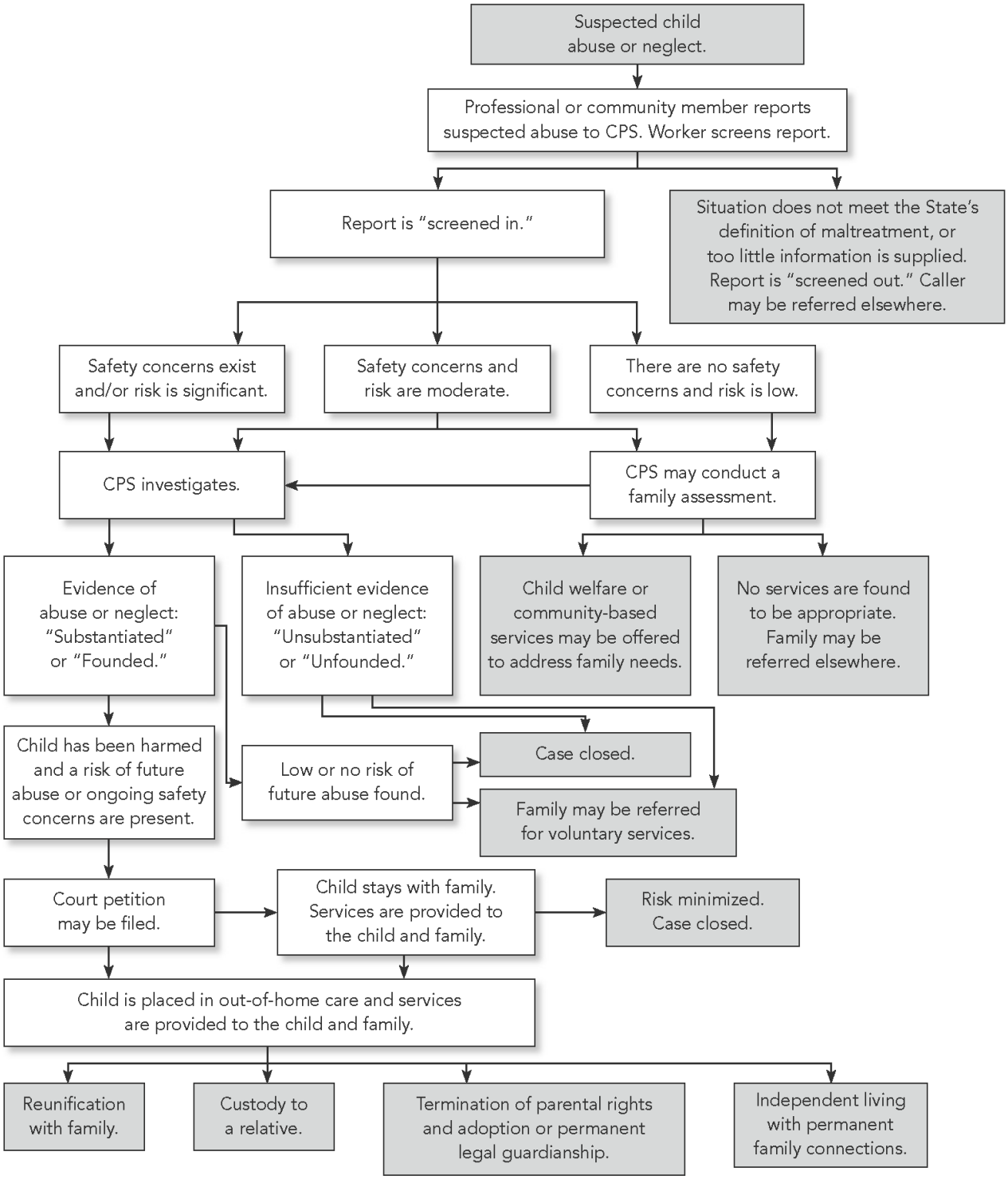
How Do I Become a Foster Parent?

To find out more on how to become a licensed foster parent you can visit our Licensing web page, call NC KIDS at 1-877-NCKIDS (1-877-625-4371) or contact your local County Department of Social Services. Your local County Department of Social Services can offer information that will help you decide if foster parenting is right for you.

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

Source: NC Division of Social Services http://www.ncdhhs.gov/dss/fostercare/ and http://info.dhhs.state.nc.us/olm/forms/dss/dss-5201.pdf

The Child Welfare System



Child Welfare:

WICKED PROBLEMS, GRAND CHALLENGES, & EVIDENCE-BASED SOLUTIONS

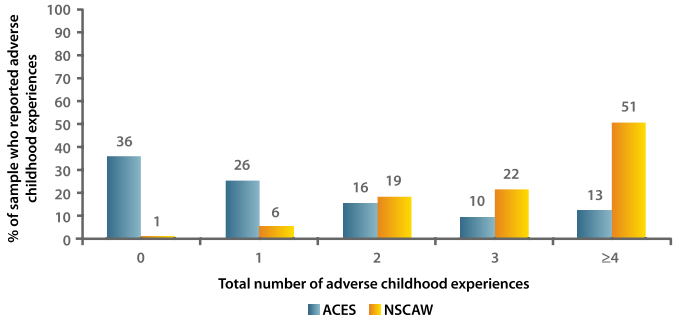
A WICKED PROBLEM

Child welfare is a wicked problem. By "wicked," we mean it is a problem that defies ordinary solutions.[1] It is wicked because as the priorities of the government change, definitions of the source of the problem shift between fixing the blame on inadequate and irresponsible parenting versus tying it to the stresses of the larger social environment. Whatever its source, child welfare problems are interconnected to drug abuse, domestic violence, and unmarried parenthood, at the individual level; concentrated poverty, institutional racism, and ineffective social policies, at the societal level. In setting policy, government continues to struggle with how to measure success and whether it is best to focus narrowly on child safety or a more broadly on social and emotional well-being.

Addressing the wicked problems of child welfare not only promises to prevent harm to children, it can potentially save money. Data from the National Survey of Child and Adolescent Well-Being (NSCAW) illustrate the widespread prevalence of Adverse Childhood Experiences (ACEs) among children who come to the attention of the child welfare system.[2] Studies show that "… cumulative exposure to ACEs may accelerate an individual's disease experience, putting them at increased risk for premature mortality."[3] If untreated, childhood trauma not only leads to poor health outcomes for individuals, but also expensive burdens for society.

Adverse Childhood Experiences[4]:
Physical abuse by a parent
Emotional abuse by a parent
Sexual abuse by anyone
Growing up with alcohol and/or drug abuse in household
Domestic violence
Experiencing incarceration of a household member
Living with family member experiencing mental illness
Loss of a parent
Emotional neglect
Physical neglect

Figure 1. Adverse childhood experiences in NSCAW vs. ACES



THE BARRIERS IMPEDING PROGRESS TOWARD RESOLVING THE WICKED PROBLEMS OF CHILD WELFARE CAN BE SURMOUNTED BY:

- Extending the authorization for IV-Waiver programs that promote fiscal responsibility and give states the flexibility to advance cost-effective solutions that are proven to work;
- Supporting the National Survey of Child and Adolescent Well-Being which is the only source of national data on child well-being outcomes;
- Prioritizing interconnected responses to child maltreatment by encouraging local collaborations via public-private and university-agency partnerships.

WICKED PROBLEMS INSTITUTES

To help shed light on the wicked problems of child welfare and to help drive a productive conversation towards practice-informed, evidence-based research to address these wicked problems, the University of North Carolina School of Social Work partnered with the Children's Home Society of America to convene a series of institutes that were held in 2012–2014 in Chapel Hill, Chicago, and Washington, DC. These Wicked Problems Institutes brought together child welfare administrators, service providers, researchers, philanthropists, and policymakers. The ideas and insights of this diverse, interdisciplinary group led to the identification of eight (8) grand challenges for child welfare that if addressed, could set a new direction for building innovative, evidence-based, and sustainable solutions to the wicked problems of child welfare.

EIGHT GRAND CHALLENGES

The nature of a wicked problem is such that it cannot readily be resolved by a single discipline or one sector of society. It requires overcoming grand challenges that if removed, could help resolve a wicked problem with substantial probability of success. Over the last two years, the Wicked Problems Institutes have assembled experts, service providers, and government officials to debate the wicked problems of child welfare and identify eight (8) grand challenges that must be overcome to set a new direction for building innovative, evidence-based, and sustainable solutions:

1. Reversing the adverse effects of child maltreatment on brain development
2. Harnessing the natural motivations of parents and kinship caregivers
3. Synthesizing research evidence on the effects of out-of-home care
4. Sustaining family continuity after legal permanence
5. Strengthening the voice of youth in the child welfare system
6. Linking well-being measures to administrative data on child safety and family permanence
7. Attracting private investments and using performance contracts to improve child and family services
8. Preparing the workforce for child welfare's future wicked problems and grand challenges

INNOVATIVE, EVIDENCE-BASED SOLUTIONS

Strengthening the evidence-base is essential if we are to address the wicked problems and grand challenges of child welfare. First, although we may intuitively have a feel for how to best address complex issues, we can't truly understand a wicked problem until we have evidence of a solution that works. The vigorous use of IV-E waivers coupled with rigorous evaluation can advance our understanding and improve child welfare. Second, the interconnected nature of wicked problems necessitates an interconnected response that includes public, private and university partnerships. Lastly, child well-being is the appropriate way to evaluate the effectiveness of child welfare interventions to support safe and permanent homes for children.

Through the Wicked Problems Institutes, we can learn critically important lessons that will help inform child welfare policy, practice and financing decisions at the local, state, and federal levels and move us forward toward achieving the interconnected goals of safety, permanence, and well-being.

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[1]Thorp, H. & Goldstein, B. (2010). *Engines of innovation: The entrepreneurial university in the twenty-first century.* Chapel Hill: The University of North Carolina Press.

[2]Stambaugh, L., Ringeisen, H. Casanueva, C., Tueller, S., Smith, K., & Dolan, M. (2013). Adverse childhood experiences in NSCAW. *Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, Report #2013-26.*

[3]Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults—The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258.

[4]Centers for Disease Control and Prevention. (2011). *Adverse Childhood Experiences (ACE) Study.* Retrieved May 1, 2012, from http://www.cdc.gov/ace/index.htm.

Overview

Well-Being: Federal Attention and Implications

Bryan Samuels & Clare Anderson

Well-being is core to a healthy, happy, and productive life. The well-being trajectory starts early and is intertwined with child development. Emerging science shows how adverse childhood experiences, trauma, and toxic stress derail healthy development and impact health (Centers for Disease Control and Prevention, 2013) and overall functioning throughout the lifespan (O'Connor, Finkbiner, & Watson, 2012). This issue of CW360° explores the concept of well-being as it relates to the needs of children served by the child welfare system as these children often experience significant adversity before and after they become involved with child welfare (Stambaugh et al., 2013). In this article, we provide an overview of federal policy and recent activity related to well-being along with implications for using a well-being framework in child welfare.

Federal Policy and Action Focused on Well-Being

For more than two decades, Congress has made the well-being of children known to child welfare an important component of its legislative agenda. Statutory requirements, both large and small, have directed child welfare to attend to the well-being needs of children. At times this has been an explicit directive such as in the Adoption and Safe Families Act (1997), which identifies safety, permanency, and "well-being" as equal goals. Other legislation requires action to address the emotional, educational, or social needs of children such as the Child and Family Services Improvement and Innovation Act of 2011 (i.e. State plans to address monitoring and treatment of emotional trauma associated with a child's maltreatment and removal from home). Even the founding piece of legislation, the Child Abuse Prevention and Treatment Act, has been amended over time to include "supporting and enhancing interagency collaboration…to address the health needs, including mental health needs, of children identified as victims of child abuse or neglect, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports" (2010).

In addition to Congressional legislation, special attention is being given to well-being at the Federal level. The Administration on Children, Youth and Families (ACYF) and its Children's Bureau are elevating the importance of well-being in their approach to improving child welfare outcomes. An organizing framework is guiding the field's understanding of well-being and its relationship to child development (i.e. "Promoting the Social and Emotional Well-being of Children and Youth Receiving Child Welfare Services" [Samuels, 2012a]), multiple discretionary grant opportunities and programs are being directed toward addressing well-being needs (e.g. "Initiative to Improve Access to Needs-Driven, Evidence-Based/ Evidence-informed Mental and Behavioral Health Services in Child Welfare" [ACYF, 2012]), and significant policy levers include well-being as a priority (i.e. "Child Welfare Demonstration Projects for Fiscal Years (FYs) 2012–2014" [Samuels, 2012b]). For more information on what is currently being undertaken at the federal level, please see Associate Commissioner of the Children's Bureau Joo Yeun Chang's article in this issue.

Well-being is now being more fully integrated with the safety and permanency pillars of child welfare, and this is driving action and innovation both federally and across the states.

Well-being is now being more fully integrated with the safety and permanency pillars of child welfare, and this is driving action and innovation both federally and across the states.

Child Development and Well-Being Framework

The framework identified above, released in 2012 by ACYF, defines an actionable well-being approach (Samuels, 2012a). It identifies four basic domains of well-being: cognitive functioning, physical health and development, behavioral/emotional functioning, and social functioning. Each of these domains includes measurable indicators that vary by age or developmental stage. This framework is strikingly similar to the one developed by Anthony Biglan and colleagues as part of the Promise Neighborhoods Research Consortium, which is based on 30 years of research (see Biglan, in this issue). In both frameworks, core domains of well-being are linked with measureable indicators of healthy child development. These frameworks provide a new way to understand which services and supports should be provided (i.e. evidence-based interventions that help a child get back on target developmentally) and to what end (i.e. measurable improvements in developmental functioning).

Meeting children's developmental needs, particularly those in the social and emotional domains, are fundamental to the work in child welfare. It is now clear that focusing on safety and permanency is necessary but not sufficient in addressing the developmental impacts of trauma and adversity. Recent advances in brain and developmental science show that it is these profound impacts that impede both short- and long-term functioning across the well-being domains. (For more on this topic, see Semanchin Jones & LaLiberte and Anda & Kovan, both in this issue).

Addressing Mental Health and Physical Health Needs – Service Use and Costs

Two new resources, when read together, provide important data on the usage and expense of both health and mental health services for children in foster care as covered by Medicaid. The Department of Health and Human Services Substance Abuse and Mental Health Services Administration's (SAMHSA) "Diagnoses and Health Care Utilization of Children Who are in Foster Care and Covered by Medicaid" (Center for Mental Health Services & Center for Substance Abuse Treatment, 2013) and the Center for Health Care Strategies' "Examining Children's Behavioral Health Utilization and Expenditures" (Pires et al., 2013) show that expenses for this population of children are driven predominately by their mental and behavioral health needs, and their health care costs are higher as well. The CHCS analysis also considers the quality of services and found that more often than not, all children in Medicaid with mental/behavioral health needs received "usual care" rather than a promising or evidence-based intervention.

These analyses help us understand the connection between the trauma experienced by children who have been maltreated and are in foster care, their resulting mental and behavioral health needs, the current approaches undertaken to address these needs and the associated costs, as well as the opportunities to reconsider whether children are receiving quality care.

Intervening More Effectively and Implications of Using a Well-Being Framework

Understanding trauma's impact on children's social and emotional functioning and health is an important place to start when considering how best to intervene and get children back on track developmentally. ACYF is providing significant resources and technical support to increase the use of valid and reliable trauma screening tools and tools that assess developmental functioning as these provide invaluable information about children's needs. Once a child's, or a group of children's, needs are identified, evidence-based interventions appropriate to age can be selected and implemented. It is also possible to use the assessment tools during or after the intervention to measure whether or not a child is returning to healthy functioning across the well-being domains and indicators. This evidence-based approach can provide not only a higher return on the fiscal investment but also improved outcomes (Lee et al., 2012; The California Evidence-Based Clearinghouse for Child Welfare, 2013). Secretary Sebelius' blog post of July 2013, "Helping Victims of Childhood Trauma Heal and Recover," announced the release of guidance from ACYF, SAMHSA, and the Centers for Medicare and Medicaid Services (CMS) on improving service delivery to include the use of screening, assessment, and evidence-based interventions (Sheldon, Tavenner, & Hyde, 2013).

Well-being deserves equal attention and resources as safety and permanency have received over the past two decades. This issue of CW360° provides many examples of the emphasis now being placed on well-being. While more collective effort is needed to fully realize the potential of this approach, much work has already begun. Federal leadership, innovations in states, organizations, and philanthropy, and a growing body of research and evidence all point toward a new landscape that emphasizes the importance of healthy development and well-being.

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Presidential Budget for FY2015

The Presidential Budget for FY 2015 includes an allocation for a new Medicaid demonstration project that would help states provide evidence-based psychosocial interventions to children and youth in foster care. Such interventions would work to reduce reliance on psychotropic medications and improve outcomes for children and youth in foster care. This budget request comes at a time of increased scrutiny and calls for oversight regarding psychotropic medication use among children and youth in foster care, as research has shown that this population is prescribed one or more psychotropic medications at a disproportionate rate. For more information on the Presidential Budget, please visit: http://z.umn.edu/presbudget

A Framework for Understanding and Promoting Child Well-Being[1]

There are various constructs, or frameworks, that have been designed to present, in an easily understood fashion, how both healthy and impaired functioning affects children across multiple domains of their lives and relates directly to how they interact with others and function on a daily basis. Many of these frameworks describe "domains of functioning" that have some commonality or overlap with other constructs.

The framework developed by the Administration on Children, Youth, and Families (ACYF) focuses on social and emotional well-being. The framework, which is adapted from the research of Lou, Anthony, Stone, Vu, & Austin (2008), establishes four well-being domains across which a child's functioning can be assessed, and provides for flexibility and refinement, depending on the age and developmental level of the child. For instance, independent living skills are indicators of well-being only for older youth. The framework's purpose is to present a way for child welfare agencies to understand and promote well-being that is aligned with ACYF's overall focus on system change, and, as such:

- Engages in continuous quality improvement (CQI) of child/youth functioning
- Takes a proactive approach to social and emotional needs
- Uses developmentally specific interventions
- Focuses on child and family outcomes
- Promotes healthy relationships for children and youth

In their research, Lou et al. found that some of the existing well-being frameworks were either too focused on deficits or did not account for the child's resilience or environmental supports. ACYF's framework addresses these concerns, incorporating two intermediate outcome domains, "environmental supports" and "personal characteristics," into the overall framework to illustrate factors that may influence a child's ability, positively or negatively, to cope with trauma. Environmental supports include family income, family social capital, and community factors such as neighborhood. Personal characteristics include the child's temperament, cognitive ability, identity development, and self-concept. The various factors within these two intermediary domains are related to the child's protective and coping factors.

Well-Being Domains

The four Well-Being Domains of the ACYF framework are:

- **Cognitive functioning**, which includes competencies such as language development, approaches to learning, problem-solving skills, academic achievement, school engagement, and school attachment
- **Physical health and development**, which incorporates the normative standards for growth and development, gross and fine motor skills, overall health, and risk-avoidance behavior related to health

[1] Excerpted from Child and Family Services Reviews Information Portal. Full text available online at: https://training.cfsrportal.org/section-4-trauma-child-welfare-system/2453

- **Emotional/behavioral functioning**, which includes competencies such as self-control, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms, self-esteem, emotional intelligence, self-efficacy, motivation, pro-social behavior, positive outlook, and coping
- **Social functioning**, which is defined by social competencies, attachment and caregiver relationships, social skills, and adaptive behavior

The components that make up these domains directly relate to how children live their day-to-day lives, or how they deal with frustrations, cope with tasks and responsibilities, and interact with others. In addition, the ACYF framework assesses functioning across the domains according to the child's age and developmental stage, as per these four stages:

- Infancy (0-2)
- Early childhood (3-5)
- Middle childhood (6-12)
- Adolescence (13-18)

Cognitive Functioning

The effects of maltreatment can linger long after the neglect or abuse occurs. Because caregivers have such a critical role in fostering children's cognitive development, the sensory deprivation caused by caregiver neglect appears to be particularly detrimental to the cognitive development of young children. Many neglected infants and toddlers demonstrate delays in language development, as well as deficits in overall intellectual ability.

Research has consistently found that maltreatment increases the risk of low academic achievement and problematic school performance. School performance is also significantly associated with a child's ability to regulate emotional responses and interact competently with peers and authority figures, abilities that are adversely affected by complex trauma. This may be manifested in the child as over-reliance on teachers for completion of tasks, reluctance to try challenging or new tasks, and poor relationships with classmates.

In early elementary school, maltreated children may show short attention spans and an inability to concentrate and organize thoughts or conform to the structure of the school setting. In middle school, children affected by complex trauma are more likely to face disciplinary actions. By adolescence, maltreated children may show problems with abstract reasoning and problem solving. Also, because of their ongoing behavioral issues, they may experience more frequent disciplinary action. Consequently, they may disengage academically.

Physical Health and Development

Aside from the obvious effects of serious injuries, like broken bones or brain injuries, and possible resulting disabilities from physical abuse, the physical pain from other types of abuse will eventually pass. However, maltreated children frequently experience additional kinds of

physical issues, such as failure to thrive (delayed weight gain and growth) and even brain damage, stunted growth, and mental retardation from chronic malnutrition. Because neglected and emotionally abused children must focus their mental energies on having their primary needs met, they cannot spend adequate time in motor activities and explorations. Consequently, delays in their physical development are not uncommon.

A report completed by the U.S. Department of Health and Human Services indicated that maltreated children from birth to 36 months are at substantial risk of experiencing developmental problems. The level of risk for developmental delay remains high even years after the initial maltreatment. Infants and toddlers who are neglected may exhibit poor muscle tone, delays in fine and gross motor skills, poor coordination and muscle control, and delays in reaching developmental milestones. They may be difficult to soothe and may have small stature. They may also be chronically ill; many have upper respiratory infections and digestive problems.

Trauma-affected children, particularly preschoolers, may also regress in their development and lose skills they had previously mastered. For example, toilet-trained children may suddenly lose their ability to control their bladders and have to re-learn toileting control. Maltreated children of school age may show general delays in physical development, with awkward gait and motor movement, poor coordination and muscle tone, speech and language difficulties, and low levels of strength as compared to their peers. They may also lack the coordination and skills necessary for perceptual-motor activities, such as playground activities or sports. As maltreated children enter their adolescent and teen years, they may begin to participate in risky behaviors such as smoking, promiscuous and/or unsafe sex, picking fights, and substance abuse, all of which may further affect their well-being.

The Adverse Childhood Experiences Study (ACE), an ongoing, decade-long collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Department of Preventive Medicine, addresses the effects of childhood experiences on adult health. Findings show that children who experienced adversity such as neglect, physical and sexual abuse, or exposure to domestic violence may likely have health problems in adulthood as a result. The study states that there is "a powerful relationship between our emotional experiences as children and our physical and mental health as adults." In other words, the effects of childhood trauma and maltreatment that distort children's lives can last for a lifetime.

Behavioral/Emotional Functioning

Children affected by trauma may present a variety of emotional issues. They may have experienced ongoing assault to their self-esteem from blaming or humiliating messages from a caregiver, or from lack of positive attention in a neglectful environment. They may feel powerless, vulnerable, exploited, and unlovable.

Because capacities to safely express emotions and to regulate emotional experiences are linked, children exposed to complex trauma may show impairment in both of these skills due to

neurological deficits and resort instead to maladaptive coping behaviors such as dissociation or emotional detachment to avoid further pain and anxiety. Dissociation can occur to varying degrees; in its most intense form, children may emotionally separate from their bodies during a traumatic event and become unaware of their surroundings. Following the trauma, memories of that experience may trigger the dissociative reaction. Other maladaptive coping behaviors include avoidance, which is withdrawal from a stressor or situation, and substance use or abuse.

Children exposed to trauma may also be “internally agitated" and display hyper-vigilance, an exaggerated startle response, a fast heart rate, and increased muscle tone. They may also have great difficulty maintaining a state of internal calm. Many traumatized children are diagnosed with Post-Traumatic Stress Disorder (PTSD), which may bring with it any number of these effects as well as panic attacks. Other common emotional and psychological effects of trauma are attention problems, bed-wetting, concentration problems, sexual reactivity, and acting out. The traumatized child may suffer from insomnia, depression, eating disorders, inability to concentrate, and self-mutilation. Additionally, a maltreated child may experience excessive loneliness, paranoia, lack of interest in daily activities, and poor relationships with others.

Because trauma-affected children may have multiple emotional issues and deficits, behavioral problems are not uncommon. Children who have experienced trauma may react with apathy, defiance, aggression, cruelty, and even rage in their day-to-day lives; they may appear unreceptive to treatment and efforts to intervene, and may be difficult for caregivers and teachers to manage. These children tend to have more placement changes in care, and caseworkers may be inclined to blame them for taxing caregivers to the point that the child's removal is requested. Many maltreated children exhibit emotional problems to the extent that a mental health diagnosis is made. Thus, it is critical that child welfare agencies screen for and assess trauma, and employ evidence-based, trauma-focused treatments for children in care.

Social Functioning

Social functioning is yet another aspect of a child’s life that may be negatively affected by maltreatment. The ability to become emotionally attuned to others and regulate emotions, otherwise referred to as "social competence," encompasses the capability to take another person's perspective, share experiences and learn from them, and apply that learning to further interactions with others. This ability to communicate and relate effectively to others is the building block for future interactions with people in all walks of life.

Because of their early negative experiences and possible alterations in neurological development, many maltreated children lack the capacity for basic trust in others and find it difficult to form appropriate friendships. The traumatized child may feel inferior and incapable around other children and may be overwhelmed by peer expectations of academic, social, and athletic performance. This can lead to the child becoming detached and withdrawn. Trauma-affected children may also be impulsive, have emotional outbursts, and experience difficulty in

deferring gratification. Schoolmates may view them with dislike and derision, and they may become scapegoats among peers.

Some maltreated children, particularly those who have experienced complex trauma, have difficulty learning basic social skills and may either over-comply with or defy authority figures. They may also be extremely shy and passive or, on the other hand, may employ aggression to solve interpersonal issues. In addition to their social awkwardness, trauma-affected children may have low self-esteem and be easily victimized by both peers and adults. These social difficulties, if left untreated, may affect children throughout their adult lives.

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

ACYF Well-Being Framework

	Intermediate Outcome Domains		Well-Being Outcome Domains			
	Environmental Supports	Personal Characteristics	Cognitive Functioning	Physical Health and Development	Emotional/Behavioral Functioning	Social Functioning
Infancy (0-2)	Family income, family social capital, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Temperament, cognitive ability	Language development	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Early Childhood (3-5)	Family income, family social capital, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Temperament, cognitive ability	Language development, pre-academic skills (e.g., numeracy), approaches to learning, problem-solving skills	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, self-esteem, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Middle Childhood (6-12)	Family income, family social capital, social support, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Identity development, self-concept, self-esteem, self-efficacy, cognitive ability	Academic achievement, school engagement, school attachment, problem-solving skills, decision-making	Normative standards for growth and development, overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competencies, social connections and relationships, social skills, adaptive behavior
Adolescence (13-18)	Family income, family social capital, social support, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Identity development, self-concept, self-esteem, self-efficacy, cognitive ability	Academic achievement, school engagement, school attachment, problem solving skills, decision-making	Overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competence, social connections and relationships, social skills, adaptive behavior
					Social and Emotional Well-Being Domains	

Source: U.S Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau, ACYF-CB-IM-1M-12-04, 04/17/2012

The Impact of Maltreatment on Children's Development[1]

There is a well-recognized relationship between child maltreatment and a variety of negative emotional, developmental, and health consequences. However, relatively new evidence also indicates that childhood trauma can actually alter the physiology of a child's brain, which may lead to significant negative impacts on the child's neurological development and mental health, and thus the child's social, emotional/behavioral, cognitive, and physical/developmental domains. These effects can diminish a child's relational competence and lead to the development of behavioral problems, which together can diminish the child's capacity to maintain effective interpersonal relationships, progress academically and vocationally, and become a productive member of his or her community. Furthermore, psychotropic medications may be inappropriately used to treat these effects.

Neurological Development

To understand how maltreatment can affect a child's neurological development, it is important to first understand that the brain is organized into and develops within four distinct regions. These regions range from least to most complex, and each region develops, organizes, and becomes fully functional at different stages of a child's development.

One of the more critical functions of the lower, or "micro-level," brain regions is the creation of neural networks that facilitate simultaneous communication across the regions. Impairment of these neural networks can result in a myriad of dysfunctions that extend from the lower regions to the higher, or "macro-level," regions. Thus, brain development in the higher regions that control functions like perception, reasoning, emotion, and problem-solving is dependent on development in the lower regions.

Many of the micro-level brain processes, including the critical development of neural networks, are dependent on an optimal level of activation, which in part comes from the environment or experience of the child. When the child has adverse experiences, such as loss, threat, neglect, or abuse, the brain's developmental processes can be disrupted in the micro-level areas and the neural connections can wither. This, in turn, can have a cascading negative effect on the macro-level regions of the brain. Depending on the degree and duration of the adverse experience, these effects can be significant and hamper the child's functioning well into adulthood.

Early childhood, during which neurons are organized to form the complex workings of the brain, is a critical time for brain development. This development includes essential neurological processes that establish patterns of behavioral and emotional functioning during subsequent stages of life. Since a child's early experiences and environment can significantly affect the development of specific areas of the brain, the impact of neglect and the impact of abuse on a

[1] Excerpted from Child and Family Services Reviews Information Portal. Full text available online at: https://training.cfsrportal.org/section-4-trauma-child-welfare-system/2446

child's brain can seriously affect his or her ability to regulate emotions and become emotionally connected with others in the future.

Impact of Neglect

Whether it is a lack of emotional or physical nurturance, neglect can negatively affect the child's neurological development. If a caregiver is depressed, chronically stressed, inconsistent, or absent, this can adversely affect the brain's neural networks that help the child to regulate stress and benefit from healthy, nurturing support. Essentially, these early experiences between the caregiver and child create a template for the child's brain, setting up associations that help determine the child's balance between resilience and vulnerability. Bonding and healthy caregiver/child interaction are critical in ensuring normal brain development; thus, the negative impact of neglect on the developing brain, beginning in the lower regions and expanding into the higher regions, can significantly impede a child's ability to develop socially and emotionally, and to meet developmental milestones.

For example, one of an infant's primary tasks is to determine how to have his or her needs met. Infants constantly assess whether their cries for comfort and food are answered or ignored. When infants feel safe and secure and their needs for food and soothing are met, their brains are free to explore, focus on the objects and people in the world around them, and develop socially and cognitively. If, however, responses to them are inconsistent or harsh, infants will concentrate their energy and brainwork on survival or ensuring that their needs are met. As a result, it becomes increasingly difficult for them to interact with surrounding people and objects, as their mental and emotional resources are focused on other tasks and their brains shut out the stimulation needed to develop healthy cognitive and social skills.

Impact of Abuse

Abuse, like neglect, can severely affect a child's neurological development. While mild or moderate levels of stress for a child within a supportive and nurturing environment can promote adaptive coping skills, abuse or severe neglect can expose children to chronic and abnormal levels of stress, which in turn can lead to elevated levels of cortisol, a stress hormone. These levels can become toxic and stunt the tissue growth of the hippocampus, an area of the brain that affects the child's ability to respond to future stress, regulate emotion, and retain memory.

Heightened stress can also impede the development of the prefrontal cortex, a part of the brain that controls critical functions like focusing, planning, self-regulation, and decision-making. All of these functions are essential for children to successfully navigate their way later in life, academically, in relationships, and in the workplace.

Mental Health

Children who have been maltreated, particularly those who have experienced complex trauma, may experience higher rates of mental health issues and more mental health diagnoses than other children. Some of the most common diagnoses of maltreated children include:

- Post-traumatic stress disorder (PTSD)
- Attention deficit/hyperactivity disorder (ADHD)
- Major depressive disorder (MDD)
- Conduct disorder (CD)/oppositional defiant disorder (ODD)

Since many of the children entering the child welfare system meet the diagnostic criteria for mental health disorders before they enter foster care, it is important that child welfare agencies promote mental health screening and assessment early in the child's involvement with the system. It is equally important to remember that there is currently no single diagnosis for the full range of issues that can be experienced by children affected by complex trauma. Behavioral health specialists may instead use one or several mental health diagnoses in an attempt to categorize the array of difficulties shown by many traumatized children. However, traditional mental health treatments may not aid traumatized children to better control behaviors and improve social relationships.

For example, in a comprehensive analysis of trauma-informed assessments administered to children who entered foster care in Illinois between 2005 and 2011, the researchers found that it was possible for children to have a mental illness and, at the same time, display trauma symptoms. The primary concern identified was that children did not receive trauma-focused treatment when they were either misdiagnosed with a mental illness or did not meet the criteria for PTSD. In both cases, the critical need to effectively address the trauma symptoms was neglected.

Child welfare agencies must focus on developing effective trauma-based screenings and assessments to capture trauma history and symptoms in children whom they serve, rather than relying solely on mental health screening and diagnoses to pinpoint behavioral and mental health needs. To be effective in this task, the relationship between trauma and mental health, and how decisions about treatment are affected by this interplay, must be understood. Otherwise, a traumatized child's condition may be treated in isolation, thereby ignoring the disarray of the traumatized child's condition as a whole.

Relational Competence

Relational competence refers to a child's ability to engage in beneficial caregiver and peer relationships, and navigate other social interactions. Trauma-affected and vulnerable children frequently have difficulty forming and sustaining relationships. This may be due to the absence of an early nurturing relationship with their primary caregiver. Nurturing relationships provide the context within which a child learns about reciprocal relationships. Also, in early

adolescence, the neurological development of the brain areas most crucial to successfully forming interpersonal relationships may be hindered by traumatic stressors.

If, however, children in the child welfare system are able to form and sustain supportive relationships with peers and adults, and other protective and coping factors are strengthened, their ability to cope with trauma can be greatly enhanced. Child welfare agencies should strive, through effective trauma-based screenings and assessments and trauma-informed systems, to strengthen the child's capacity to successfully build meaningful relationships with others, including the child's caregivers, by emphasizing the development and employment of critical interpersonal skills like cooperation, seeing another's perspective, boundaries, and empathy.

While this skill-building is taking place, agencies, caregivers, and others must continually strive to enhance the child's protective and coping factors by surrounding the child with caring, supportive adults; listening to the child; keeping the child's world as predictable as possible; and ensuring that the child has a secure attachment relationship. The goal is not only to enhance the child's self-esteem, but to make the child feel as psychologically and physically safe as possible.

Behavioral Problems

The National Survey of Child and Adolescent Well-Being (NASCAW) study showed that behavioral problems warranting mental health or behavioral services are common in children who have been maltreated or traumatized. Many of these children lack sufficient ability to regulate their emotions or impulsivity and may also have difficulty describing their feelings. They may be unable to articulate their wishes and desires in a socially acceptable way, and may manifest behavioral problems externally through bullying, fighting, or opposition; or internally through withdrawal, anxiety, or fear in the face of non-threatening events, or crying easily.

Caregivers of traumatized children with behavioral issues in the child welfare system frequently have difficulty coping with these children in the home. They do not understand why a child fails to respond to their affection, support, and structure with improved behaviors. The caregiver may eventually ask for the removal of a child with behavioral problems, particularly if the child is defiant and aggressive. This may further compound the child's social and emotional difficulties, and make permanency even more elusive.

Psychotropic Medications

The use of psychotropic medications for children has risen over the past 10-15 years, although there is currently no definitive, comprehensive information that shows the prevalence of psychotropic medication use among children in the child welfare system. However, published studies do indicate that there are higher rates of psychotropic medication use among children involved in child welfare than in the general population; older children, males, and children in residential or group settings are the most likely to have psychotropic medications prescribed.

Unfortunately, the full effect of these medications on a child's growth, development, and maturing neurological system remains unknown. What is known is that psychotropic medications can have a variety of side effects, including lethargy, withdrawal, weight gain, poor appetite, irritability, and sleep disturbances. They can also cause hallucinations, intrusive thoughts, and paranoia.

There are growing concerns that some children in foster care are prescribed too many psychotropic medications, that their dosages exceed approved recommendations, and that they are being prescribed psychotropic medication at too young an age. There has, in fact, been a dramatic rise over the past 20 years in the use of antipsychotic medications with foster children. A seven-state study found that the rate of antipsychotic medication use among foster children was almost nine times that of other Medicaid-covered children, even though foster children made up only three percent of the population of children on Medicaid. An additional concern is that because there is no clear diagnostic label for complex trauma, a default to a mental health diagnosis is resulting in the inappropriate over-use of psychotropic medication for traumatized children.

Despite these concerns, the high rates of psychotropic medication use among children in foster care may indicate, at least in part, the high level of emotional and behavioral needs of this population. Psychotropic medication may be necessary to effectively treat children or adolescents struggling with a mental illness, and can be helpful when children are so overwhelmed by their own behavior that their symptoms cannot be managed in other ways. However, if untreated emotional trauma underlies the presenting symptoms, use of medication as a primary treatment may be ineffective or even exacerbate existing problems, and the stabilization needed to effectively support growth and healing will not occur.

Pending Developments in Psychotropic Medication

Some states have made attempts to regulate, at least to some extent, the use of psychotropic medication for behavior and mood management among foster children, encouraging caregivers to become more skilled in dealing with children's challenging behaviors. Agencies are promoting more effective, evidence-based treatments for these children, coupled with trauma-focused training and education for staff and foster parents about caring for and managing behaviors of children with significant emotional and behavioral needs. The issues surrounding psychotropic medication use for children in foster care are being addressed through several Federal initiatives outlined in the Administration for Children, Youth and Families (ACYF) Information Memorandum, Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care (ACYF-IM-12-03).

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The Developmental Impact of Adverse Childhood Experiences Across the Life Course

Nikki Kovan, PhD & Rob Anda, PhD

The current scientific consensus suggests that the origins of many major health and social problems can, in large part, be found in the experiences of childhood (Anda et al., 2006; Shonkoff, Boyce, & McEwen, 2009). Understanding early development and how childhood experiences provide the foundation for healthy brain development is critical for promoting positive adaptation, health, and well-being (Anda & Brown, 2007; Shonkoff et al., 2009).

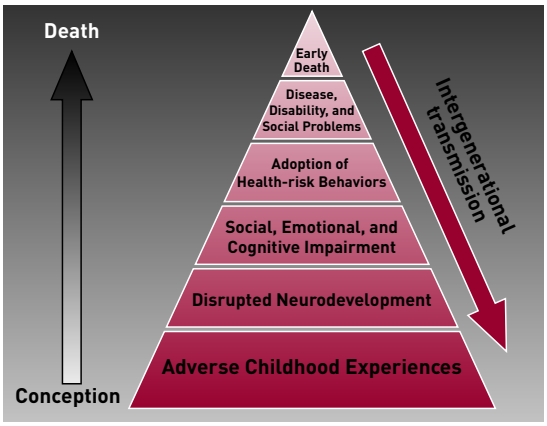
Infants are born with nearly all of the neurons, or brain cells, they will ever need, but a vast amount of brain development occurs after birth and well into early adult life. Responsive and predictable care promotes healthy brain development and functioning through the strengthening of adaptive connections, while experiences of adversity and neglect can disrupt and derail development of both the structure and functions of the brain (National Scientific Council on the Developing Child, 2005/2014), and can have implications for well-being and health throughout the life course.

The Adverse Childhood Experiences (ACE) study has been critical in demonstrating the impact of early adversity over the life course. The key concept underlying the ACE study is that stressful or traumatic childhood experiences such as abuse, neglect, witnessing domestic violence, or growing up with alcohol or other substance abuse, mental illness, parental discord, or crime in the home (which we termed adverse childhood experiences—or ACEs) are a common pathway to social, emotional, and cognitive impairments that lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability, and premature mortality (Figure 1; Anda, Butchart, Felitti, & Brown, 2010).

The study compared health and social histories of 17,421 adult Health Plan members of Kaiser Permanente (68% of the eligible participants) to their experiences in childhood (Anda et al., 1999; Felitti et al., 1998). It assessed 10 categories of childhood adversity and found that in the primarily middle class, well-educated study cohort, nearly two-thirds (64%) had at least one ACE (Dong et al., 2004).Thus, individual ACEs are common and highly interrelated; people who had one ACE tended to have others (Dong et al., 2004).

The ACE Score was developed to assess the cumulative impact of childhood adversity on development and therefore, its impact on a variety of health and social priorities in our country. The main finding was that the ACE Score is strongly related to many common health and social problems in the U.S., from leading causes of death such as heart and lung disease; to risk factors for poor health such as smoking and alcohol abuse; to poor mental health (Anda et al., 2010). And the probability of having such problems increased as the ACE Score increased. For example, when compared to participants with an ACE score of 0, participants who had a score of 4 or more were 3.6 times more likely to feel depressed, 7.2 times more likely to be an alcoholic, and 5.5 times greater risk of perpetrating intimate partner violence (Anda et al., 2006).

Figure 1. ACE Pyramid



This array of problems that arise from ACEs and the tendency for ACEs to co-occur calls for an integrated perspective on the origins of health and social problems throughout the lifespan. This perspective may improve our understanding of many seemingly unrelated health and social problems that tend to be identified and treated as categorically separate issues in Western society. In practical terms, both the systems and the people who work with children and adults who have experienced an ACE should use an integrated systems approach that 1) recognizes the inter-relatedness of ACEs and other risks (e.g. poverty) and 2) provides supports, services, and treatment that are comprehensive, including not only the individual but the context and environment in which the person lives.

There are strategies and factors that can promote healing and resilience to ACEs. First, intervening as early as possible, when brains are most amenable to change, is the best strategy to get healthy development back on track. This highlights the critical nature of adhering to the mandate through the Child Abuse and Prevention and Treatment Act (CAPTA), that all children, birth to three, receive a referral to Part C Early Intervention Services through the Individuals with Disabilities Education Act (IDEA) (Child Welfare Information Gateway, 2013).

Because ACEs are often transmitted from one generation to the next and tend to affect more than one member of the family, treatment and intervention efforts should be directed toward children, their parents, and other adults that interact with them. For example, the creation of safe, stable, and nurturing relationships can protect children from the consequences of adversity and promote healing after experiencing such trauma as the disruption of an attachment relationship (Sroufe, Egeland, Carlson, & Collins, 2005). For adults who have ACEs and may be transmitting them to future generations, access to a strong social support network may reduce the health risks associated with ACEs and help break the cycle of adversity (Porter, 2013). Finally, because most changes to the brain result from repeated exposure to the activated stress response, it is usually not enough to have just brief, short-term interventions when major disruptions to development have occurred.

Although the ACE research highlights the need for greater attention to prevention efforts, it is important to recognize that exposure to ACEs does not mean that any individual will have the problems associated with them. ACEs create risk, but ACEs are not destiny.

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From Foster Care to Advocacy: My Journey to Supporting Youth in the Foster Care System

By Marcella J. Middleton, age 23

I am originally from Denver, Colorado. I have three older brothers and a younger sister, and I am still very much in contact with my siblings as well as my biological mother and father. My siblings and I have a great relationship, and while it's not perfect, we all love and deeply care for one another. My mother and I have an on and off relationship but I still love her very much, and my father and I have just recently started building a bond. It's definitely a small bond, but it's a work in progress.

While in foster care, I had an estimated 16 plus moves/foster homes that I lived in, and that is not counting when I lived in Colorado. That also doesn't count the number of times that I was placed in respite care (another placement for foster youth when their foster parents go out of town, etc.). My moves became more frequent when I moved here to North Carolina, during my teenage years.

My future goals will always include advocacy work with and for youth in the substitute care system as well as youth who are not in the substitute care system but are still at-risk based on their parents' not so fitting choices and the lack of resources and support in their communities. I will continue to do this through my work with SAYSO (Strong Able Youth Speaking Out) as well as CFFACE (Center for Family and Community Engagement). I am also a singer/musician/writer, and I aspire to be a professional recording artist. Not because of the lights and the fame, but to be on a level where I can reach my young people and truly influence them to be the best "them" they can possibly be, because I love them. They are worth the hard work and dedication.

Education

I am a recent graduate from the University of North Carolina at Pembroke, and I graduated with my Social Work degree.

In high school I was suspended, in school, out of school, I was sent to alternative schools, I moved to over 5 different high schools, I was tormented by my peers in school for being in foster care. The list goes on, but what is salient in all that is the trauma that I was dealing with, the invisible suitcase that was my life and is the life of the youth I work with. The invisible suitcase is the suitcase that we foster youth bring to every home we are moved to, and it is first packed when we are taken from our biological families' homes. It is the trauma, the pain, the loss, all the undealt-with emotions from what we experience, and the load of that suitcase gets heavier with every move we make, every misguided foster family we deal with, every lost social worker, etc. I was angry, I was hurt and I was broken, as many of the youth I work with feel, but I knew I wanted better.

In my tenth grade year of high school, I decided that I was no longer going to be misunderstood, misrepresented, or taken for granted, and I was going to make and be a better me. So I stopped getting in trouble in school, which was difficult because people did things that of course upset me, but I knew that I had to gain self-control because my goals in life tremendously towered over those confrontational situations. My grades had improved, my attitude had improved, my spirit was finally free and I was becoming the person I've always known I was. I was overall balanced. I remember having a conversation with my social worker prior to this, and we were discussing my attending college. I mentioned to her that I wanted to go to UNC Chapel Hill and she told me that I wouldn't be able to get in. When I asked why, she told me "because of (my) behavior, no school would accept that type of behavior." Her honesty was the boost that I needed to continue to correct my own behavior. I will forever love her for that.

I wasn't supposed to be in college, and I really wasn't supposed to graduate college either, but I did and it was because I had the determination to succeed and be the best me that I could possibly be, but I also had a wonderful support team. That team includes my wonderful social worker, who was nothing but honest and loving towards me from the first day we met. I had my SAYSO family who loved me no matter what, and I had the support and love of the NC Reach and ETV (Education and Training Voucher Program) coordinator who guided me through college, all four years. Each one of these supports never gave up on me even when I made mistakes, and they all did that without being asked. If someone questioned how I know that, I would simply state, none of these people carried me for nine months, none of them were there when I learned to tie my shoes, or ride my first bike, but they all have acted like they were. They all loved me like I was their child. They are still in my life, and I am no longer in the foster care system – if that isn't raw proof then I don't know what is.

Life Skills

Many of the life skills that I was taught came from my biological mother. She taught my siblings and me how to cook, how to clean, how to keep our hygiene in order, etc. My mother taught me so many life skills. While I was in foster care, most of my foster parents didn't have time to teach me life skills. My social worker taught me how to drive, how to get my license, etc. I also got books from Independent Living Resources (ILR, Inc). For example, two books titled "Where's Mom Now that I Need Her?" and "Where's Dad Now That I Need Him?" filled the gaps for so many unlearned skills in my life. I learned how to keep up with the maintenance of my vehicle, I learned how to store food and not waste it and many more things.

Normalizing Foster Youth Lives

In my honest opinion I think that normalizing foster youths' lives happens when you:

Encourage shared parenting because youth are not going to let go of their parents no matter how bad they treated them. My biological mother has done so many heinous things to me, and I still call her and make sure she is okay and tell her I love her. We can encourage shared

parenting, and I think most youth might not go home to their biological parents if they see that they are not doing everything possible to get their child back and make a better life. I saw it with my mother so I loved her, but I still stayed in foster care because I saw that it was more stable for me, and in order for me to progress I needed stability.

Stop allowing placements to use “no contact with siblings” as punishment. When I was living with my biological mother if one of us got in trouble at school my mother didn’t punish us by saying we couldn’t talk to our sibling.

Allow siblings to see their family in jail. My brother was placed in jail when I was 16. It was one of the most devastating things to happen to me. I didn’t get to physically see him until three years later, and I’m still dealing with that loss.

Extending Foster Care

Research shows us that youth between the ages of 18 and 25 have the same growth spurt of children ages 0 to 5, and just the same way children are sponges during those years, young adults are, too. Research also shows that for every move that a youth in foster care makes, they lose about a year of maturity, so an 18-year-old who has had 6 moves is functioning at the maturity level of a 12-year-old. That is salient in understanding that most of the youth that I work with may be 18 but because of the many moves that they have had to make in foster care, they are really functioning at a much younger level and are not prepared to smoothly transition into adulthood. If these youth had a longer stay in foster care, they would have a greater chance at a smooth transition into adulthood.

Personally I am very happy that I was able to stay in foster care until the age of 21, because I wasn’t ready at 18 to fully be an adult and I knew that. I signed the CARS agreement (an agreement that allows you to have a stable place to come to if you are a full time student).

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

Repacking the Invisible Suitcase

Chaney Stokes As told to Johanna Zabawa, Research Assistant

"I believe that every young person should have a voice and I am striving to be that person who gives them the strength they need to be empowered." –Chaney Stokes.

Chaney Stokes is currently the Assistant Program Coordinator for SAYSO (Strong Able Youth Speaking Out), a non-profit organization in North Carolina. Stokes has been involved with SAYSO since entering into foster care at age fifteen. Since her transition from foster care, Stokes has become a dedicated advocate for change within the foster care system as well as an ally and support to those children and youth who have been through foster care placements. Below, Stokes discusses the "Invisible Suitcase," a concept that describes the thoughts and beliefs children with a history of trauma may carry with them about themselves, their caregivers, and the world at large (NCTSN.org).

Tell us a little about yourself

My name is Chaney Stokes and I am currently the Assistant Program Coordinator for SAYSO. After entering into foster care, I spent the majority of my teenage years in and out of placement. Being in foster care was very difficult for me at first because I still had a lot of unanswered questions about my past. I could not understand why people were telling me "it's not your fault," but I had to be removed from my home, my family, and my friends.

Tell us a little about your work with resource parents in the foster care system.

Over the last several years, I have worked closely with resource parents through state and national collaboratives. I have also been involved in the Resource Parenting Curriculum training (developed by the Child Welfare Committee of NCTSN), where I am a Family-Partner co-trainer. My role as a co-trainer is to support the curriculum material using my personal life experiences. A Family Partner co-trainer adds an authentic dynamic to the curriculum.

You've mentioned the "invisible suitcase;" can you tell us more about that?

In the Resource Parenting Curriculum, there is a module which gives information about an "invisible suitcase." The "invisible suitcase" is explained as being something that a young person who has experienced trauma will carry with them. Many young people in foster care will carry physical suitcases with them as they move from one place to another. The "invisible" suitcase is different because you can't see it which makes it harder to identify.

How does the "invisible suitcase" affect children in foster placement?

Besides the fact that a young person in foster care has experienced trauma and may have been hurt by someone they love, they will also carry thoughts about themselves that may be negative. For most young people in foster care it is not their choice or their fault that they have to be removed from their home, family, and friends. With unanswered questions about his/her life, it becomes very easy to think negative thoughts about yourself.

What are some of the most important things that caregivers should know about the "invisible suitcase"?

The best thing caregivers can know about the "invisible suitcase" is that it can be repacked with positive thoughts. When a young person enters into care, it is best to know that he/she may have thoughts about adults, themselves, and others that are probably negative. The best way to repack those thoughts is by saying and doing the opposite of what they already believe. If a young person feels that all adults lie, a caregiver can show that young person that not all adults lie by always telling that young person the truth.

What happens if the suitcase is never addressed?

If the "invisible suitcase" is never repacked, a young person can have a hard time coping, building new relationships, or even staying connected to past relationships. He or she can also go into adulthood with negative thoughts and possibly prevent successful achievement in their lives.

How did learning about and identifying the contents of your own "invisible suitcase" help you?

The "invisible suitcase" is something I know all too well. My "invisible suitcase" was filled with things like "No one cares about me", "It's my fault", "I'm not pretty", "All adults will do things for their own benefit", "I can't be loved", "I will never have a family." I wasn't sharing this information, so no one knew how I truly felt about myself. Eventually, several adults entered my life who took the effort to repack my "invisible suitcase." I was able to see that I am loved, that being in foster care was not my fault, and, despite not being connected to my biological family, that I am a part of many different families and they all love me as one of their own. Having a brand new "invisible suitcase" has helped me become the person I am today.

The "invisible suitcase" is explained as being something that a young person who has experienced trauma will carry with them.

For more information on "The Invisible Suitcase" visit the National Child Traumatic Stress Network at www.NCTSN.org.

Chaney Stokes is Assistant Program Coordinator for SAYSO (Strong Able Youth Speaking Out), in North Carolina. She can be reached at chaneyporter85@yahoo.com.

IMPROVING FAMILY FOSTER CARE

Findings from the Northwest Foster Care Alumni Study[1]

During fiscal year 2003 in the United States, 800,000 children were served by foster care services; 523,000 children were still in care at the end of that year. Relatively few studies have examined how youth formerly in care ("alumni") have fared as adults, and even fewer studies have examined what changes in foster care services could improve their lives. The Northwest Foster Care Alumni Study provides new information in both areas.

Case record reviews were conducted for 659 alumni (479 of whom were interviewed) who had been in the care of Casey Family Programs or the Oregon or Washington state child welfare agencies between 1988 and 1998. Findings for three domains are presented: Mental Health, Education, and Employment and Finances. This summary also provides an overview of a predictive analysis showing which foster care services, when optimized, hold the greatest promise for improving the outcomes for foster youth.

DEMOGRAPHICS AND PLACEMENT HISTORY

- Sample: 60.5% women and 54.4% people of color
- Average age at the time of interview: 24.2 years
- Mean length of time in care: 6.1 years
- Mean placement change rate: 1.4 placements per year

KEY FINDINGS

Mental Health

Compared to the general population, a disproportionate number of alumni had mental health disorders. Within the 12 months prior to being interviewed, their diagnoses included:

- One or more disorders: 54.4%
- Post-traumatic stress disorder (PTSD): 25.2% (a rate nearly double that of U.S. war veterans)[2]
- Major depression: 20.1%
- Social phobia: 17.1%

Education

Alumni completed high school (via diploma or GED credential) at rates similar to the general population; however, they used GED programs to complete high school at six times the rate of the general population.

Other findings included:

- Experienced seven or more school changes from elementary through high school: 65.0%
- Completed high school (via a diploma or GED credential): 84.8%
- Obtained a GED credential: 28.5%
- Received some education beyond high school: 42.7%
- Completed any degree/certificate beyond high school: 20.6%
- Completed a vocational degree: 16.1% (25 years and older: 21.9%)
- Completed a bachelor's degree: 1.8% (25 years and older: 2.7%)

Employment and Finances

Alumni experienced difficult employment and financial situations. Their employment rate was lower than that of the general population, and they lacked health insurance at almost twice the rate of the general population (ages 18 to 44 years).

Other findings included:

- Homeless for one day or more after age 18: 22.2%
- Employed full- or part-time (among those eligible to work): 80.1%
- Currently receiving cash public assistance: 16.8%
- Had household incomes at or below poverty level: 33.2%
- Had no health insurance: 33.0%

WHAT CAN IMPROVE FOSTER CARE OUTCOMES?

Statistical simulations were conducted to determine the effect of optimizing specific foster care experiences, including Placement History and Experience, Education Services and Experience, and Resources upon Leaving Care (a proxy for better preparation for independent living). When foster care experiences were optimized, estimated outcomes improved, revealing the potential power of targeted program improvements. Combining all improvements had an even more powerful effect on youth outcomes.

Placement History and Experience

Optimal Placement History and Experience was defined as having a low number of placements; short length of stay in care; low number of placement changes per year; and no reunification failures, runaway episodes, or unlicensed living situations with friends or relatives.

- Statistical optimization of this area reduced estimated negative education outcomes by 17.8% and reduced estimated negative mental health outcomes by 22.0%.

Education Services and Experience

Optimal Education Services and Experience was defined as having few school changes and access to supplemental education resources.

- Statistical optimization of this area reduced estimated negative mental health outcomes by 13.0%.

Resources upon Leaving Care

Optimal Resources upon Leaving Care was defined as having at time of exit from care $250 in cash, dishes and utensils, and a driver's license.

- Statistical optimization of this area reduced estimated negative education outcomes by 14.6% and reduced estimated negative employment and finance outcomes by 12.2%.

RECOMMENDATIONS

Mental Health

- Federal and state governments should eliminate barriers to valid assessment of mental health conditions and evidence-based mental health treatment. Barriers include restrictive eligibility requirements for funding and inadequate worker capacity for identifying and treating mental health problems.
- Maintain placement stability, which appears to have a large positive effect on adult mental health.

Education

- Emphasize the importance of obtaining a high school diploma, and create policies that support completion of high school by age 18 or 19.
- Caseworkers, foster families, and other stakeholders should encourage young people in foster care to plan for college or vocational school, and support them in being adequately prepared for higher education and training. Inform older youth about local college-preparatory programs, such as GEAR UP, TRIO, and Upward Bound, and help them enroll in these programs.[3]
- Minimize school placement change.

Employment and Finances

- Encourage the development of lifelong relationships with foster parents and other supportive adults so that alumni have places to live during difficult times.
- Implement systems-reform efforts to strengthen transitional housing and public/community housing systems.
- Reform life-skills development approaches to be more hands-on. Provide youth who are leaving care with a variety of opportunities to learn independent living skills and provide tangible resources, such as cash, household items, and a driver's license.

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[1] Abstracted from Pecora, P. J., Kessler, R. C., Williams, J., O'Brien, K., Downs, A. C., English, D., White, J., Hiripi, E., White, C. R., Wiggins, T., & Holmes, K. E. *Improving family foster care: Findings from the Northwest Foster Care Alumni Study.* Seattle, WA: Casey Family Programs. Available at http://www.casey.org.

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[3] Casey Family Programs (2003). *Higher education reform: Incorporating the needs of foster youth.* Seattle, WA: Author.

Midwest Evaluation of the Adult Functioning of Former Foster Youth[i]

Introduction

For most young people, the transition to adulthood is a gradual process (Furstenberg, Rumbaut, & Settersten, 2005). Many continue to receive financial and emotional support from their parents or other family members well past age 18. This is in stark contrast to the situation confronting youth in foster care. Too old for the child welfare system, but often not yet prepared to live as independent young adults, the approximately 28,000 foster youth who "age out" of care each year (U.S. Department of Health and Human Services, 2011) are expected to make it on their own long before the vast majority of their peers.

The federal government has recognized the need to help prepare foster youth for this transition to adulthood since Title IV-E of the Social Security Act was amended in 1986 to create the Independent Living Program. For the first time, states received funds specifically intended to provide their foster youth with independent living services. Federal support for foster youth making the transition to adulthood was enhanced in 1999 with the creation of the John Chafee Foster Care Independence Program. This legislation doubled available funding to $140 million per year, expanded the age range deemed eligible for services, allowed states to use funds for a broader range of purposes (e.g., room and board), and granted states the option of extending Medicaid coverage for youth who age out of foster care until age 21. Vouchers for postsecondary education and training have also been added to the range of federally funded services and supports potentially available to current and former foster youth making the transition to adulthood.

More recently, there has been a fundamental shift toward greater federal responsibility for supporting foster youth during the transition to adulthood. The Fostering Connections to Success and Increasing Adoptions Act of 2008 amended Title IV-E to extend the age of Title IV-E eligibility from 18 to 21. States are now able to claim federal reimbursement for the costs of foster care maintenance payments made on behalf of Title IV-E eligible foster youth until they are 21 years old.

This change in federal policy was informed by findings from the Midwest Evaluation of the Adult Functioning of Former Foster Youth (the "Midwest Study"), the largest longitudinal study of young people aging out of foster care and transitioning to adulthood since the passage of the John Chafee Foster Care Independence Act in 1999.

Background on the Midwest Study

The Midwest Study is a collaborative effort among the public child welfare agencies in the three participating states (Illinois, Iowa, and Wisconsin), Chapin Hall at the University of Chicago, and the University of Wisconsin Survey Center. Its purpose is to provide states with the first comprehensive view of how former foster youth are faring as they transition to adulthood since the John Chafee Foster Care Independence Act of 1999 became law.

Youth were eligible to participate in the study if they were in the care of the public child welfare agency at age 17, if they had entered care prior to their 16th birthday, and if the primary reason for their placement was not delinquency. We make comparisons between the 596 young adults in our sample of former foster youth and a nationally representative sample of 890 25- and 26-year-olds who participated in the fourth wave of the National Longitudinal Study of Adolescent Health (henceforth referred to as the "Add Health Study").[ii]

The report describes what we learned about how these young adults were faring across a variety of domains, including living arrangements, relationships with family of origin, social support, education, employment, economic well-being, receipt of government benefits, physical and mental well-being, health and mental health service utilization, sexual behaviors, pregnancy, marriage and cohabitation, parenting, and criminal justice system involvement.

The picture that emerges from the following chapters is disquieting, particularly if we measure the success of the young people in our study in terms of self-sufficiency during early adulthood. Across a wide range of outcome measures, including postsecondary educational attainment, employment, housing stability, public assistance receipt, and criminal justice system involvement, these former foster youth are faring poorly as a group. As we discuss in the conclusion of the report, our findings raise questions about the adequacy of current efforts to help young people make a successful transition out of foster care.

Outcomes at Ages 25 and 26

Living Arrangements

- Just under one-third were living in their "own place" (Add Health study peers: nearly one-half), while 18 percent were living with a biological parent or other relative (Add Health Study peers: 17 percent).

- Thirty-one percent reported having couch surfed or been homeless, including 7 percent who had experienced episodes of both.

Relationships with Family of Origin and Mentoring

- Despite having been removed from home and placed in foster care, seventy-four percent reported feeling very close, and another 20 percent reported feeling somewhat close, to at least one biological family member.

- A majority reported having maintained a positive relationship with a caring adult other than a parent since age 14. Nearly three-quarters felt very or quite close to his or her mentor.

Education

The educational deficits that were observed among Midwest Study participants at each of the first four waves of data collection have persisted into their mid-twenties.

- One-fifth did not have a high school diploma or a GED. Compared with their Add Health counterparts, Midwest Study participants were three times more likely not to have a high school diploma or GED.
- Add Health Study participants were almost six times more likely to have a postsecondary degree (46% vs. 8%), and 9 times more likely to have a degree from a four-year school than their counterparts in the Midwest Study (36% vs. 4%).
- Just over one-third reported that they had ever dropped out of a postsecondary educational program. The most common reason for dropping out was needing to work, and the most common barriers cited in preventing them from continuing their education were being unable to pay for school and needing to work full time.
- Nearly 80 percent of the Midwest Study participants believed they need additional education to achieve their career goals

Employment, Earnings, Economic Hardships, Receipt of Government Benefits

- Seventy percent of the young adults in the Midwest Study reported having any income from employment during the past year (Add Health study peers: 94%).
- The difference in median annual earnings between the groups was more than $18,000.
- Participants who were currently employed earned an average of $10.73 per hour.
- Nearly three-quarters of those who were employed part-time reported that they wanted full-time work.
- Less than half of the Midwest Study participants reported having a checking or savings account. About the same percentage owned a motor vehicle and only 9 percent owned a home (Add Health study peers: 30%). More than one third reported having debt, *excluding* student, home, or auto loans.
- Approximately one-quarter put off paying a bill in order to buy food and nearly as many received emergency food from a pantry.
- Two-thirds of the young women and 42 percent of the young men reported that they had been food stamp recipients during the past year.

Physical Health and Access to Health Care Services

- More than four-fifths of the Midwest Study participants described their health as good to excellent and fewer than one in five reported having a chronic health condition. However, they were twice as likely as their Add Health counterparts to describe their health as fair or poor and nearly twice as likely to report that a health condition or disability limits their daily activities. Only 7 percent reported that they were currently taking medication or receiving treatment for their health condition or disability.

- Over half of the Midwest Study participants reported at least one emergency room visit during the past year, and one-fifth reported being hospitalized at least once.

- Nearly 6 in 10 Midwest Study participants reported having health insurance. Approximately two-thirds of the young adults who had health insurance were covered by a government program (e.g., Medicaid or S-CHIP). Still, young adults in the Midwest Study were significantly less likely to report having health insurance than their Add Health counterparts.

Mental Health: Symptoms and Service Utilization

- Social Phobia: Over one-third of the Midwest Study participants reported having experienced unusually strong fears of social situations during the past year.

- Depression: Nearly one in four Midwest study participants reported having experienced at least 2 weeks of feeling sad, empty or depressed for most of the day during the past year, and more than one in five reported having lost interest in most activities they usually enjoy. Approximately 6 percent reported thinking about suicide within the past 12 months, including 2 percent who reported attempting suicide.

- Posttraumatic Stress Disorder (PTSD): Nearly 80 percent reported being exposed to one of nine specific types of traumatic events over the course of their lifetimes or some other extremely stressful or upsetting event not specifically mentioned. Nearly 60 percent of those who were exposed to an extremely stressful or upsetting event reported experiencing at least one negative cognitive, emotional, or physical symptom during the past 12 months when reminded of the event.

- Alcohol Use: Fifty-six percent of the Midwest Study participants reported consuming at least 12 alcoholic beverages during the past year. Sixteen percent of those met the DSM-IV criteria for alcohol abuse and 13 percent met the criteria for alcohol dependence.

- Substance Use: Twenty-five percent of the Midwest Study participants reported using any of a long list of substances during the past year, with marijuana being the most commonly used by far. Nearly 23 percent of the Midwest Study participants who reported using drugs

during the past year met the DSM-IV criteria for substance abuse and 20 percent met the criteria for substance dependence.

- Mental Health Service Utilization: One in five Midwest Study participants reported receiving mental or behavioral health care services during the past year, with psychotropic medication being the most common and substance use treatment being the least common. Five percent reported being hospitalized for mental health problems since their last interview. The most frequently cited reasons for not receiving mental health care were similar to the most frequently cited reasons for not receiving physical health care: treatment being too expensive and not having insurance.

Marriage, Cohabitation, and Pregnancy

- Midwest Study participants were less likely to be currently married or cohabiting than the young women and young men in Add Health, and they were also less likely to ever have been married.

- Nearly 80 percent of young women had ever been pregnant (Add Health study peers: 55%). Nearly one-third of the young women had been pregnant before age 18.

- Young men who had gotten a partner pregnant since their most recent interview were less likely to report that they had been married to their partner and less likely to report that they had been using birth control around the time of conception than their peers in the Add Health Study.

Illegal Behavior and Criminal Justice System Involvement

- One-third of the young men and 18 percent of the young women in the Midwest Study reported engaging in at least one of 17 illegal behaviors during the past year.

- A majority of the young women and more than four-fifths of the young men reported ever having been arrested.

Civic Participation

- Nineteen percent reported that they had performed volunteer or community service work during the past 12 months (Add Health study peers: 38%).

- Nearly three-quarters reported that they were currently registered to vote, and two-thirds had voted in the most recent presidential election.

Life Satisfaction and Future Orientation

- Almost two-thirds of the young adults in the Midwest Study reported feeling satisfied or very satisfied with their lives as a whole.
- Nearly 90% reported feeling fairly to very optimistic about their futures.

Discussion and Next Steps

We began following this sample of young adults when they were just 17 or 18 years old and still in foster care. Although these 26-year-olds still have much of their lives ahead of them, they are now well into early adulthood. Unfortunately, as a group, they are faring poorly. What, then, should we conclude from our data about current efforts to prepare young people aging out of foster care for a successful transition to adulthood? The outcomes of the Midwest Study participants at age 26 suggest that young people are aging out of foster care without the knowledge and skills they need to make it on their own. Hence, more attention should be paid to evaluating the services and supports that this population now receives, using methodologically sound research designs (Montgomery, Donkoh, & Underhill, 2006).

Some states have responded to the older-youth provisions in the Fostering Connections Act by extending foster care through age 21; others will do so over the coming years. The National Youth in Transition Database will, over time, reveal whether these changes bear fruit in terms of improved foster youth outcomes. Moving forward, we will continue to analyze the Midwest Study data to identify factors that predict which young people are likely to struggle to make it on their own and which are likely to experience a successful transition to adulthood.

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

[i] Text excerpted and condensed from *The Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26*, Chapin Hall, 2011. Full text is available online at: http://www.chapinhall.org/sites/default/files/Midwest%20Evaluation_Report_4_10_12.pdf

[ii] Add Health is a federally funded study designed to examine how social contexts (families, friends, peers, schools, neighborhoods, and communities) influence the health-related behaviors of adolescents and how those health-related behaviors are related to young adult outcomes.

THE REAL COST OF
CHILD ABUSE AND NEGLECT

July 2014

Child Welfare agencies and Medicaid programs can collaborate to reduce these costs and improve health outcomes for children. To learn more about these opportunities and examples of successful collaboration go to http://www.publicconsultinggroup.com/landingpage/white_papers/approaches.html

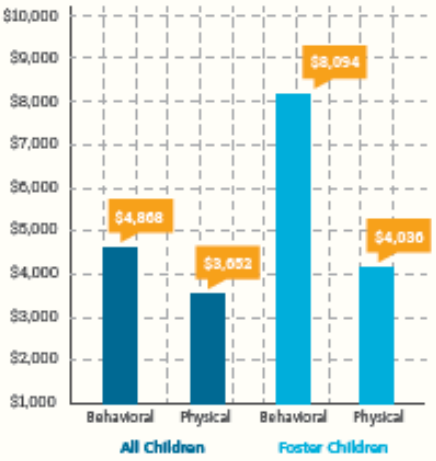
1.5X

Children investigated by the welfare system have been found to have **1.5X** more chronic health conditions than the general population.

28%

Over **28%** of children involved with maltreatment investigations are diagnosed with chronic health conditions during the three years following the investigation.

Average behavioral and physical health expenditures for children in foster care are much higher than other similar Medicaid peers:

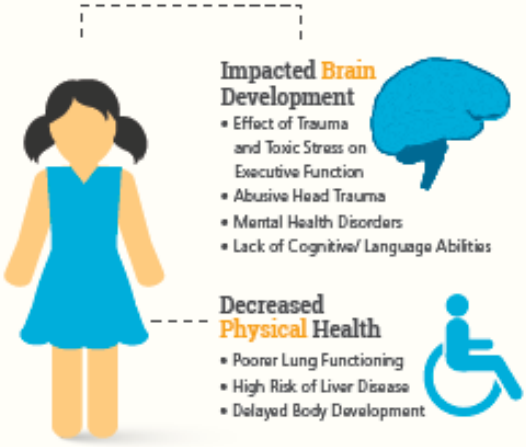


Children in foster care who are prescribed psychotropic medication are more likely than other Medicaid children to receive multiple medications.

49% prescribed 2+

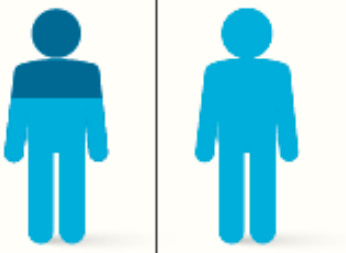
20% prescribed 3+

Children in foster care represent just **3%** of the Medicaid child population, but account for **15%** of those using behavioral health services, and **29%** of total behavioral health spending for children.



Impacted Brain Development
- Effect of Trauma and Toxic Stress on Executive Function
- Abusive Head Trauma
- Mental Health Disorders
- Lack of Cognitive/ Language Abilities

Decreased Physical Health
- Poorer Lung Functioning
- High Risk of Liver Disease
- Delayed Body Development



74% **100%**

Children with maltreatment reports have a **74-100%** higher risk of hospital treatment.

$$$$

The estimated lifetime cost per victim of nonfatal child maltreatment is over **$200,000**, which includes **$32,648** in childhood health care costs.

PUBLIC CONSULTING GROUP

Sources:

1 Chronic Conditions Among Children Investigated by Child Welfare: A National Sample. February 18, 2013; Pediatrics - Official Journal of the American Academy of Pediatrics

2 Child Abuse Prevention and Treatment Act (CAPTA), (42 U.S.C.A SSA5106g)

3 Child Maltreatment and Pediatric Health Outcomes: A Longitudinal Study of Low-Income Children. June 2010; Journal of Pediatric Psychology

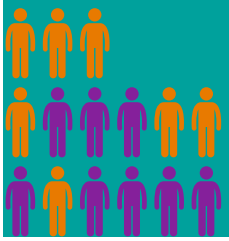
4 The economic burden of child maltreatment in the United States and implications for prevention. Child Abuse & Neglect, February 2012, Volume 36, Issue 2

5 Administration for Children and Families, Office of Planning, Research and Evaluation (ACF/OPRE), 2007.

6 Pires, SA, Grimes, KE, Allen, KD, Gilmer, T, Mahadevan, RM. 2013. Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures. Center for Health Care Strategies: Hamilton, NJ

CHCS Center for Health Care Strategies, Inc.

FACES OF MEDICAID DATA BRIEF
December 2013



IDENTIFYING OPPORTUNITIES TO IMPROVE CHILDREN'S BEHAVIORAL HEALTH CARE:
An Analysis of Medicaid Utilization and Expenditures

By Sheila Pires, Katherine Grimes, Todd Gilmer, Kamala Allen, Roopa Mahadevan, and Taylor Hendricks

IN BRIEF

Children with behavioral health needs served by Medicaid require an array of services to support their health and well-being, but the current system often does not meet their needs, resulting in missed opportunities to improve outcomes. To better understand the patterns of service use and costs for these children, the Center for Health Care Strategies analyzed behavioral health care use and expense for children in Medicaid in all 50 states. This brief highlights key findings from the analysis, revealing that:

- Children using behavioral health care represented under **10 percent** of the overall Medicaid child population, but an estimated **38 percent** of total spending for children in Medicaid;
- Children in foster care and those on SSI/disability together represented **one-third** of the Medicaid child population using behavioral health care, but **56 percent** of total behavioral health service costs; and
- Almost **50 percent** of children in Medicaid who were prescribed psychotropic medications received no identifiable accompanying behavioral health treatment.

These findings point to significant opportunities for quality improvement in the organization, delivery, and financing of care for children with behavioral health needs in Medicaid. For complete study findings, access the full report, *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures*, at **www.chcs.org**.

Children with significant behavioral health needs typically require an array of services to support their physical, intellectual, and emotional well-being. These children, however, are often served through fragmented systems, leading to inefficient care, costly utilization, and poor health outcomes. As a significant source of funding for children's behavioral health care,[1] Medicaid programs can advance fundamental improvements in care coordination and delivery for these vulnerable children.

To identify ways to improve behavioral health care, the Center for Health Care Strategies (CHCS) conducted a nationwide analysis, *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures* (*Faces of Medicaid*). This study analyzes data from all 50 states to explore: (1) behavioral and physical health service use, expense, and diagnoses; (2) use of psychotropic medications; and (3) service use and expense for children in foster care and those with developmental disabilities. This analysis, which uses 2005 data (the most recent data available when the study began), provides a critical baseline for examining child behavioral health utilization and expenses for Medicaid populations. CHCS is pursuing a follow-up study using 2008 data to further explore trends in this area.

State policymakers and other key stakeholders can use the findings to inform quality improvement efforts in children's behavioral health systems, such as:

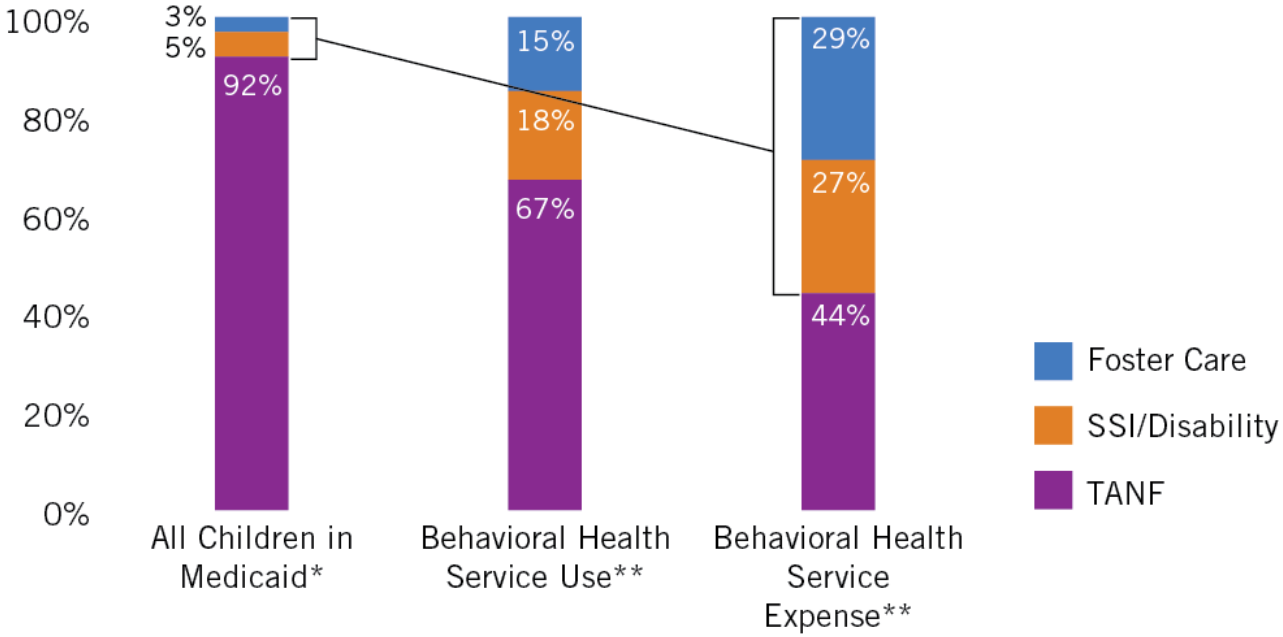
- **Expanding access to appropriate and effective behavioral health care**, particularly therapeutic interventions with an existing or emerging evidence base, and home- and community-based services;
- **Investing in care coordination** models that use a wraparound approach to facilitate delivery of needed supports and services for vulnerable populations; and
- **Ensuring collaboration across child-serving systems** to increase care coordination and improve oversight and monitoring of psychotropic medication use.

Made possible by the Annie E. Casey Foundation, with additional support from the Substance Abuse and Mental Health Services Administration and The Commonwealth Fund.

Examining Children's Behavioral Health Service Utilization and Expenditures

Children in foster care and those with SSI/disability eligibility together represent only 8% of the Medicaid child population, but their care accounts for 56% of total behavioral health spending.

MEDICAID ENROLLMENT, BEHAVIORAL HEALTH SERVICE USE, AND EXPENSE BY AID CATEGORY



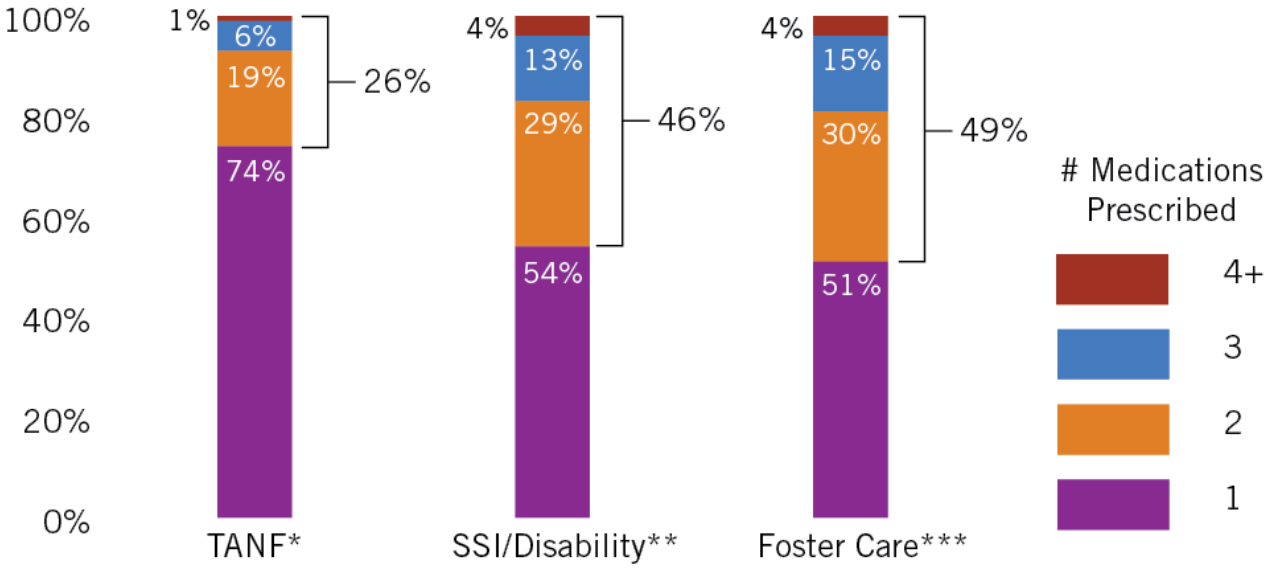
* All children in Medicaid in 2005, N=29,050,305.
** Behavioral Health service use and expense in 2005, N=1,958,908.

Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

CHCS Center for Health Care Strategies, Inc.

Children in foster care who are prescribed psychotropic medications are more likely than children in other aid categories to receive multiple medications, with 49% prescribed 2 or more, and close to 20% prescribed 3 or more.

CONCURRENT PSYCHOTROPIC MEDICATION USE AMONG CHILDREN IN MEDICAID

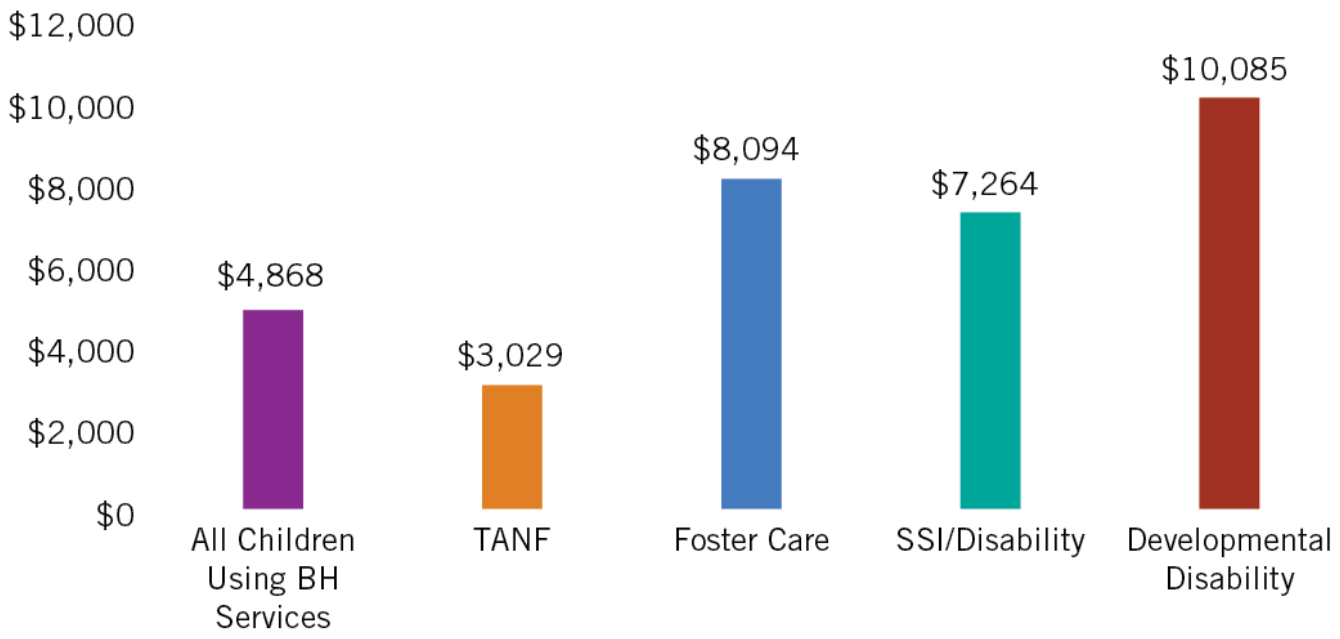


*N=1,119,266 **N= 354,945 ***N= 212,176

Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, 2013.

Behavioral health expenses for children in Medicaid with a developmental disability are significantly higher than for other children using these services.

MEDICAID BEHAVIORAL HEALTH SERVICES SPENDING PER ENROLLEE*



* Only includes children in Medicaid using behavioral health services in 2005, with or without concomitant psychotropic medication use, who are not enrolled in a comprehensive managed care organization; All Children Using Behavioral Health Services, N = 1,213,201; TANF, N = 730,764; Foster Care, N = 227,688; SSI/Disability, N = 254,749; Developmental Disability, N = 52,151.

Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

Behavioral Health Service Utilization and Cost for North Carolina's Foster Children: A Report for Partnering For Excellence

By Susan Cohen Foosness, MSW MPP

Introduction

The foster care population in North Carolina is of special interest to policymakers, politicians, Medicaid officials, child welfare professionals, and healthcare providers. This group of infants through young adults faces unique challenges in their educational, social, emotional, developmental, physical growth and especially their cost to a number of our social service systems. Their elevated needs put extra pressure on already stressed systems with limited financial resources. High levels of behavioral health and emotional problems lead to placement disruptions, costly interventions, and require extra diligence on the part of caseworkers, foster parents, and professionals to manage crises and keep foster children safe.

It is essential to identify strategies to address the behavioral health needs of foster children within the constraints of limited resources, and in ways that take advantage of the most recent research on evidence-based treatments. These strategies should aim to reduce placement disruptions and promote healthy outcomes for foster children. By using existing data collection systems within the Department of Social Services and Local Management Entity-Managed Care Organizations (LME-MCOs), we can gain important insight into this population's health and mental health needs, access to services, utilization, and cost. These data will also provide us with an opportunity to improve the existing systems and recommend policy changes.

Medical Costs and Foster Care in North Carolina

According to data provided by CCNC:

- Foster children's average Per Member Per Month (PMPM) cost in the second quarter of 2013 was $936, four times higher than the average non-foster care child enrolled in CCNC ($232). The PMPM cost is limited to claims data and does not encompass the care coordination services essential for children with special health care needs provided by CCNC.
- Foster children were also more likely to have visited an Emergency Room than non-foster children enrolled in CCNC.

Behavioral Health Diagnoses of Foster Children in North Carolina

Using diagnostic codes and data collected in the quarter ending in July 2013, CCNC found that:

- About 24% of the 7,626 children in foster care had a diagnosis of ADHD compared to 8% in the non-foster care child population.

- 51% of foster children seen by a primary care physician in the CCNC network had at least one mental health diagnosis (depression, PTSD, bipolar, anxiety, schizophrenia, or other).
- Foster children enrolled with CCNC have higher rates of Developmental Disabilities (17%) than the general non-foster care child population (5%). These children require additional case management and supplementary therapies in educational and outpatient settings such as physical therapy, speech and language therapy, and occupational therapy.

North Carolina Behavioral Health Costs

Data on the costs of behavioral health services in North Carolina for foster children are difficult to collect due to the fractured health delivery system. While utilization and costs for medical services are processed through CCNC, each LME-MCO has their own data on behavioral health services, and foster children are often not tracked.

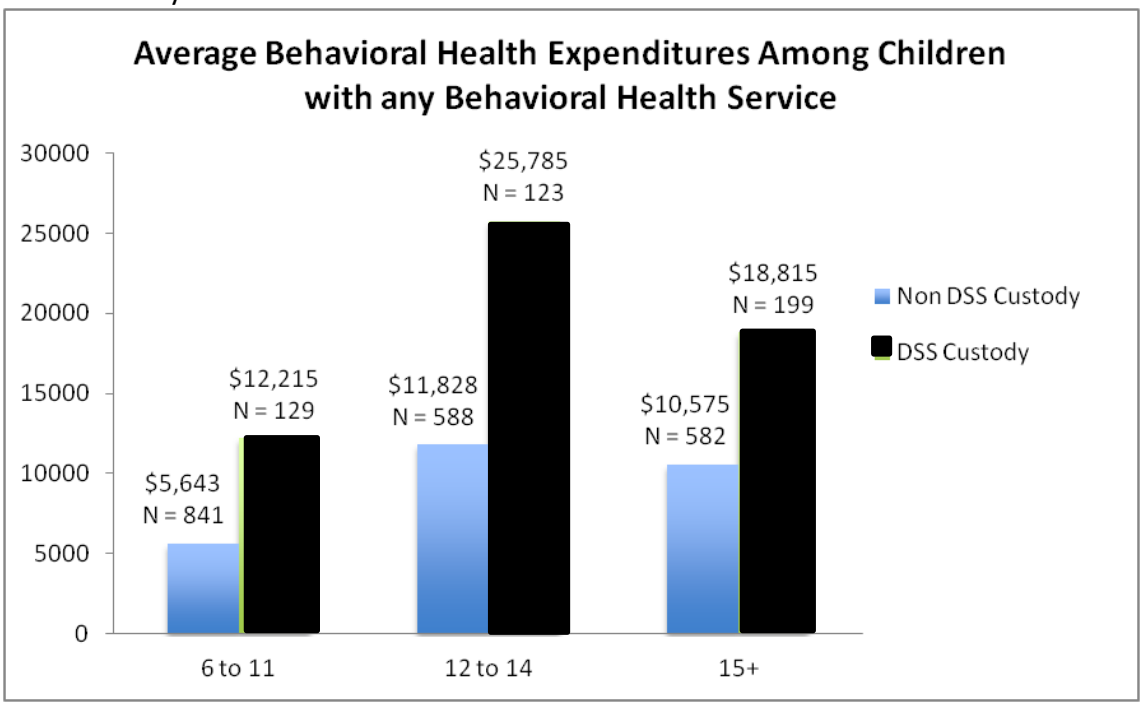
Some limited preliminary data are available from Project Broadcast, a project funded by the Children's Bureau of the US Department of Health and Human Services Administration for Children & Families piloted in nine counties in North Carolina.

- In 2011, approximately 30% of children in foster care in Buncombe, Craven, Cumberland, Hoke, Pender, Pitt, Scotland, Union and Wilson had a prescription for at least one psychotropic drug.
- These medications cost Medicaid on average $150,000 each month just for the 350 children in these nine counties.
- Children were most commonly prescribed second-generation antipsychotics (Seroquel, Abilify, and Risperdal) used for behavioral issues and mood disorders.
- Placement in a Psychiatric Residential Treatment Facility (PRTF) is a costly residential option for children with the most severe mental health needs. On average about 30 children across the nine Project Broadcast counties were placed in PRTFs in 2011. The cost for this treatment varies between $300,000 and $400,000 per month for this group of foster children.

Behavioral Health Service and Expenditure Data from One N.C. County

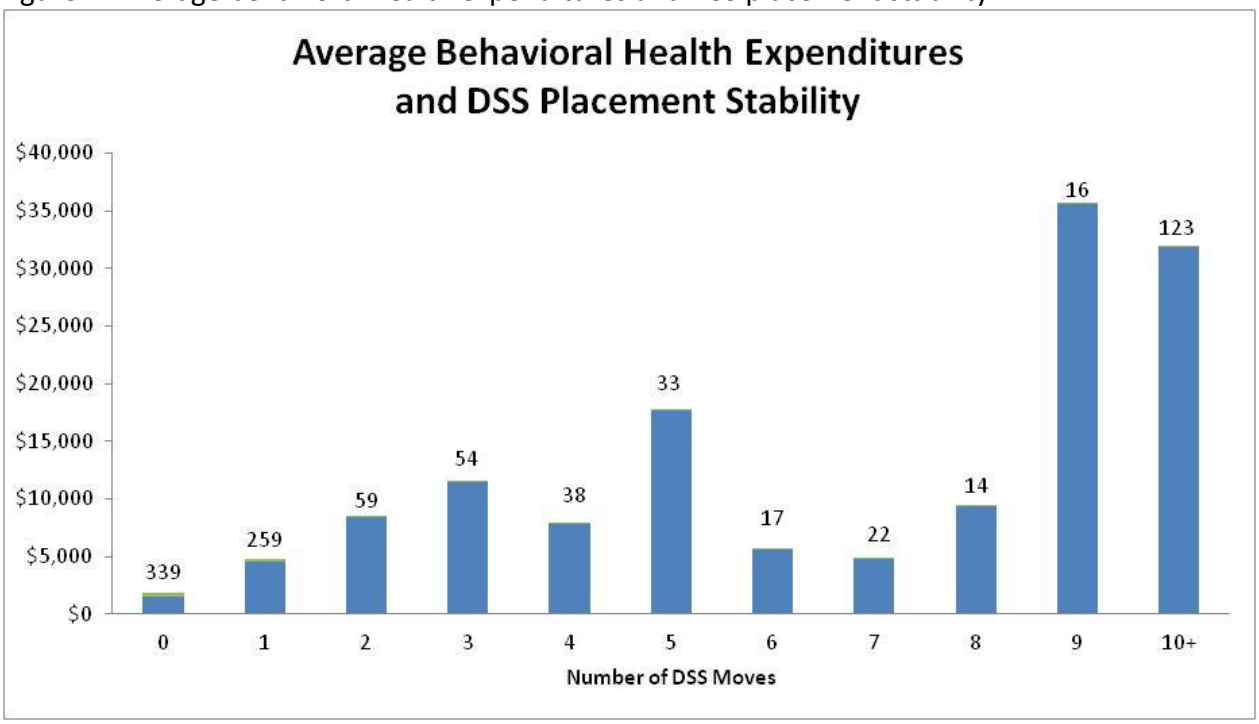
In this study the average Medicaid behavioral health expenditures associated with each unique CPS investigation in Rowan County were calculated using Medicaid claims data and matched with child welfare data. Figure 1 highlights that **the average behavioral health expenditures for children in DSS custody** which, as expected, consistently exceeds those of similar peers also investigated by CPS who received any behavioral health service. It is the degree of these differences that should be the focus of policy. Older children also tend to have greater behavioral health expenditures than the 6- to 11-year-old category.

Figure 1: Average behavioral health expenditures by custody and age among children who received any behavioral health service



For children in DSS custody, **placement instability is associated with increased average behavioral health expenditures**.

Figure 2: Average behavioral health expenditures and DSS placement stability



Figures 3 and 4 highlight the **average behavioral health expenditures associated with a particular psychiatric diagnosis or behavioral health service**. The actual costs of treating a particular condition may be much higher, but this provides a useful proxy as to how costly various conditions can be to treat. This analysis was limited to the average costs associated with a CPS investigative assessment in which a particular psychiatric diagnosis or behavioral health service was observed. Children can receive more than one psychiatric diagnosis and more than one behavioral health service.

Figure 3: Average behavioral health expenditures by psychiatric diagnosis

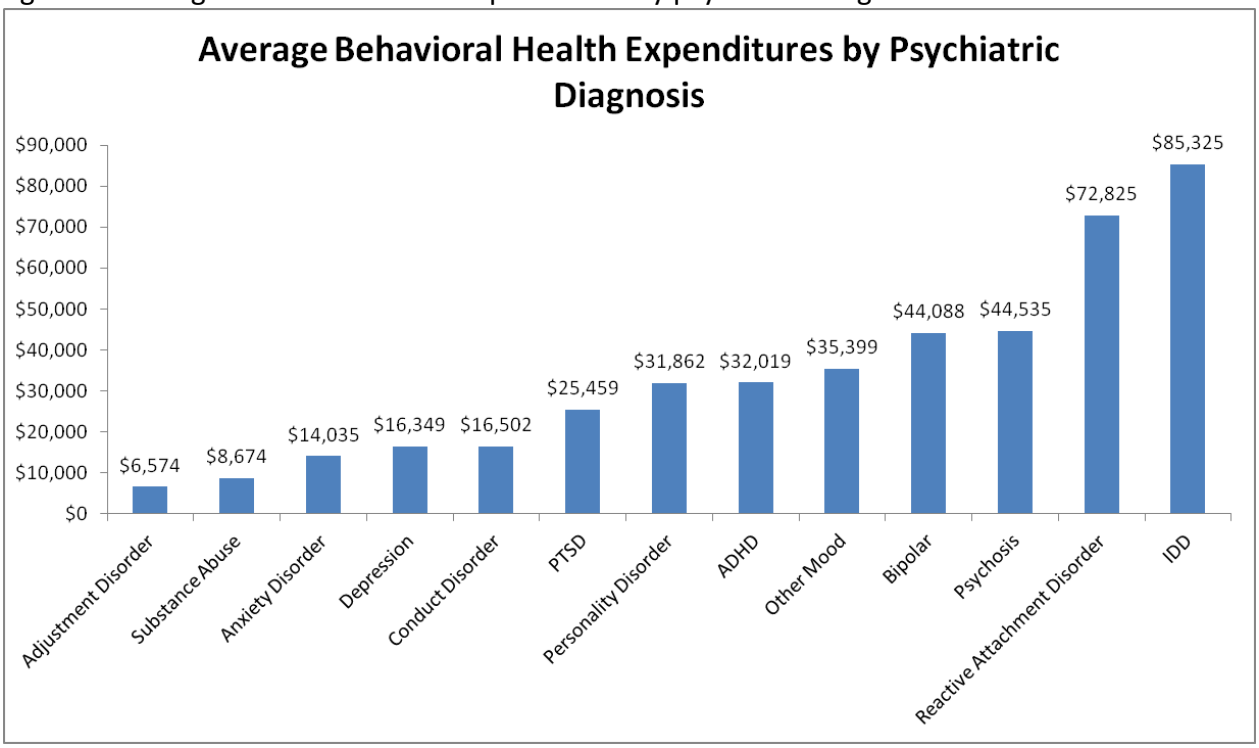
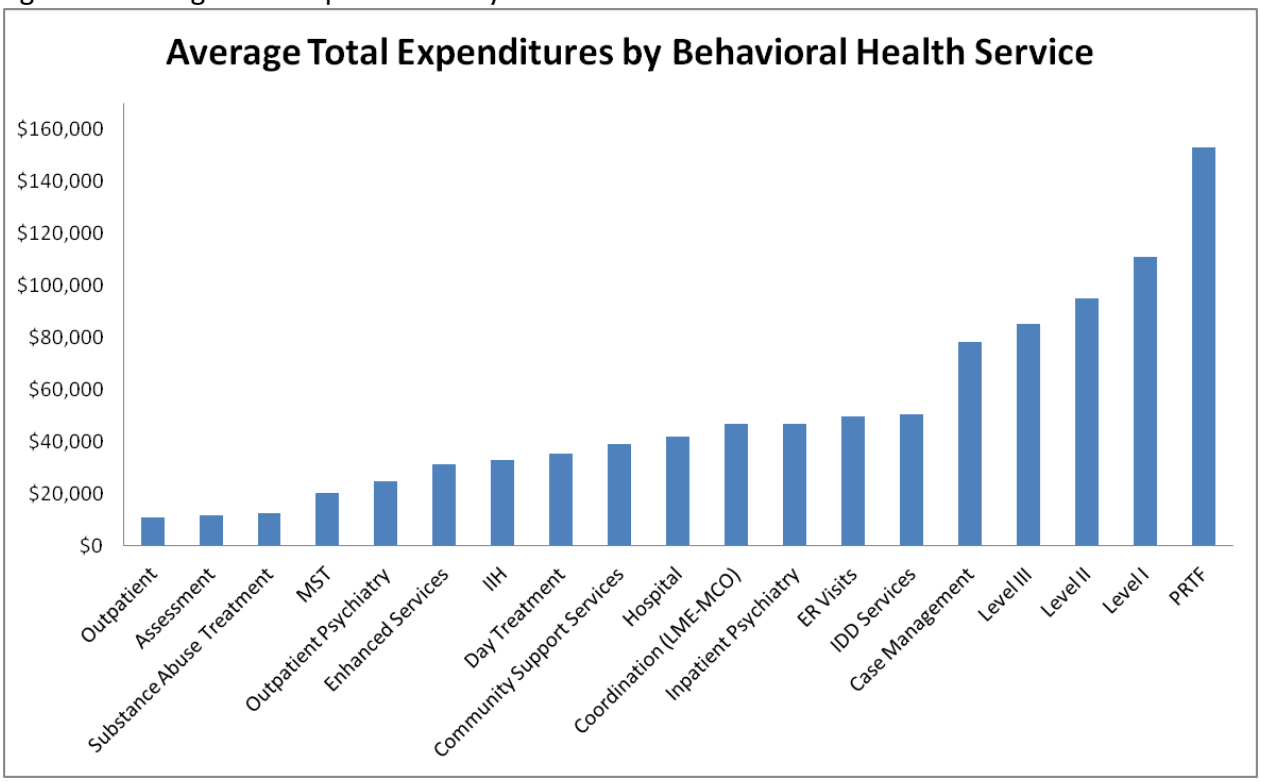


Figure 4: Average total expenditures by behavioral health service



In regards to Psychiatric Residential Treatment Facility (PRTF) placement exclusively, expenditures for CPS assessments associated with PRTF placement ranged from $3,350 to $410,769 per case. PRTFs are frequently used for children and youth with conduct disorder and other externalizing behavioral problems, in spite of evidence that there may be more cost effective and therapeutically appropriate services available in the community.

In North Carolina one possible alternative to psychiatric residential treatment facilities is Multisystemic Therapy (MST). MST was developed 30 years ago for adolescents (ages 12 and older) with serious behavioral issues and is provided in the home and community by a highly trained licensed clinician who works intensively with the parent, adolescent, and other adults in the youth's life to stabilize behavior, reduce risk, and promote communication and safety. In over a dozen studies MST has been shown to reduce out-of-home placements by up to 50%, reduce arrest rates by up to 70%, improve family functioning and school attendance, and decrease psychiatric problems and substance abuse.[1] MST has also been adapted for families where child abuse and neglect has occurred. One randomized clinical trial found that among physically abused adolescents MST-CAN reduced youth mental health symptoms, decreased parental psychiatric distress, increased social support, and decreased out-of-home placement by 63% fewer days.[2]

[1] Multisystemic Therapy. (2013). Retrieved October 19, 2013, from http://mstservices.com/

[2] Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R., & Mayhew, A. M. (2010). Multisystemic Therapy for Child Abuse and Neglect: a randomized effectiveness trial. *Journal of Family Psychology, 24*(4), 497.

In this study Multisystemic Therapy (MST) was explored separately and restricted to those services provided only to cases where CPS investigation ended after January 1, 2007, when MST became widely available in Rowan County. As Figure 5 below indicates, **MST appears to be underutilized for adolescents with conduct disorders, particularly those in DSS custody**. Even for those kids with the highest risks of costly out-of-home placements, MST is rarely provided: among youth who spent time in a PRTF, only 6% of those over age 11 with a diagnosed conduct disorder received MST. This is consistent with reports from MST Services[3] that MST is underutilized state-wide despite high levels of Conduct Disorder, Oppositional Defiant Disorder and externalizing behavioral health issues. **This study also found that receiving MST is associated with shorter lengths of DSS custody (129 days less on average)**. While this correlation does not imply that MST caused a decrease in DSS lengths of custody, it is bolstered by the robust scientific literature that demonstrates that MST reduces out of home placements.

Figure 5: Exploring MST

	Has Conduct Disorder Category Diagnosis	Has Conduct Disorder Category Diagnosis and DSS Custody
Received MST	72 (18%)	14 (12%)
No MST	334 (82%)	102 (88%)
Total	406	116

Conclusion

The data analyses in this paper confirm what the literature on foster children across the United States has found: **foster children have significantly greater behavioral health issues, utilize more services, and account for a disproportionate amount of behavioral health expenditures.** The analysis presented in the larger paper highlights a concern that there may be inadequate and inconsistent behavioral health assessments of high-risk children who have contact with CPS, and particularly for children in DSS custody. There may be practical barriers or case coordination issues that are preventing timely and comprehensive clinical assessments of these children.

The analysis presented in this paper also highlights the concerns about placement stability for children in DSS custody. Children with short first placements (less than 100 days) and more than one placement go on to have more placements overall and these placements are short, indicating that these children are "bouncing around" through placements. Placement instability is also associated with increased average behavioral health expenditures. Research has shown that placement disruptions, particularly in the first 100 days of care, exacerbate foster children's mental health issues and are associated with more frequent placement changes in the future.

[3] Personal communication with Lisa Reiter, March 2014

Finally, this paper emphasizes the value in utilizing wraparound services such as care coordination by the LME-MCO or Multisystemic Therapy (MST) prior to or following more expensive and intensive residential treatment options. Care coordination can improve the communication between providers, help ensure continuity of care during placement changes, and delay or prevent hospitalizations and other crises. MST has demonstrated effectiveness in preventing out-of-home placements and can effectively address conduct disorder behaviors that can lead to placement disruption and later reliance on institutional care or criminal behavior.

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

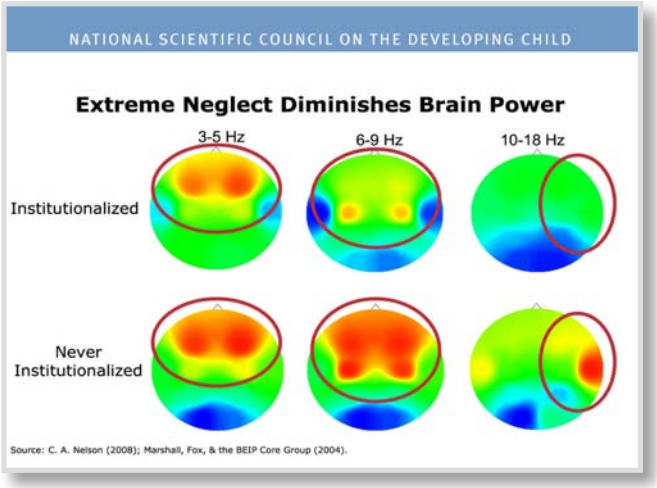
This paper was excerpted from Behavioral Health Service Utilization and Cost for North Carolina's Foster Children: A Report for Partnering For Excellence, *a student paper prepared in May 2014 by Susan Cohen Foosness in partial completion of the requirements for the Master's Project, a major assignment for the Master of Public Policy at the Sanford School of Public Policy at Duke University. Full version available online at:* http://dukespace.lib.duke.edu/dspace/handle/10161/8444

A series of brief summaries of the scientific presentations at the National Symposium on Early Childhood Science and Policy.

What happens in early childhood can matter for a lifetime. To successfully manage our society's future, we must recognize problems and address them before they get worse. In early childhood, research on the biology of stress shows how major adversity, such as extreme poverty, abuse, or neglect can weaken developing brain architecture and permanently set the body's stress response system on high alert. Science also shows that providing stable, responsive, nurturing relationships in the earliest years of life can prevent or even reverse the damaging effects of early life stress, with lifelong benefits for learning, behavior, and health.

1 Early experiences influence the developing brain. From the prenatal period through the first years of life, the brain undergoes its most rapid development, and early experiences determine whether its architecture is sturdy or fragile. During early sensitive periods of development, the brain's circuitry is most open to the influence of external experiences, for better or for worse. During these *sensitive periods*, healthy emotional and cognitive development is shaped by responsive, dependable interaction with adults, while chronic or extreme adversity can interrupt normal brain development. For example, children who were placed shortly after birth into orphanages with conditions of severe neglect show dramatically decreased brain activity compared to children who were never institutionalized.

2 Chronic stress can be toxic to developing brains. Learning how to cope with adversity is an important part of healthy child development. When we are threatened, our bodies activate a variety of physiological responses, including increases in heart rate, blood pressure, and stress hormones such as cortisol. When a young child is protected by supportive relationships with adults, he learns to cope with everyday challenges and his stress response system returns to baseline. Scientists call this *positive stress*. *Tolerable stress* occurs when more serious difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury, are buffered by caring adults who help the child adapt, which mitigates the potentially damaging effects of



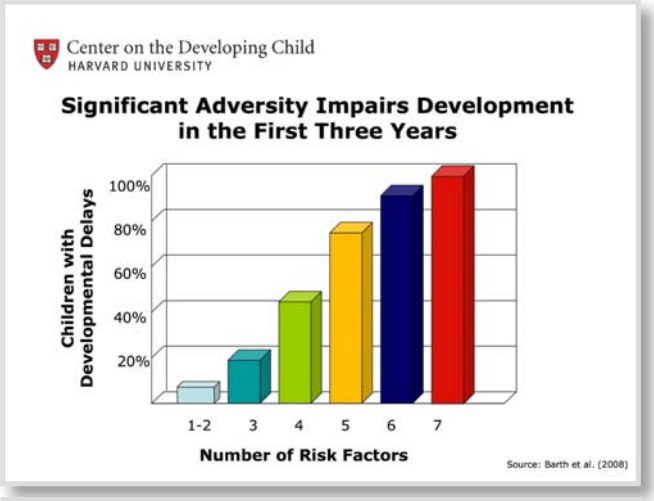
The brain's activity can be measured in electrical impulses—here, "hot" colors like red or orange indicate more activity, and each column shows a different kind of brain activity. Young children institutionalized in poor conditions show much less than the expected activity.

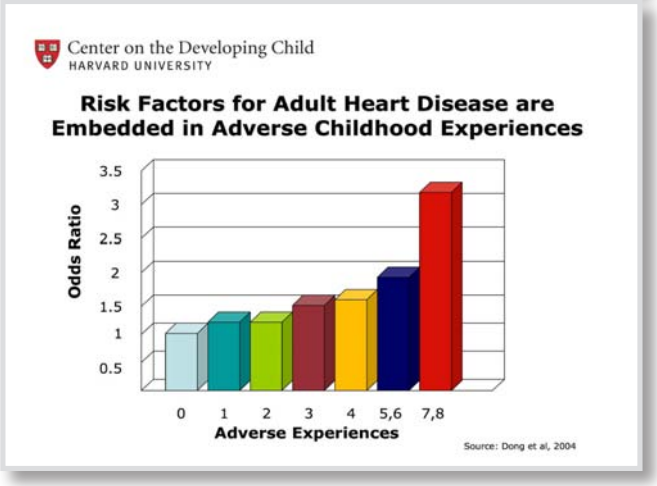
POLICY IMPLICATIONS

- The basic principles of neuroscience indicate that providing supportive and positive conditions for early childhood development is more effective and less costly than attempting to address the consequences of early adversity later. Policies and programs that identify and support children and families who are most at risk for experiencing toxic stress as early as possible will reduce or avoid the need for more costly and less effective remediation and support programs down the road.
- From pregnancy through early childhood, all of the environments in which children live and learn, and the quality of their relationships with adults and caregivers, have a significant impact on their cognitive, emotional, and social development. A wide range of policies, including those directed toward early care and education, child protective services, adult mental health, family economic supports, and many other areas, can promote the safe, supportive environments and stable, caring relationships that children need.

abnormal levels of stress hormones. When strong, frequent, or prolonged adverse experiences such as extreme poverty or repeated abuse are experienced without adult support, stress becomes *toxic*, as excessive cortisol disrupts developing brain circuits.

3 Significant early adversity can lead to lifelong problems. Toxic stress experienced early in life and common precipitants of toxic stress—such as poverty, abuse or neglect, parental substance abuse or mental illness, and exposure to violence—can have a cumulative toll on an individual's physical and mental health. The more adverse experiences in childhood, the greater the likelihood of developmental delays and other problems. Adults with more adverse experiences in early childhood are also more likely to have health problems, including alcoholism, depression, heart disease, and diabetes.





As the number of adverse early childhood experiences mounts, so does the risk of developmental delays (top). Similarly, adult reports of cumulative, adverse experiences in early childhood correlate to a range of lifelong problems in physical and mental health—in this case, heart disease (bottom).

4 Early intervention can prevent the consequences of early adversity. Research shows that later interventions are likely to be less successful—and in some cases are ineffective. For example, when the same children who experienced extreme neglect were placed in responsive foster care families before age two, their IQs increased more substantially and their brain activity and attachment relationships were more likely to become normal than if they were placed after the age of two. While there is no "magic age" for intervention, it is clear that, in most cases, intervening as early as possible is significantly more effective than waiting.

5 Stable, caring relationships are essential for healthy development. Children develop in an environment of relationships that begin in the home and include extended family members, early care and education providers, and members of the community. Studies show that toddlers who have secure, trusting relationships with parents or non-parent caregivers experience minimal stress hormone activation when frightened by a strange event, and those who have insecure relationships experience a significant activation of the stress response system. Numerous scientific studies support these conclusions: providing supportive, responsive relationships as early in life as possible can prevent or reverse the damaging effects of toxic stress.

For more information, see "The Science of Early Childhood Development" and the Working Paper series from the National Scientific Council on the Developing Child.

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Child Maltreatment and Trauma[1]

To fully understand the negative role that trauma can play within the child welfare system, one must first understand the impact of child maltreatment upon children who enter the system. While states have varying legal definitions, the term "child maltreatment" typically refers to a child who is physically, sexually, or emotionally abused or neglected; exploited; or exposed to domestic violence by a parent or caregiver. These types of maltreatment can lead to childhood trauma.

Trauma itself can be defined as "simple" or "complex." **Simple trauma** refers to a single, isolated, definable traumatic event. Even a single incident of maltreatment can be traumatic and lead to a wide range of potentially negative short-term psychological and behavioral responses from the child that include fear, dissociation, inability to regulate emotions, loss of trust, attachment disorders, and many other issues.

However, evidence also suggests that different types of abuse and neglect rarely occur in isolation. In other words, maltreated children often experience multiple types of abuse or neglect, which in turn results in even greater maladjustment and negative outcomes. **Complex trauma**, also referred to as “chronic interpersonal trauma,” refers to a child’s experience of multiple traumatic events or maltreatment that often occur within the context of the child’s caregiving situation. This chronic maltreatment can result in a lack of secure bonding between the child and his or her primary caregiver, which in turn can cause significant negative effects across multiple well-being domains. However, children vary enormously in how they are affected by complex trauma, due in large part to a variety of protective and coping factors that each child may or may not possess.

For years, child welfare agencies have provided treatments to maltreated children that focus primarily on a child's mental health. However, these traditional therapeutic treatments are often ill-designed to deal with victims of trauma and often fail to provide needed long-term support and flexible approaches. To be effective in their work with maltreated children, agencies must be aware of the differences between treatments traditionally focused on mental health and treatments that are truly part of a trauma-informed system.

Complex Trauma

The National Child Traumatic Stress Network (NCTSN), located at www.nctsnet.org, has defined complex trauma, also called "chronic interpersonal trauma," as a child’s experiences of multiple and sequential traumatic events within the context of the caregiving system. Typically, these traumatic events incorporate two or more types of child maltreatment that begin in early childhood.

[1] Excerpted from Child and Family Services Reviews Information Portal. Full text available online at: https://training.cfsrportal.org/section-4-trauma-child-welfare-system/2438

Complex trauma typically involves the lack of a secure bond, or attachment, between a child and his or her caregiver. The relationship between complex trauma and attachment is complicated. A disruptive attachment pattern can be the source of complex trauma; conversely, traumatic events can disrupt the normal attachment process. Because a caregiver bond is normally the fundamental source of stability and security in a child's life, the lack of a primary attachment can result in the child's inability to self-regulate emotion and relate beneficially to others.

Children exposed to complex trauma often experience lifelong problems that place them at risk for multiple dysfunctions, including:

- Substance abuse or other addictions
- Psychiatric disorders
- Chronic physical illnesses
- Poor parenting of their own children
- Relationship and workplace problems
- Involvement with the criminal justice system

Needless to say, the impact of complex trauma can be severe, diverse, and persistent across several domains of functioning, with difficulties extending from childhood through adolescence and into adulthood.

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

Overview

What is Traumatic Stress?

Lucy Berliner, MSW

What is a Trauma?

Traumas are events involving threat or danger. They do not have to be actually violent. The perception that something terrible could happen can make the event traumatic. Traumas may be directly experienced, witnessed or happen to a close loved one. They include child abuse, rape, violent crime, witnessing DV or community violence, serious accidents or natural disasters, and the violent or sudden death of a loved one. Not all bad experiences are traumas. Neglect, not being loved, foster care, parental incarceration and mental illness are adversities that can have negative effects.

The Prevalence of Traumatic Events

Exposure to trauma is very common. According to Finkelhor (Finkelhor et al, 2009) each year about 60 % of children experience at least one trauma. A subset, about 22%, has four or more different types of traumas. Traumas can range from the less serious, being hit by a sibling occasionally, to the extremely serious such as being raped or witnessing a parent murdered. Trauma exposure is almost universal among children in the child welfare system (CWS). For example, even though neglect comprises the majority of all CWS cases, many neglected children have witnessed DV or community violence.

What is Posttraumatic Stress (PTS) and How Does it Differ from Trauma?

Being exposed to a trauma is almost always upsetting. Trauma-specific reactions are called posttraumatic stress (PTS). PTS is unwanted and upsetting memories or dreams of the trauma and intense emotional and physical reactions when thinking about or being reminded of the traumas. Avoidance coping strategies decrease the negative emotional states when thinking about the traumas. PTS also includes heightened physical arousal responses such as jumpiness, irritability, difficulty concentrating, and trouble sleeping. Traumatic stress is a normal reaction to a very bad experience; most children exposed to traumas have at least some symptoms. PTS is not the only consequence of exposure to a trauma observed in children. Symptoms of general anxiety, depression, and behavioral disruption are also seen following traumas. Some children do not show distress following traumas, and for most the PTS will subside over time without treatment.

What is Post-Traumatic Stress Disorder (PTSD) and How Does it Differ from PTS?

A minority of children will experience persisting or worsening traumatic stress that becomes Post-Traumatic Stress Disorder. Occasionally, children develop PTSD after a period of appearing to be fine. To make the diagnosis, a qualified professional conducts a systematic assessment to find out if the symptoms required by the Diagnostic and Statistical Manual (DSM) are present. The diagnosis requires a certain number of symptoms of intrusive memories, avoidance or numbing reactions, and hyperarousal symptoms and that symptoms have persisted for at least a month and interfere with functioning. Just being exposed to a trauma or being upset about the trauma does not mean PTSD.

Finding out that a child has been exposed to trauma creates the opportunity for all involved in child serving settings to actively contribute to the child's recovery from the impact.

Predictors of PTSD in Children

Certain factors place children at greater risk for developing PTSD. The main predictors are more serious traumas, perception of life threat, prior traumas or psychiatric problems, and being female. A negative reaction from others also is associated with PTSD. Recent biological research demonstrates an association between child abuse and neglect, PTSD and altered brain structures and stress response systems. It is not clear whether these biological differences create increased susceptibility to PTSD or are the biological explanation of PTS (Neigh, Gillespie, & Nemeroff, 2009). Overall, research shows that the accumulated burden of multiple and different bad experiences (traumas and adversities) is more important than the specific type of trauma in predicting PTSD.

Immediate Responses to Trauma

We now have strategies to help children who have experienced trauma and have PTS. Psychological First Aid (PFA) (National Child Traumatic Stress Network, www.nctsn.org) is an approach for acute situations where the trauma has just occurred. It was originally designed for disasters, the psychological field response accompanying other rescue efforts. The main ingredients are focusing on here and now concerns, providing psychoeducational information and normalization, support, reinforcement of coping skills, and, when needed, facilitating access to ongoing services. With children, engaging caregivers is key. PFA usually involves one or two sessions. This type of approach can be used in emergency rooms, during child welfare investigations, in Child Advocacy Centers, and DV shelters. A

slightly more intensive approach is the Child and Family Traumatic Stress Intervention (Berkowitz, Stover, & Marans, 2011). This four session intervention is delivered within a month of the traumatic event and can significantly lower PTS and PTSD.

Screening for PTS and PTSD

Routine screening is the best way to identify children who have high levels of PTS or PTSD and would benefit by trauma-specific therapy. It is most important in child serving settings where children have high rates of exposure and are most likely to be significantly affected by their experiences, such as child welfare, mental health and juvenile justice. Experience shows that children are not distressed at being asked about traumas and are more likely to report when asked. There are checklists for screening for a trauma history (see the article by Conradi in this publication for more detailed information on screening). Screening is the first step to insure that children are assessed for mental health needs and to facilitate access to evidence-based therapy such as Trauma-Focused CBT (Cohen, Mannarin, & Deblinger, 2006). Professionals operating within the best practice multidisciplinary model or a Child Advocacy Center are well equipped to seamlessly facilitate access to trauma-specific assessment and therapy.

Providing Support

Simply asking about abuse and trauma is not sufficient since the children already know what they have experienced. The key is to learn about children's reactions and respond in a supportive way. Professionals and others such as foster parents can provide non-clinical interventions that are immediately helpful, such as normalizing PTS reactions, offering support and giving comfort. Even children who do not have significant PTS may have been affected by their experiences and appreciate acknowledgement that the trauma was bad, frightening or wrong. CPS investigators or forensic interviewers may be required to take care in the degree to which they validate children's reports of abuse, but they can still express appreciation and offer support.

PTS is a common reaction to exposure to trauma. Finding out that a child has been exposed to trauma creates the opportunity for all involved in child serving settings to actively contribute to the child's recovery from the impact. Simple steps such as acknowledgement, normalizing reactions, and providing support can reduce stress and potentially avert the development of longer-term consequences. It is also the platform for facilitating access to assessment and evidence-based trauma-specific treatment when necessary. The key to making a difference is not avoiding the trauma but rather communicating directly about the trauma and making sure there is access to needed care.

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Overview

The Impact of Trauma from Early Childhood through Adolescence: A Developmental Perspective

Keri LM Pinna, PhD and Abigail Gewirtz, PhD, LP

The impact of potentially traumatic experiences on a child's adjustment varies significantly depending on the developmental stage at which the child experiences trauma. This is true regardless of the nature of potentially traumatic event (i.e. whether it be abuse, neglect, exposure to violence, or some other traumatic event). Children's perceptions of threat during and following a potentially traumatic event (Kahana, Feeny, Youngstrom, & Drotar, 2006) and the nature of caregiver responses following the trauma (Scheeringa & Zeanah, 2001) are among the strongest predictors of children's adjustment following trauma. Children's perceptions of their experiences vary as a function of development as do the outcomes associated with caregiver responsiveness. Manners in which trauma-related symptoms manifest following a potentially traumatic experience also vary by developmental level. Thus, we explore developmental variations in children's perceptions of threat, outcomes associated with caregiver response to the child following trauma, and manifestations of trauma-related symptoms across developmental stages from infancy through adolescence.

Perceptions of Threat

Understanding how a potentially traumatized child experienced a traumatic event is the first step in determining how best to meet the child's needs in the immediate and longer-term aftermath. For an infant, facial expressions, tones of voice, sudden loud noises, and experience of caregiver responsivity to the infant's cues (e.g. crying) serve as the basis for interpreting safety versus danger (e.g. Moore, 2009). While an infant may not be capable of thinking "This is terrifying!," angry voices and facial expressions, and the sound of breaking glass in the next room are processed as threatening in the infant brain. Further, the absence of comfort in response to terrified cries leads an infant to learn that her caregivers cannot be trusted to provide comfort in times of need.

With each stage of development, perception builds on prior stages. For example, a **toddler** or **school aged child** also perceives facial expressions, tones of voice, sudden loud noises, and parental non-responsiveness to the need for comfort. As cognitive development becomes more advanced, the capacity for imagining the possibility of negative outcomes increases (Grist & Field, 2012). Thus, perception of threat begins to include what a child *imagines* could have happened if, for example, the police were not called when mommy and daddy were fighting near the kitchen knives. An **adolescent** is more likely to be able to gather and evaluate information about a potentially traumatic event to determine the actual threat involved but may also overestimate his/her sense of safety (Wickman, Greenberg, & Boren, 2010). The adolescent child of an abused mother may underestimate the risk involved in stepping in to protect his mother from her abusive partner. The adolescent's sense of invincibility may lead him to becoming the victim of the partner's abuse in the process, or even an unwitting perpetrator.

Caregiver Response & Attachment

When a child is traumatized in the presence of supportive caregivers, his responses may mimic those of the parent (van der Kolk, 2003). Children whose caregivers are unresponsive and/or inconsistent in their responses to the child's distress may develop insecure attachments and associated emotion regulation deficits. Disorganized attachment (one form of insecure attachment) develops when a parent responds to a child inconsistently, with frustration, violence, intrusiveness, or when a parent is severely neglectful. Children with disorganized attachment learn that they are unable to rely on their caregivers becoming either

extremely anxious and/or aggressive, or appearing paralyzed or frozen. Because their expressed emotions and behavioral attempts at gaining comfort from caregivers have been unsuccessful, they may have difficulty learning to trust their emotions or perceptions of danger. These attachment styles are developed early in life during **infancy** and the **pre-school years**.

The type of attachment relationship that is developed with a caregiver is believed to set the framework for the child's subsequent friendships during the pre-school and school aged years and for intimate relationships during adolescence (Furman, 2001). This likely contributes to the maltreated child's impairments in peer relationships and risk for aggressive behaviors (seen even more often following severe neglect than following physical abuse; Widom, 1989). Because social support is a strong buffer against future adversity, failure to develop healthy peer relationships contributes to an increased risk for poor adjustment following future adversity in children who have been traumatized in the absence of a supportive caregiver.

Similarly, failure to develop healthy romantic relationships also increases the risk for poor adjustment. Furthermore, violence within such relationships is a risk faced by many adolescents with histories of traumatic experiences. Attachment style has been shown to predict this risk differently for boys versus girls (Wekerle & Wolfe, 1998). Boys with a history of maltreatment who have developed avoidant and ambivalent attachment styles have been found to be at increased risk of perpetrating abuse within their romantic relationships while previously maltreated boys who developed anxious-ambivalent attachment styles were at risk of *being victimized* at the hands of their female partners. In adolescent girls, secure attachment despite a history of maltreatment was associated with *lower* likelihood of female-to-male perpetration. Avoidant attachment style has also been found to predict risk for violence within romantic relationships during adolescence regardless of gender (Weiss, MacMullin, Randall, & Werkle, 2001).

Developmental Variations in Trauma-related Symptoms

Traumatized youth often develop symptoms of anxiety, aggression, depression, and/or academic impairment. Temporary (and normative) unwanted and upsetting memories or dreams of the trauma, and intense emotional and physical reactions in response to reminders of the trauma appear to be nearly universal. Both these temporary/normative reactions and more severe, long-lasting, and debilitating symptoms present differently across different developmental stages.

Infants and Toddlers. Among infants who have been traumatized, sleep is often impaired and emotion regulation compromised (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Specifically, as secure attachment is disrupted or is never achieved, the infant does not benefit from caregiver attempts at soothing his/her distress, and the development of emotional self-regulation suffers. As infants grow into toddlers and become more mobile, they may become more reckless, accident prone, or inhibited (Lieberman & Knorr, 2007). These responses might also be understood as the hyperarousal, avoidance and emotional numbing symptoms that are associated with post-traumatic stress disorder (PTSD, a type of anxiety disorder). Hyperarousal may also present as increased anxiety, irritability, sleep disturbance, difficulties concentrating, and difficulties sitting still. These latter symptoms are sometimes misinterpreted as attention deficit-hyperactivity disorder (ADHD). Emotional numbing can manifest as withdrawal from play and peers. Toddlers and preschoolers often engage in symbolic play in which the trauma is re-enacted. This may reflect the behavioral manifestation of intrusive memories and the toddler/preschooler's effort at understanding the trauma. Children may also show regressive behaviors (e.g., a previously toilet trained child may begin wetting or soiling again).

School-aged Children. As children enter school, difficulties concentrating and sitting still (PTSD hyperarousal symptoms) may persist contributing to academic difficulties. As language becomes more sophisticated, symbolic play may decrease, and the child may become more able to use words to describe traumatic memories. However, the child may have difficulty understanding his/her emotional and behavioral responses to trauma-related cues. Traumatized children often more readily read social cues as threatening and aggress in response (Weinberg & Tronick, 1998). Classroom and playground altercations may be triggered by reminders of the traumatic event(s).

Adolescents. Problems sleeping are common across all developmental stages. However, given that moving towards independence is a crucial task for adolescents (and that hormonal and lifestyle changes are associated with different sleep patterns), caregivers may be unaware of the presence or extent of sleep problems. Post-pubertal adolescents are often physically similar to adults, but they do not yet possess the emotional maturity of adulthood. Thus, trauma-exposed adolescents are particularly at-risk for acting-out behaviors (e.g. truancy, risky sexual and drug use behaviors) that can be dangerous for themselves and others. Most adolescents in the juvenile justice system have been exposed to maltreatment and/or other traumatic events.

Increasing attention is being paid to 'crossover' youth, those involved in both the child welfare and juvenile justice systems. As many as two thirds of youth in the juvenile justice system have two or more disorders, including both externalizing (e.g. oppositional defiant disorder, drug & alcohol use disorders) and internalizing disorders (e.g. PTSD, depression; Ulzen & Hamilton, 1998). Such high rates of morbidity are believed to be the direct result of the traumatic experiences to which these youth have been exposed. Evidence for elevated rates of both trauma and trauma-related disorders in delinquent youth highlights the importance of maintaining awareness that trauma may manifest in acting out behaviors both in adolescents and at earlier developmental stages. Children's trauma-related symptoms, including both acting out and internalizing symptoms, are likely familiar to most experienced child welfare workers. Understanding these symptoms and how they vary across development can enhance trauma-informed care for vulnerable children.

> Understanding how a potentially traumatized child experienced a traumatic event is the first step in determining how best to meet the child's needs in the immediate and longer-term aftermath.

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Overview

The Heart of the Matter: Complex Trauma in Child Welfare

Joseph Spinazzola, Ph.D., Mandy Habib, Psy.D., Angel Knoverek, Ph.D., LCPC, Joshua Arvidson, MSS, LCSW, Jan Nisenbaum, MSW, Robert Wentworth, MSW, Hilary Hodgdon, Ph.D., Andrew Pond, LICSW, and Cassandra Kisiel, Ph.D.

Complex trauma involves chronic or repeated, typically early-onset exposure to two or more of the following forms of trauma exposure: sexual, physical or emotional abuse, domestic violence, or neglect, as well as severe caregiver impairment and school/community violence (Kisiel et al., 2009). A national sample of over 2,200 children in child welfare found that over 70% met exposure criteria for complex trauma (Greeson et al, 2011). A substantial subset of children—typically those with the fewest social and economic resources, and those living amidst poverty, crime or cultural minority status (Cohen, 2007)—have experienced all of these forms of exposure.

Complex trauma impacts multiple core domains of functioning: children's physiology and brain development; their ability to identify, tolerate, control and appropriately express emotions, impulses and bodily sensations; to concentrate, learn and engage in goal-directed behavior; to form a positive and cohesive sense of self, meaningful values and hopeful future outlook; to cultivate secure and healthy attachment bonds, sustain intimate relationships, safely negotiate conflict and communicate their needs; and to interpret social cues accurately, set healthy personal boundaries and differentiate safe from threatening situations and interactions with peers and adults (Cook et al, 2005; Kisiel et al, 2009; Spinazzola et al, 2005). By the time they reach adolescence, many complexly traumatized youth are already caught in a vortex of intense somatic, behavioral and emotional dysregulation in which daily life is fraught with an ever-expanding host of traumatic reminders and subtle false alarms that activate extremes of hyper- and hypo-arousal. Like "live wires," complexly traumatized youth can become charged with heightened vigilance and physiological reactivity at levels that are emotionally overwhelming and debilitating to the immune system. Like "walking dead," they can retreat or slip into extended periods of severe withdrawal, emotional constriction, avoidance and numbing of consciousness induced via coping strategies that include dissociation, binge eating or substance dependence.

The legacy of unresolved complex trauma is staggering, and has been causally linked with increasingly dire outcomes across the lifespan that collectively place an enormous economic burden on society, conservatively estimated at over $200,000 per impacted child and over 100 billion per year (Fang et al, 2012). Long-term outcomes include scholastic failure, dropout and unemployment; early pregnancy, sexually transmitted disease, rape and domestic violence; chronic mental and physical illness, health risk behaviors, disability and premature mortality (Edwards et al, 2004; Felitti et al, 1998, Ford et al, 2010).

The legacy of unresolved complex trauma is staggering, and has been causally linked with increasingly dire outcomes across the lifespan that collectively place an enormous economic burden on society, conservatively estimated at over $200,000 per impacted child and over 100 billion per year

Psychological maltreatment: The sleeping giant of complex trauma

Psychological maltreatment has been recognized by the American Pediatric Association as the most prevalent form of child maltreatment and thus far the most overlooked despite substantial evidence of its deleterious impact at levels comparable to more readily recognizable forms of maltreatment such as physical and sexual abuse (Hibbard et al, 2012). Psychological maltreatment is comprised of various overt and subtle forms of chronic emotional abuse and neglect, including prolonged verbal abuse, terrorizing, shunning, and social isolation. A recent study on a large sample of over 5,000 children and adolescents from the Core Dataset of the NCTSN revealed psychological maltreatment to have equal or significantly greater association than physical or sexual maltreatment to 27 out of 30 frequency and severity symptom, diagnostic and risk indicators assessed (Spinazzola et al, 2011). Psychologically maltreated youth were the most likely to exhibit significant internalizing, attachment and substance abuse problems and the most likely to develop anxiety and depressive disorders. Also notable was that exposure to psychological maltreatment resulted in equal levels of PTSD symptom severity compared to physical or sexual abuse. The child welfare system can serve as a critical gatekeeper of suspected and reported psychological maltreatment in children and families with its power and authority to open the door to thorough investigation of its presence and impact in reported youth.

The term **complex trauma** was introduced by a special taskforce of the National Child Traumatic Stress Network (NCTSN) to help multidisciplinary service providers better understand and respond to the multifaceted relationship between children's exposure to multiple traumatic events and the wide-ranging, long-term impact of this exposure (Complex Trauma Taskforce, Cook et al, 2003, 2005, 2007). The complex trauma construct differs in important ways from other conceptual frameworks of child maltreatment. Whereas "polyvictimization" addresses the circumstances of children's exposure to multiple, often inter-related traumatic forms of trauma (Finkelhor et al., 2007, 2009), complex trauma speaks to the cascading interplay between trauma exposure, impact and (mal)adaptation. Moreover, unlike "Complex Posttraumatic Stress Disorder," introduced in an attempt to characterize a broader and more pronounced symptom-set exhibited in a subset of traumatized adults (Herman, 1992), the complex trauma construct was formulated in realization that the PTSD diagnosis neither typically nor sufficiently captures the cardinal features of disturbance observed in youth exposed to prolonged and severe maltreatment, violence, and neglect (Ackerman et al., 1998; Spinazzola et al., 2005).

What lies beneath: The need for comprehensive assessment

Children impacted by complex trauma are not only at high risk for revictimization but are more vulnerable than other youth to exposure to other forms of acute, non-interpersonal trauma. For example, chronically neglected children are at significantly increased risk of exposure to accidents and burns in the home. The aberrant socialization that frequently accompanies familial incest or emotional abuse can increase children's susceptibility to school bullying and lead to juvenile delinquency, substance abuse and high-risk sexual behaviors. In turn, chronic physical abuse often underlies and fuels conduct problems and social aggression. Comprehensive evaluation that includes a thorough caregiving and trauma history and integrates developmental, psychiatric, behavioral, scholastic and interpersonal strengths and difficulties is essential. The child welfare system can play a pivotal role not only through early screening and assessment, triage, and trauma-informed referral but in working with providers to connect all the dots. "Unpacking" these exposure, risk and protective trajectories for youth in the child welfare system is the critical first step toward rerouting pathways to healthy outcomes, fostering resilience, and disrupting intergenerational cycles of complex trauma (Layne et al, 2008).

Placement instability: The sine qua non of complex trauma?

Children in child welfare with complex trauma have been found to have significantly higher rates of placement disruption (Kisiel et al., 2009). A child's risk for poor outcomes can increase exponentially in child welfare as a result of cycles of impaired caregiving followed by periods of separation from primary caregivers, potential incidents of placement instability, revictimization in the new home, failed reunification attempts, or ultimate loss of primary caregivers. For children whose sense of self, intimate attachments, material possessions, access to friends and siblings—in effect, their entire world—hangs in the balance of the success or failure of these placements, each juncture can be experienced as another complex trauma exposure irrespective of the efforts and intentions of child welfare personnel and foster, kinship, or biological parents. The child welfare system can play a pivotal role in mitigating this risk by: a) recognizing the critical importance of placement stability in altering risk trajectories for complexly traumatized children, b) prioritizing careful deliberation around the timing and nature of placement decisions, c) establishing structures

to support emotional regulation of children facing unavoidable placement transitions, and d) delineating proactive strategies to prevent or rapidly respond to child decompensation associated with abrupt placement disruption.

Helping the most vulnerable: Complex trauma and residential care

Placement in a residential treatment facility can be a common outcome for those children most severely and chronically impacted by complex trauma. In turn, complex trauma is heavily over-represented in youth in residential care. Analysis of the NCTSN Core Dataset revealed that when compared with traumatized youth receiving outpatient or community-based services, those receiving residential services had the highest rates of trauma exposure and associated impairment (Briggs et al, 2012). While the majority of outpatient youth no longer exhibited symptoms by the end of treatment, a substantial percentage of complexly traumatized youth in residential care continued to manifest impairment indicating the need for more extensive services. The highly structured, predictable and consistent environment and caregiving offered within trauma-informed residential settings may provide these children with a sufficient sense of safety and emotional containment to begin to shift from a survival-based preoccupation with threat detection and avoidance to a more present and future-oriented focus on skill acquisition and identity development. A residential placement can afford child service providers a unique window of opportunity to guide complexly traumatized children in the development of internal capacities for self-control and affect management, in the rehearsal of effective problem-solving and communication skills, and in the delineation of interpersonal boundaries and cultivation of safe and healthy relationships. The child welfare system can provide leadership on initiatives that ensure maximal treatment gains for complexly traumatized children by making purposeful, collaborative, treatment-goal driven decisions about the timing, duration and type of residential placements to which complexly traumatized children are assigned, extended, transitioned and discharged.

Complex trauma requires complex solutions

Traditional treatment of PTSD in children has focused on processing and resolving vivid and painful memories, beliefs, and emotions associated with one or more specific traumatic experiences. Intervention models designed to treat complex trauma of necessity attend to the broader array of deficits and domains of maladaptive functioning. Of the over two dozen evidence-based and empirically supported interventions created or advanced by members of the NCTSN over the past decade (NCTSN, 2012), several have been specifically developed to treat complex trauma by addressing six core components identified in complex trauma intervention: safety; self-regulation; attachment; identity development; trauma experience integration; and strength-based cultivation of self-worth, positive affect, personal competencies and mastery experiences (Cook et al, 2005). Treatment models are predicated upon a shared recognition that training is insufficient to achieve successful intervention with complexly traumatized children; responsible treatment of complex trauma entails ongoing training, supervision, fidelity assessment and careful adaptation responsive to unique cultural, setting and developmental needs of

The Heart of the Matter: Complex Trauma in Child Welfare

those being served.

Two complex trauma intervention models bear special mention given their widespread dissemination with ethnoculturally diverse child welfare populations served in outpatient, residential, specialized foster care and scholastic settings. The Attachment, Self-Regulation and Competency (ARC) model provides a comprehensive, system-based approach to treating complexly traumatized children aged 3-21 (Blaustein and Kinniburgh, 2010; Kinniburgh et al., 2005). Particularly notable among published outcome evaluations on the ARC model is the finding that children involved in the Alaskan child welfare system who successfully completed ARC treatment exhibited placement stability rates over twice that of the state average only one year after starting treatment. Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) is a well-supported, 16-session, manualized, group-based intervention for complex trauma that has been used extensively with high-risk youth populations (DeRosa and Pelcovitz, 2008). A project with youth served by the Illinois child welfare system found that adolescents in foster care who received SPARCS were half as likely to run away and one-fourth less likely to experience placement interruptions (e.g. arrests, hospitalizations) compared to a standard of care group (Mental Health Services & Policy Program, 2008).

The child welfare system can advance effective intervention for complexly traumatized children by facilitating appropriate referrals to empirically supported interventions designed to treat the whole child. This begins with education of child welfare personnel on the overarching treatment needs of complexly traumatized children and the specific evidence-based treatment models designed to target these clinical objectives and is followed by support of initiatives to establish and sustain local and regional service hubs trained to provide complex trauma treatment for child welfare-referred clients.

Conclusion

Consideration of childhood trauma from a complex trauma framework invites a subtle but pivotal paradigm shift: from the traditional premise that "traumatic stress" derives from exposure to one or more events that lead to specific manifestations of distress which in turn compromise certain aspects of a child's otherwise normative functioning, to the recognition that under certain circumstances the fundamental elements of a child's daily life can be characterized by violations so egregious or deficits so severe that these become primary determining factors shaping a child's foundational capacities and overall development. Cumulative exposure to trauma exponentially increases the likelihood of revictimization. In turn, maladaptive coping strategies developed in effort to survive experiences overwhelming to the child—including running away, self-harm, aggression or substance abuse—can evolve into direct or vicarious traumatic experiences in and of themselves for the child, their caregiving system, and secondary victims. These patterns of trauma exposure, coping deficits, illness, and retraumatization form the building blocks of intergenerational trauma. As prevention, detection and response to precisely these deleterious childhood adversities is, for better or worse, its unique purview, the child welfare system seeking to become truly trauma-informed cannot afford to overlook complex trauma. After all, it has always been the heart of the matter.

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surveyed expert trainers on the CWTTT. The majority of trainers responded that all training modules were clear, easy to use, contained all relevant content for the child welfare workforce, and had the correct time allotment necessary to cover the material. Trainer feedback was both positive and constructive with recommendations for revision and improvement.

CTISP is leading a sub-committee of the NCTSN to revise the CWTTT incorporating feedback from trainers and other professionals in the field of child welfare. The revisions will incorporate recent research about trauma and its treatment as well as principles of adult learning and implementation science. These revisions include: streamlining and reorganizing the Essential Elements and structure of the CWTTT to facilitate training and integration; enhancing content related to topic areas including trauma among young children, the impact of trauma on brain development, trauma and culture, birth parent trauma, and secondary traumatic stress in the child welfare workforce; and providing guidance and support on training delivery and implementation. It is hoped that the revisions, which will be complete in the fall of 2012, will improve the quality of the CWTTT and its usefulness as a resource for educating child welfare professionals about trauma and for teaching them how to intervene to more effectively help children and families heal from traumatic experiences.

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Overview

The Impact of Traumatic Stress on Parents Involved in the Child Welfare System

Erika Tullberg, MPH, MPA, Roni Avinadav, PhD, Claude M. Chemtob, PhD

Thomas is a new caseworker supervising a visit between his client, Denise, age 25, and her three children, Christopher, Jr., age 5, Tanya, age 3, and Damon, age 2. This visit has already been rescheduled twice – it was supposed to happen after the agency's weekly domestic violence group, which Denise is mandated to attend as part of her service plan, but she keeps missing the meetings. Thomas wants to talk to Denise about how she needs to come to these groups if she wants her kids back, but he has seen her temper and doesn't want to do anything to make today's visit go badly so decides to let it go.

Damon has not said anything since arriving at the agency; he is still strapped into his stroller and since coming into the visitation room has been whining and reaching up to Denise, but she keeps telling him to "behave" while she tries to get his siblings to settle down. After a few minutes of running around Christopher trips on his shoelaces and starts bleeding from his head – Tanya shrieks when she sees the blood, and Denise yells at Christopher saying that he's ruined the visit and is always out of control, just like his father. Thomas goes to comfort Tanya, who has started to shake and cry uncontrollably, but Denise steps in front of him saying that she can handle her kids and that they don't need his help.

The child welfare system has become increasingly attuned both to the trauma that children and youth in the system have experienced and to the importance of addressing such trauma as part of ensuring their safety, permanence and well-being (Kisiel, Fehrenbach, Small, & Lyons, 2009). Research on the impact of trauma on foster care placement stability in the short term, and long-term health outcomes over the lifespan, has helped to spur increased training on trauma for staff, resource parents, and other system stakeholders and availability of evidence-based interventions for children and youth (Landsverk, Garland, Reutz, & Davis, 2011).

However, we know that for children in the child welfare system, the trauma they have experienced has often happened at home: abuse or neglect from a caretaker, exposure to domestic violence, or separation from a parent due to homelessness, incarceration or other family stressors. For parents who grew up under similar circumstances, or who have experienced traumatic events in adulthood, it may be difficult to provide their own children with support and structure if their own trauma remains unaddressed. Research has demonstrated, in fact, that a parent's trauma history may increase his or her children's risk of maltreatment (Banyard, Williams, & Siegel, 2003; Cohen, Hien, & Batchelder, 2008), and that the parent's trauma-related symptoms and ability to respond in a protective manner to his or her children is a predictor of a child developing trauma symptoms following exposure to a traumatic event (Chemtob, Nomura, & Abramovitz, 2008). If parents do not feel safe, they will be less able to keep their children safe.

Research has shown that parents with histories of trauma can be harder to engage in services and have difficulty trusting service providers (Kemp, Marcenko, Hoagwood, & Vesneski, 2009; Dawson & Berry, 2002). Despite this and the prevalence of trauma among parents in the child welfare system, our experience is that it is relatively uncommon for parents to receive trauma-specific screening, much less trauma-informed mental health services – and many child welfare staff are not trained to recognize

For parents who grew up under similar circumstances, or who have experienced traumatic events in adulthood, it may be difficult to provide their own children with support and structure if their own trauma remains unaddressed.

Anecdotal evidence and growing research suggests that trauma is very common among parents receiving child welfare services. In New York City, the ACS-NYU Children Trauma Institute's **Safe Mothers, Safe Children program** is addressing trauma experienced by mothers receiving child welfare preventive services. During project planning interviews conducted in 2008, East Harlem preventive service program directors reported concerns about trauma experienced by their clients, citing related problems with their ability to have patience with, empathy for, and express affection towards their children. During subsequent screenings with mothers receiving services from a subset of these agencies, 92 percent reported at least one prior traumatic experience with the average being 2.6 categories of traumatic events. Fifty-four percent of mothers met probable criteria for post-traumatic stress disorder, 62 percent met probable criteria for depression, and 49 percent met probable criteria for both PTSD and depression (Chemtob, Griffing, Tullberg, Roberts, & Ellis, 2011).

trauma symptoms and how trauma can impact parenting and child safety. As a result, child welfare staff may be more likely to regard parents like Denise as non-compliant, disengaged, detached from their children, angry and defensive.

How else could Thomas understand Denise, the decisions she's making, and how she responds to her children? How can he use that knowledge to help her? With the benefit of a "trauma lens," the above scenario could be reframed as follows:

- **Ask questions.** Caseworkers are often worried that asking clients detailed questions about their past traumatic experiences may cause their clients to become anxious or distraught, but after being trained to conduct trauma screenings by Safe Mothers, Safe Children project clinicians, caseworkers said they learned helpful information while reporting low levels of distress for themselves and their clients (Chemtob, Griffing, Tullberg, Roberts, & Ellis, 2011). Asking may also

help ease the shame associated with clients' past experiences and result in their feeling more supported and less alone.

- **Anticipate trauma triggers.** The domestic violence between Denise and her children's father was likely a traumatic experience for both her and her children, and the fact that she is not attending domestic violence groups may be due to avoidance, a common trauma symptom. Denise may be more likely to attend visits with her children if they were scheduled at a different time than these groups. Likewise, if Thomas approached Denise's non-attendance with this understanding and empathy, helping to explore the impact of her past experiences on her current actions, rather than by using a punitive approach, he could be more successful in engaging her in services.
- **Understand the impact of trauma on parent-child relationships.** Trauma can cause parents to have a negative world view and, in particular, develop negative attributions regarding their children's behavior. Their child's actions, or even their appearance, may trigger them resulting in them reacting in an overly harsh or punitive way. Helping parents to understand that their reactions may be a result of their trauma, and are not the fault of their children, can help them respond more positively to their children.
- **Understand the impact of trauma on children's development and mental health.** Children who have also experienced trauma, such as exposure to domestic violence, may have their own trauma symptoms—such as Tanya's extreme reaction to her brother's fall and her mother's harsh response—which can in turn be triggering for the parent. Children's development can also be impacted by trauma, and concerns such as Damon's potential speech delay may not be recognized by the parent because he or she is overwhelmed and/or does not have information about expected child development. When working with a parent or family that has experienced trauma, child welfare staff should be attuned to how it may have impacted each of the children.
- **Recognize and manage trauma reactions.** Thomas's past experiences with Denise's anger and defensiveness have led him to avoid addressing an important part of Denise's service plan and Christopher, Tanya and Damon's safety. He may also be frustrated by what he perceives to be her lack of concern for her children and lack of urgency around her service plan goals. Using a "trauma lens" could help Thomas better understand Denise's behavior towards her children and how he (as a man and as a person in a position of authority) could be triggering for her, and provide strategies for working together with her rather than feeling like they are at cross-purposes. This could help Thomas depersonalize Denise's reactions towards him, regulate his own emotions, and feel less frustrated putting him in a better position to approach her openly and with compassion.

Trauma can impact parents in many ways including their ability to keep their children safe. As described above, using a "trauma lens" can help child welfare staff more effectively partner with families, working together to ensure both their physical and psychological safety.

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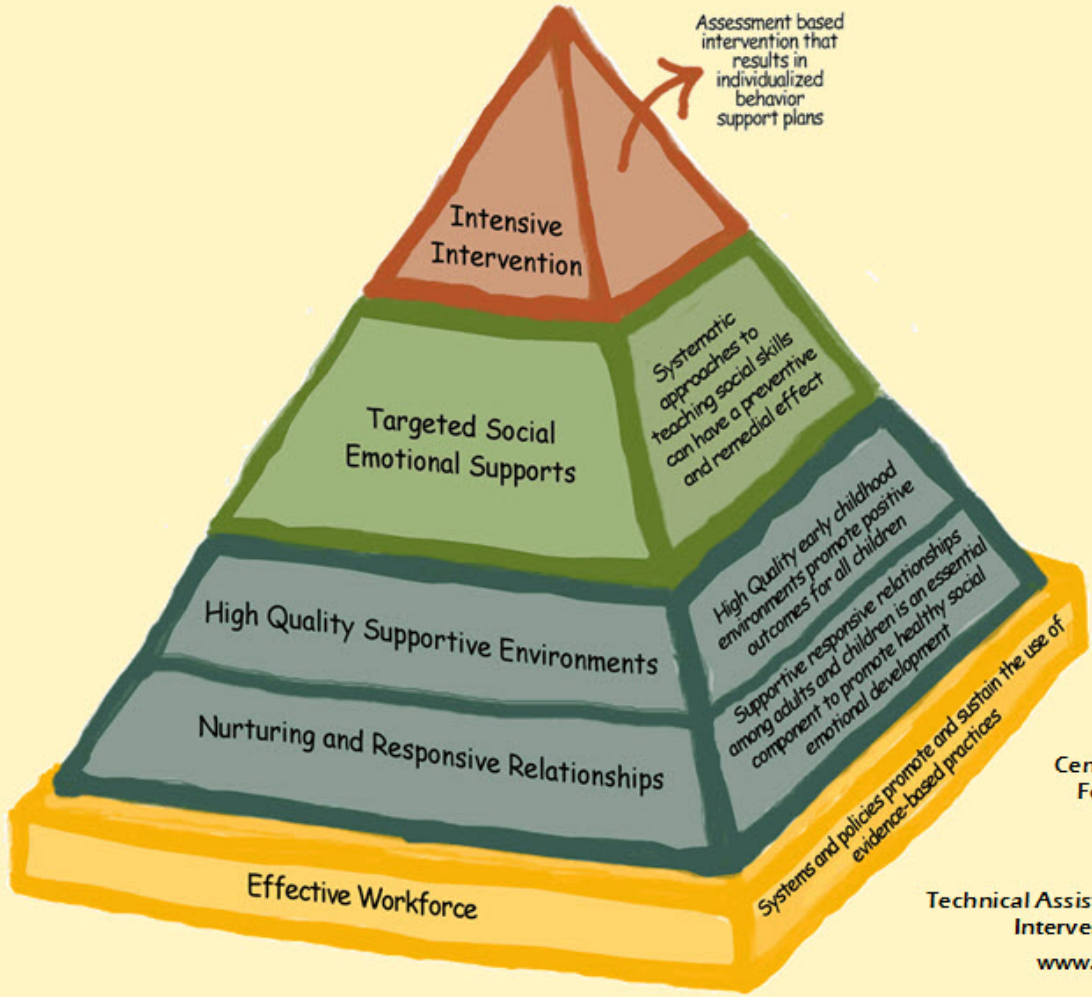
Pyramid Model

for Promoting Social Emotional Competence in Infants and Young Children



Center on the Social and Emotional Foundations for Early Learning

www.vanderbilt.edu/csefel

Technical Assistance Center on Social Emotional Intervention for Young Children

www.challengingbehavior.org

Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services[i]

Focusing on Social and Emotional Well-Being

Focusing the work of a child welfare system on well-being, particularly social and emotional well-being, requires a concerted effort on behalf of all staff and stakeholders, from directors, to managers, to supervisors, to caseworkers, to foster parents. It entails (a) understanding the challenges that children who have experienced maltreatment bring with them when they come to the attention of the child welfare system, (b) considering how services are structured and delivered at each point along children's trajectory through the child welfare system, and (c) de-scaling practices that are not improving outcomes while simultaneously installing and scaling up effective approaches. Administration for Children, Youth and Families (ACYF) recognizes that it is not simple to transform a system in this way and that these processes take time. As the logical next step in reforming the child welfare system, it requires the careful development of capacity to integrate new research and implement new practices without compromising ongoing efforts to achieve safety and permanency for children who have experienced maltreatment.

Understanding the Impact of Maltreatment and Anticipating Challenges: As discussed above, maltreatment leaves a particular traumatic fingerprint on the development and functioning of children and youth. Often the behavioral, social-emotional, and mental health problems that children in foster care have are assumed to be the result of their experience with the child welfare system. McMillan, et al. (2005) and Griffin, Kisiel, McClelland, Stolback, & Holzberg (2012) have shown that children and youth frequently display these challenges before they enter foster care. An understanding of the impact maltreatment has had on children when they come to the attention of the child welfare system allows providers to be more proactive, knowing what to look for and anticipating the services that may be needed. This capacity is necessary at the caseworker-level, but also at the level of administrators who are making decisions about the array of services needed internally or through contracts.

This is not to say that foster care is never detrimental to the well-being of children and youth. However, the fact that children display problems before they come to the attention of the child welfare system indicates that the experience of maltreatment often predicates their difficulties.

Responding and Intervening along the Child Welfare Continuum: Focusing child welfare on improving social and emotional well-being requires careful consideration of how services are structured and delivered throughout the system. For example, a child welfare system with a focus on social and emotional well-being might be characterized by the following:

- Assessment tools used with children receiving child welfare services are reviewed to ensure that they are valid, reliable, and sensitive enough to distinguish trauma and mental health symptoms.
- Children are screened for trauma when their cases are opened.

- In-home caregivers receive services that have been demonstrated to improve parenting capacities and children's social-emotional functioning.
- Child welfare staff and foster parents receive ongoing training on issues related to trauma and mental health challenges that are common among the children and youth being served by the system.
- Assessments take place at regular or scheduled intervals to determine whether services being delivered to children and youth are improving social and emotional functioning.
- Independent living and transitional living programs implement programs to support youth's development of self-regulation and positive relational skills.

De-Scaling and Scaling Up: When child welfare systems make changes, new programs and practices are often added onto the already existing array of services. Ongoing contracts and the need to provide continuous services make it difficult to discontinue or downsize programs that are not improving outcomes for children and youth. Transforming the array of services, rather than simply augmenting it, requires "de-scaling" programs that are not reliably enhancing child functioning by divesting funds and simultaneously shifting resources to support proven practices. Additional dollars may be necessary initially to support installation of evidence-based practices. However, de-scaling programs that are not working and reallocating resources ensures that effective services can be sustained without requiring new, ongoing funding.

Transforming child welfare services by de-scaling and/or converting interventions that are not working while scaling up evidence-based treatments is unquestionably complex and difficult work. Other systems have grappled with this challenge; for example, as mental health services are increasingly provided in community-based settings, the role of residential treatment facilities has been widely reexamined. As new research emerges and the population receiving services changes, it is necessary to reevaluate the way those services are delivered. To start, states can conduct an inventory of the services they are currently providing to children with child welfare involvement and gather information about how effective these services are in improving children's functioning. This information can help drive decision-making about the steps that are necessary to align state, county, and local resources to improve outcomes.

Child welfare agencies that coordinate efforts within and across departments to innovatively re-tool the complement of services available to youth and families in the child welfare system are more likely to achieve sustainable change. Service coordination at the state and local level can benefit from the growing effort across Federal agencies, including the Substance Abuse and Mental Health Services Administration, National Institutes of Mental Health, National Institute on Drug Abuse, Department of Justice, Department of Education, and others, to promote improved well-being outcomes and the use of effective practices.

Strategies for Shifting the System to Promote Social and Emotional Well-Being

There are many ways that child welfare systems can begin to embed a focus on social and emotional well-being in their work. A few specific examples are listed below.

Services. This information memorandum (IM) has shown that children who have experienced abuse or neglect have significant behavioral, social, and emotional challenges; it has also shown that there are evidence-based practices and interventions that can improve outcomes for children and their families. Delivering effective services is the most critical component of a focus on promoting social and emotional well-being.

- **Screening and Functional Assessment:** Conduct high quality and regular trauma screenings and functional assessments of children, youth, and families to determine exposure to and impacts of maltreatment and other forms of complex interpersonal trauma. The American Academy of Child and Adolescent Psychiatry and the Child Welfare League of America have developed guidelines for screening and assessment to help inform child welfare systems (AACAP & CWLA, 2002). Valid and reliable mental and behavioral health and developmental screening and assessment tools should be used to understand the impact of maltreatment on vulnerable children and youth. Screens and assessments should be sensitive enough to distinguish symptoms of trauma reactions and mental health disorders. The use of such tools is important in fulfilling child welfare agencies' responsibility for ensuring the well-being of children and youth who have been exposed to complex interpersonal trauma (Levitt, 2009). Conducting assessments as early as possible when children become involved with the child welfare system and regularly thereafter allows caseworkers to know how children are doing initially and whether they are getting better with the services provided.

- **Evidence-Based Interventions:** Deliver evidence-based and evidence-informed interventions for the treatment of trauma and mental health disorders. When evidence-based screening and assessment indicate that children are suffering from trauma and/or mental health symptoms, it is necessary to provide treatments that effectively improve functioning. Child welfare systems will need to collaborate with mental health and Medicaid systems to build an array of evidence-based or evidence-informed interventions to improve trauma and mental health-related outcomes for children who have experienced maltreatment.

  In recent years, public and private sector organizations have produced extensive, publically available lists and databases of evidence-based and evidence-informed interventions for improving well-being outcomes for vulnerable children (See "Resources," below). These include, among others, Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices (NREPP) and the U.S. Department of Justice's CrimeSolutions.gov. The Agency for Healthcare Research and Quality is currently conducting an evidence review of "Interventions Addressing Child Exposure to Trauma: Child Maltreatment and Family Violence," which will be available later in the year. Additionally, many institutions, including SAMHSA and organizations funded by HHS, including the National Child Traumatic Stress Network (NCTSN) and the National Early Childhood Technical Assistance Center (NECTAC), have published publically-accessible reviews of valid and reliable instruments for screening and assessing various aspects of social-emotional

well-being with different populations and age groups. As such, it is now more feasible than ever to identify and implement evidence-based and evidence-informed interventions.

- **Services within Child Welfare:** Consider restructuring services that are the sole responsibility of child welfare. Some services fall completely within the purview of the child welfare system. For example, services provided by Independent Living and Transitional Living Programs are often dictated by the child welfare agency. Others include investigations, case management, and foster parent training. Without requiring the coordination or collaboration of other systems, it may be possible to change the way these services are delivered. Child welfare agencies could redesign programs and modify contracts to require that Independent Living and Transitional Living Programs deliver services that are trauma-informed and evidence based.

Workforce. It is essential to develop a workforce strategy that supports an emphasis on promoting social and emotional well-being. Administrators and staff of child welfare and other systems that affect children receiving child welfare services, including Medicaid, mental health, and the courts must understand the rationale for the focus and have the capacity to implement changes.

- **Capacity around Evidence-Based Practices:** Build the capacity of child welfare and mental health systems' staff to understand, install, implement, and sustain evidence-based practices. This includes: using research to identify effective interventions that improve outcomes for the population; developing an awareness of principles of evidence-based practice among staff at all levels; and reorganizing infrastructure to support implementation fidelity. While child welfare staff may not be responsible for delivering these interventions, they should be able to appropriately assess and refer children and families to evidence-based treatment providers and determine whether the interventions being delivered are having positive effects on child and family functioning. Child welfare workers should also have regular access to learning tools and communities to remain up-to-date on the latest developments in relevant evidence-based practices.

- **Training on Specific Populations:** Train staff to more effectively serve specific populations of children and youth and specific populations of prospective foster and adoptive families served by the child welfare system. While the social and emotional issues of each child differ, certain populations will share common challenges. Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are often overrepresented in the child welfare system, and they have a set of unique challenges to overcome (ACYF, 2011). In an earlier IM, States were encouraged to "claim available title IV-E reimbursement for costs associated with training staff to increase their capacity to serve young people who identify as LGBTQ and to consider how the title IV-E agency can best serve young people and keep them safe" (ACYF, 2011, p.2). Additionally, LGBT families can be an untapped resource for placement, and agencies are often working to improve

their skills and competencies in serving these families. States may use IV-E training dollars at an enhanced reimbursement rate (75 percent) to improve workers' competency in serving both LGBTQ youth in care and prospective LGBT foster and adoptive families.

- **Training for Professionals Outside of Child Welfare:** Provide training on the impact of maltreatment, trauma, and the social and emotional well-being of children who have been abused or neglected. Under the *Fostering Connections to Success and Increasing Adoptions Act* of 2008, States may use title IV-E training dollars at an enhanced reimbursement rate (75 percent) for training staff or personnel outside of the public child welfare system. Eligible personnel include: staff of private agencies contracted to perform services for the child welfare agency, court personnel, attorneys, guardians ad litem, court appointed special advocates, and prospective relative guardians, as well as foster and adoptive parents.

- **Engaging the Judiciary and the Courts:** The courts play a critical role in promoting the social and emotional well-being of children known to child welfare. The oversight role of the courts could be enhanced by providing training on the core components of social and emotional well-being and trauma, and effective screening, assessment and intervention approaches that can improve functioning. Judges are well situated to ask questions, ensure effective services are delivered, and track well-being outcomes for their individual cases and at the system level.

System. Promoting social and emotional well-being requires a careful analysis of the way the child welfare system is currently structured and the systemic changes that are necessary.

- **Program Inventory:** Examine current spending to understand where resources can be shifted to support evidence-based programs and practices. Many states are currently purchasing services that are not reliably yielding the desired results, such as generic counseling, parenting classes, and life skills training for emancipating youth. By identifying resources that are being used to support these types of services, child welfare systems can begin planning to de-scale them and repurpose funds for evidence-based interventions. Ideally, administrators will combine this work with an analysis of data describing the needs of the population of children receiving child welfare services in order to identify areas in which de-scaling and installation of new practices can improve child and family outcomes.

- **Measure Outcomes, Not Services:** It is common for child welfare systems to gauge their success based on whether services are being delivered. One way to focus attention on well-being is to measure how young people are doing behaviorally, socially, and emotionally and track whether they are improving in these areas as they receive services. At the system level, data from trauma screenings and functional assessments can help administrators understand how successful their child welfare systems are in achieving positive outcomes for children and youth. This understanding can inform

decisions about the array of services that is currently available and the procurement of services going forward.

Building a child welfare system that responds effectively to the traumatic impact of maltreatment and promotes social and emotional well-being is complex work. Multiple, complementary strategies must be employed in order to create systematic changes that improve outcomes for children. The progress that the child welfare system has made in recent years has been the result of ongoing and evolving collaborations across multiple child-serving systems, including mental health, Medicaid, education, early childhood, and more. Together, these systems integrated knowledge about the importance of permanency and family connections and structured themselves to deliver services that keep young people safer; keep children with their families more often; and ensure reunification, adoption, and guardianship for more of the children who come into foster care.

As child welfare systems continue to improve and refine their work to promote safety and permanency for children, a strengthened focus on the social and emotional well-being of children who have experienced maltreatment is the logical next step in reforming the child welfare system. Children who have been abused or neglected have significant social-emotional, behavioral, and mental health challenges requiring attention, and treating them with a trauma-focused and evidence-based approach can improve outcomes throughout child welfare. This approach can result in increased placement stability; greater rates of permanency through reunification, adoption, and guardianship; and greater readiness for successful adulthood among all children who exit foster care, especially those youth who leave foster care without a permanent home. Most importantly, it will enable children who have experienced maltreatment to look forward to bright, healthy futures.

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

[i] The text of this document was excerpted from the ACF Information Memorandum to State, Tribal and Territorial Agencies Administering or Supervising the Administration of Titles IV-B and IV-E of the Social Security Act, Indian Tribes and Indian Tribal Organizations, "Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services," 2012. Full text is available online at: https://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf

Building Trauma-Informed State Systems that Prioritize Child and Family Well-Being[i]

Understanding trauma and its impact on a child's social and emotional well-being is an important building block toward establishing a more trauma-informed child welfare system—in other words, a system that works to provide physical and psychological safety for a child; listens to the child's wants and needs; surrounds the child with caring adults; ensures that the child has an attachment with a caregiver; gives the child as much control over his or her life as possible; ensures that the child has a consistent, predictable environment; and in every way possible fosters the child's various protective and coping factors.

With that understanding, agencies can successfully use ACYF's framework for social and emotional well-being in their work. The overarching purpose of this framework is to help agencies understand and support well-being of maltreated children and foster positive system change. ACYF regards the framework to be a continuation, or logical next step, of its historical emphasis on child and family well-being. Agencies should not regard trauma-informed child welfare as an initiative that competes with other initiatives but rather employ it as a more accurate, sensitive lens through which current practice is observed and assessed, revealing fresh insights that can be integrated into everyday practice. Understanding trauma and working from that perspective will enable caseworker staff to better engage families, link them to more appropriate services, and ensure improved long-term outcomes for both children and families.

Many states are developing or initiating practice models, or conceptual maps, of how agency staff and professionals, resource families, and stakeholders will function and collaborate to meet the needs of families and ensure the safety, permanency, and well-being of children served. The core elements of a practice model include:

- Clearly stated mission, values, vision, and standards of practice
- Strategies for implementing standards of practice
- A plan for assessing needs and engaging families in services
- Clearly defined strategies for agencies to achieve outcomes
- A plan for sustaining practice and system changes

Many states are diligently working toward development or implementation of new practice models. Some, however, have not yet integrated trauma knowledge and strategies into those models. In order for frontline staff to truly embrace trauma-informed practice and trauma-focused treatments, it is essential to incorporate trauma knowledge and concepts into existing and future practice models.

It is also critical for an agency to focus on evidence-based practice. By focusing only on promising approaches that have been proven effective through research, testing, or experience, an agency can ensure the best outcomes for the populations it serves. Furthermore, initiatives to promote social and emotional well-being through trauma-focused treatments that require clinical expertise and guidance should be integrated with a state's current efforts to promote safety and permanency. This avoids replacing or compromising any effective existing practices.

The same holds true for trauma-focused interventions that go beyond treatment to include day-to-day casework and caregiver activities and practice, and that promote the child's protective and coping factors.

Trauma-Focused Treatments

According to the Chadwick Center for Children and Families' Creating Trauma-Informed Child Welfare Systems: A Guide for Administrators; common, broad goals of trauma-focused treatment include:

- Re-establishing a sense of physical and psychological safety for the child
- Helping the child (and family) manage emotions, particularly in the presence of trauma reminders
- Helping the child (and family) gain an understanding of the traumatic experience(s), while recognizing that there may be differences in how the trauma experience is understood by those who were exposed to it

The Chadwick article further defines the following as components to be worked toward in effective treatment.

- Emotion expression and regulation skills, or identifying feelings and developing coping mechanisms for managing difficult feelings such as sadness or anger
- Anxiety management and relaxation skills through practices such as visualization, deep breathing exercises, progressive muscle relaxation, etc.
- Cognitive processing or reframing, or helping the child not to self-blame, and to identify the connection between thoughts, feelings, and behaviors (the "cognitive triangle") and replace inaccurate thoughts with more helpful thoughts
- Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience. It is important that children be able to integrate their trauma experiences, so they are one/some of many life experiences rather than the defining experience(s); this includes construction of the "trauma narrative," or telling the trauma story in tolerable doses, while other techniques are utilized, so that the trauma loses its power.
- Personal safety training and other empowerment activities, or developing healthy boundaries and learning ways to enhance physical and psychological safety
- Resilience and closure, or, at treatment termination, helping children identify strengths for future coping, and helping children/families prepare for possible trauma reminders and triggers

The Chadwick Center's findings led the researchers to make several recommendations for child welfare agencies regarding trauma-focused treatment. First, agencies should universally screen and assess for trauma experiences and symptoms; they should review assessment tools carefully to ensure that they are valid, reliable, and sensitive enough to distinguish trauma and mental health symptoms. Secondly, because of the important differences between mental

health services and trauma-focused treatment, traditional mental health services should not be provided unless trauma screening has first taken place, with trauma being ruled out.

Child welfare agencies should recognize that the mental health field has related, but somewhat differing goals when working with children and parents. Mental health providers tend to work toward ameliorating the manifestations of a specific condition (or conditions) diagnosed, which is a worthwhile goal, but they may fail to recognize how trauma has pervaded and shaped the child's or adult's entire sense of self and safety. Because of this, they may sidestep dealing holistically with the wide array of trauma effects and may limit their effectiveness in developing protective and coping factors through their interventions. It is critical that mental health providers understand what the professionals in child welfare, as well as the child and family, hope to accomplish with a referral for mental health services. Additionally, they should know and understand the goals for the child and family, whether or not there is evidence of trauma in the child's and family's history, and what strategies the child welfare agency believes should be considered in treatment planning.

In general, when compared to traditional mental health treatments for diagnoses such as bipolar disorder, attention deficit disorder, and conduct disorder, the researchers found that trauma-focused treatments:

- Keep a greater focus on context, safety, and support
- Better address symptoms and risk behaviors as part of a broader set of reactions
- Develop more strengths and protective factors
- Focus less on medications
- Are less stigmatizing

Thus, great care should be taken to distinguish between mental health and trauma symptoms in children, and to ensure that treatments selected are appropriate, consider the child as a whole, and help affected children make new meaning of their trauma history.

Evidence-Based Practice

Evidence-based practice, also referred to as evidence-informed practice, is practice in which effectiveness has been validated through experience or research. The concept began in other fields, including medicine and manufacturing, and is now receiving attention from child welfare agencies. Changes in practice and services are more likely to be successful in yielding positive outcomes if they have been proven through research, testing, or previous implementation.

Selecting or developing new practice, however, is only the first step. Once a new practice or intervention has been identified, care must be taken to ensure that it is implemented with adherence to its evidence-based design. If new practices are not implemented as intended, even if they have been shown by research to be effective, they will likely not succeed or, at best, will have only mixed results.

Another aspect of effective practice is providing trauma-informed services across the child welfare continuum. This may involve modifying the service delivery system so that it incorporates across-the-board screening for trauma symptoms when children enter the system, and, as necessary, ongoing trauma-informed assessments initially and at periodic intervals to determine if services are effective and children are progressing. These processes should be coordinated and integrated with any evidence-based, trauma-focused interventions that are currently used by child welfare agencies and/or trauma informed services delivered by mental health providers. Additionally, they should become part of the State's agency-wide continuous quality improvement (CQI) systems, but regularly measured, evaluated, and adapted as needed for maximum effectiveness.

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

[i] Excerpted from Child and Family Services Reviews Information Portal. Full text available online at: https://training.cfsrportal.org/section-4-trauma-child-welfare-system/2441

Overview

The Emergence of Trauma-Informed Child Welfare Systems

Charles E. Wilson, MSSW

Over the last 30 years, society's understanding of the effects of traumatic stress has increased significantly and more recently we have begun to recognize the interaction between traumatic stress and the service systems we put in place to support vulnerable populations. Nowhere is this connection between trauma and the system more striking than in the nation's child welfare systems. Almost all children served by the child welfare system report chronic and complex trauma histories, complicated by system-imposed stresses such as removal and multiple foster care placements. Children with such experiences often require support of a skillful and well trained mental health professional, but treatment alone is not enough. Over the last six years, it has become clear to many working in the National Child Traumatic Stress Network[1] (NCTSN) that meaningful treatment of children in the child welfare system must be matched with system supports. Essentially, the entire child welfare system needs to be transformed into a "trauma-informed system."

What is a trauma-informed system? The term first appeared in substance abuse literature to recognize that many seriously addicted individuals had experienced major traumas, and those traumatic events had shaped their lives in sometimes disastrous ways (see Conradi & Wilson, 2010 for a full review of this topic). By 2004, NCTSN was applying similar concepts to child trauma victims and that work led to a variety of products and services developed within the Network. One definition of a trauma-informed system has been advanced by the Chadwick Trauma-Informed Systems Project (CTISP), with support of a national advisory committee. CTISP defines a trauma-informed child welfare system as a system *"in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers 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"* (Chadwick Trauma-Informed Systems Project, 2011).

There are key phrases in this definition that are worth pointing out. First, the definition applies to the wider child welfare system not just the public child welfare agency. Second, the definition focuses not only on child trauma victims but also their caregivers and the workforce who seek to support them. All three of these groups are affected by traumatic events, including primary traumatic experiences that threaten their own or their loved one's lives or physical integrity as well as vicarious trauma from what they see, hear, and experience when working intimately with traumatized children. The definition stresses the "varying impact of trauma," indicating that each child and adult is unique and reacts to trauma in his or her own way. Some children and adults have great resilience and may not require clinical intervention while others exposed to similar levels of trauma are devastated and require skillful intervention. The definition emphasizes that it is not enough to be knowledgeable about trauma but also asserts that the system must act to make use of that knowledge by integrating it into everyday interactions with families and their organizational cultures.

The system should offer universal screening for traumatic history and traumatic stress responses, which will assist the workers in understanding the history of a child or family.

To undertake this effort, the child welfare system needs a framework, and the NCTSN offers one in its "Essential Elements of a trauma-informed child welfare system." The NCTSN Child Welfare Committee is currently in the process of refining the essential elements, first introduced in 2006. What emerges are the following seven essential elements (Child Welfare Committee, personal communication, March 7, 2012).

1. Maximize Physical and Psychological Safety for the Child and Family

While child welfare has always had a focus on physical safety, a trauma-informed system must go further and recognize that psychological safety is important to the child's long-term recovery and social and emotional well-being and 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 safe from external harm and is critical for functioning as well as physical and emotional growth. A lack of psychological safety can impact children's interactions with all other individuals, including those trying to help them, and can lead to a variety of maladaptive strategies for coping with the anxiety associated with feeling unsafe. These "survival strategies" often include a range of symptoms and behaviors from substance abuse to self-mutilation. Children and/or adults may continue to feel psychologically unsafe long after the physical threat has been removed or they have been relocated to a physically safe environment, such as a relative or foster home.

Even after the child or adults gains some degree of security, people, places, and events may unexpectedly remind them of past traumas and draw their attention back to intense and disturbing memories overwhelming their ability to cope again. At times, a seemingly innocuous event or sensory stimuli such as smells, sights, sounds, touches, or objects may trigger subconscious reminders of the trauma that produce a strong physiological response wherein the biochemical systems of the body react as if the trauma were happening again. A trauma-informed child welfare system understands that these pressures may help to explain a child or parent's behavior and can use this knowledge to help them better manage triggers and to feel safe.

2. Identify Trauma-Related Needs of Children and Families

The child welfare workforce should be educated on trauma and how it affects an individual at any stage of development and intersects with his/her culture. The system should offer universal screening for traumatic history and traumatic stress responses, which will assist the workers in understanding the history of a child or family. The screening will help identify potential triggers and will create a guide

[1]Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States.

for direct trauma-informed case planning. Those who screen positive for trauma should receive a thorough assessment by a trained mental health provider. This professional will identify the reactions of a child or parent and determine how their behaviors are connected to a traumatic experience. This assessment will guide subsequent intervention efforts.

3. Enhancing Child Well-Being and Resiliency

A child's recovery from trauma often requires the right evidence-based or evidence-informed mental health 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 his/her trauma history.

But to truly address the child's trauma the child needs the support of caring adults in his or her life. Many trauma-exposed children have significant symptoms that interfere with their ability to master developmental tasks, build and maintain relationships with caregivers and peers, succeed in school, and lead a productive and fulfilling life. Case planning must focus on giving children the tools to manage the lingering effects of trauma exposure and to build their relational capacity so they can take advantage of opportunities as they grow and mature. By helping them develop these skills in a clinical setting and build supportive relationships, we enhance their natural resilience.

4. Enhancing Family Well-Being and Resiliency

Most birth families that interact with child welfare systems have also experienced trauma. Providing trauma-informed education and services to birth parents and resource parents enhances their protective capacities, thereby increasing the resiliency, safety, permanency, and well-being of the child.

5. Enhancing Family Well-Being and Resiliency of Those Working in the System

Working within the child welfare system can be a dangerous business, and the workforce may be confronted with threats or violence in their daily work. Adding to these stressors, many workers experience secondary traumatic stress reactions, which are physical and emotional stress responses to working with a highly traumatized population. When working with children who have experienced maltreatment, parents who have acted in abusive or neglectful ways, and systems that do not always meet the needs of families, feelings of helplessness, anger, and fear are common. A trauma-informed system must acknowledge the impact of primary and secondary trauma on the workforce and develop organizational strategies to enhance their resilience.

6. Partnering with Youth and Families

Youth and family members who have experienced traumatic events often feel like powerless "pawns" in the system, reinforcing feelings of powerlessness felt at the time of the trauma. Providing youth and families with choices and a voice in their care plays a pivotal role in helping them to reclaim the power that was taken away from them during the trauma and tap into their own resilience.

7. Partnering with System Agencies

No one agency can function alone, and in trauma-informed systems child welfare must reach out and coordinate with other systems so they too can view and work with the child and family through a trauma lens. This partnering includes:

- Teaming with law enforcement to minimize the number of front-end interviews children must experience
- Cross training with other primary partners to enhance their understanding of their roles in the intervention process, recognize how steps within their processes can exacerbate existing traumas, trigger traumatic reactions and develop processes to reduce the risk of duplicative interactions with the child, family, and collaterals.
- Working with mental health agencies to ensure therapists are trained in specialized trauma assessment and evidence-based trauma treatments
- Coordinating with schools, the courts, and attorneys.

Such coordination is necessary to prevent one part of the system undoing the good trauma- informed work of another part of the system.

In the end, a trauma-informed system produces far greater synergy as one element of the system supports the work of the others with all working to build on the natural resiliency of the child and family.

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Trauma Screening within the Child Welfare System

Lisa Conradi, PsyD and Cassandra Kisiel, PhD

Children involved in the child welfare system (CWS) are particularly vulnerable to traumatic exposure and traumatic stress symptoms whether it is by virtue of the events that brought them into the system or through the process of removal from their caregivers. A national study of adult "foster care alumni" found higher rates of posttraumatic stress disorder (PTSD; 21%) compared with the general population (4.5%) (Pecora et al., 2006). If left untreated, the effects of child trauma can be far-reaching and pervasive.

Recently, the importance of screening for trauma among children in the child welfare system has received increased attention. In December 2011, the Child and Family Services Improvement and Innovation Act of 2011 PL 112-34 amended Title IV-B, in part, to require states to screen for "emotional trauma associated with a child's maltreatment and removal from the home." While specific guidelines are not yet established on how states will implement this mandate, it suggests that policy makers recognize screening for trauma as playing a critical role in assisting child welfare systems (CWS) towards meeting their goals of safety, permanency and well-being.

A trauma screening tool is designed to be universal, administered to every child within the CWS, and typically evaluates the presence of two critical elements: (1) exposure to potentially traumatic events/experiences and (2) endorsement of traumatic stress symptoms/reactions. Using a trauma screening tool is critical to understanding the unique experiences of children and their needs; however, there are a number of barriers that impede child welfare workers from conducting trauma screens on every child who comes into care. These barriers include lack of training on administration of screening, lack of time to administer screening tools, lack of training to effectively use the information gathered for case planning, and difficulty managing the effects of secondary/vicarious trauma that may emerge when asking a child about his/her traumatic experiences.

While there are barriers to administering universal trauma screening tools, there are a number of benefits. CW workers may already be asking about the child's traumatic exposure and symptoms although they may not explicitly identify their questions as such. For instance, many practices within child welfare, including Structured Decision Making (Wiebush, Freitag, & Baird, 2001) and Signs of Safety (Turnell, 2011) include questions related to a child's trauma history, fears, and triggers. Therefore, integrating some questions about specific trauma experiences and symptoms can readily be woven into existing practices and tools. Further, caseworkers who have conducted trauma screenings can identify the types of events or situations that may potentially trigger symptoms for the child. This information can be conveyed to the foster parent along with psychoeducation and skill-building on managing difficult behaviors and trauma triggers, ultimately helping the foster parent manage difficult behaviors and minimize placement changes. Finally, a trauma screening plays a critical role in determining whether or not a child should be referred for general mental health treatment and/or trauma-focused treatment, if needed.

In December 2011, the Child and Family Services Improvement and Innovation Act of 2011 PL 112-34 amended Title IV-B, in part, to require states to screen for "emotional trauma associated with a child's maltreatment and removal from the home."

Before implementing any screening tool or process, it is useful to integrate some general recommendations into existing child welfare practice:

1. Broad training on child traumatic stress should be made available to the entire child welfare workforce. This includes training on different trauma types (e.g., sexual abuse, physical abuse, neglect, exposure to domestic violence) and various traumatic stress reactions that children may exhibit, including internalizing and externalizing problems. There are a number of resources that exist to assist child welfare systems in training on these topics, including the Child Welfare Trauma Referral Tool (Taylor, Steinberg & Wilson, 2006).
2. The child welfare system should foster relationships with its mental health partners and actively work with them to build their capacity to provide trauma-focused mental health treatment when appropriate. If a screening process determines that a child would benefit from a trauma-focused mental health assessment, it is critical to link him or her to a provider who is trained in providing such an assessment.

There are several existing trauma screening tools designed to help child welfare workers get a better sense of the child's trauma history, make sense of the child's behavior problems, and inform the case planning process. For a fuller review of some commonly used screening tools and methods of administration, refer to Conradi, Wherry and Kisiel (2011). Given the extraordinary number of children who enter the CWS with a history of trauma, it is critical to embed a process in which children are screened for trauma exposure and reactions, and then referred for trauma-focused assessment and treatment as needed.

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Screenings and Assessments Identify Trauma and Behavioral Health Concerns[i]

Screening and assessing for trauma symptoms, especially in regard to determining how trauma affects healthy functioning, are essential in determining a child's overall social and emotional well-being. Children usually present to a child welfare agency as a result of a specific incident of maltreatment. For effective case planning and treatment, it is critical that child welfare practitioners be aware of the child's history, including the child's cumulative trauma experiences, in order to ensure a holistic, trauma-informed approach to the child.

Developing the capacity to screen and assess for trauma in the child welfare system can also address broader policy considerations. The 2011 Child and Family Services Innovation and Improvement Act, for example, requires states to include in their health care oversight plans a description of how they will screen for and treat foster children for trauma associated with maltreatment. Consequently, it is very important that an agency's plan address emotional trauma for children involved in the child welfare system. States should consider integrating trauma-informed screening and assessment tools into their daily practice and carefully consider selecting tools from the wide variety available that meet their specific needs.

As appropriate, trauma assessments should be completed, initially and on an ongoing basis, to determine whether treatment strategies employed are effective and to plan further treatment.

Trauma-Informed Screening and Assessment Tools

There are distinct differences between trauma screening and trauma assessment tools. Screening tools are brief, used universally, and designed to detect exposure to traumatic events and symptoms. They help determine whether the child needs a professional, clinical, trauma-focused assessment. Functional assessments are more comprehensive and capture a range of specific information about the child's symptoms, functioning, and support systems. A trauma assessment can determine strengths as well as clinical symptoms of traumatic stress. It assesses the severity of symptoms, and can determine the impact of trauma (how thoughts, emotions, and behaviors have been changed by trauma) on the child's functioning in the various well-being domains.

If properly trained, the frontline caseworker within a child welfare setting can administer a screening tool when a child initially enters the system. Information obtained from that screening can help the caseworker determine whether a more comprehensive trauma-informed assessment is needed. If the initial screening indicates that additional assessment is needed, the child can be referred to a mental health practitioner for a trauma-informed assessment. This will provide the agency and caregiver with a fuller understanding of the child's needs and behaviors; guide the treatment plan; and determine a trauma-focused, evidence-based intervention that will stabilize and help the child heal.

Selecting a Tool

When selecting a tool, factors to consider include how well it meets the needs of the target population and fits within the agency's service delivery system. There are also properties specific to each tool that must be considered. As part of any selection process for a trauma-informed screening or assessment tool, the National Child and Traumatic Stress Network (NCTSN) recommends examining these specific properties:

- **Validity** – the degree to which the tool, including each of its specific items, accurately accomplishes its purpose, or whether the tool measures what it is intended to measure
- **Reliability** – the degree to which the tool is consistent across time and different raters
- **Standardization of Norms** – a process in instrument and measure development that allows for comparisons between data from the screening/assessment tool with general populations of the same age group

These trauma-informed screenings and assessments are similar to other types of assessments in that information is gathered as early as possible or on an ongoing basis from multiple sources such as the child, caregiver, and provider. However, they differ from traditional types of assessments in that they differentiate trauma effects from mental health disorders, which will be a critical factor in assisting child welfare practitioners to choose an appropriate course of treatment.

Functional Assessments

Functional assessments are tools that measure multiple aspects of a child's social-emotional functioning, accounting for the major domains of well-being. These tools capture the child's issues and challenges as well as strengths, skills, and capacities. Some functional assessments also capture parenting capacities and changes over time. One of the distinctions between traditional child welfare assessments and functional assessments is that functional assessments provide a more holistic approach by measuring a wide array of competencies that contribute to well-being rather than just one aspect of well-being.

Functional assessments, if administered at periodic intervals, provide a way to track progress toward the healing of social and emotional well-being issues. This makes the use of functional assessments a key component of promoting social and emotional well-being for maltreated children, because they can help agency decision-makers at all levels determine the appropriateness of services and identify the most effective interventions for children.

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

[i] Excerpted from Child and Family Services Reviews Information Portal. Full text available online at: https://training.cfsrportal.org/section-4-trauma-child-welfare-system/2440

Introduction

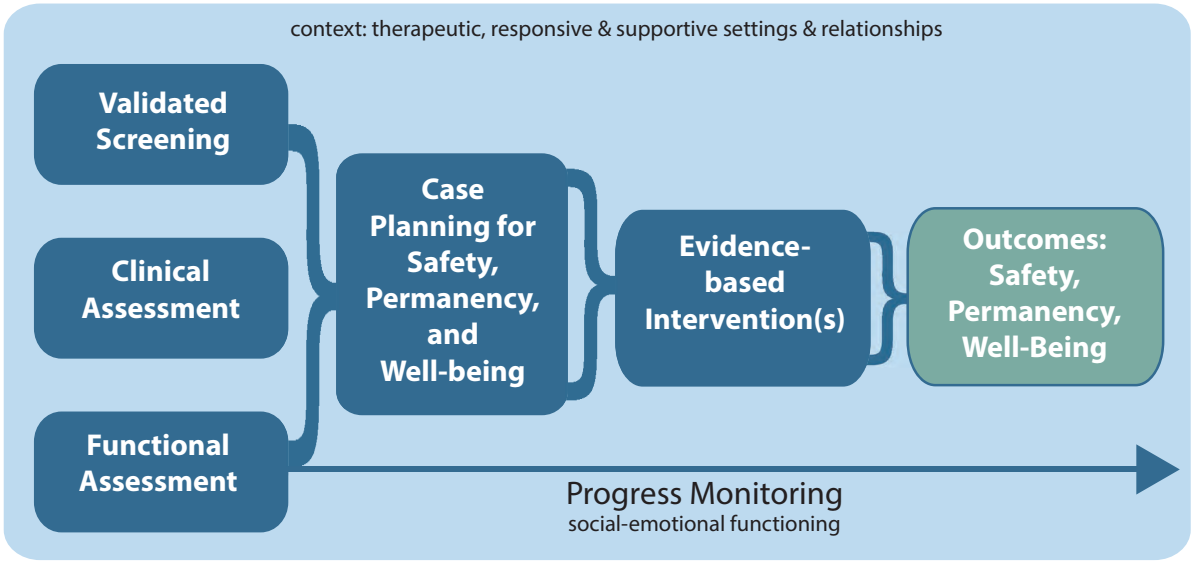
This is the second in a series of three papers informed by the well-being framework developed by the Administration on Children, Youth and Families (U.S. Department of Health and Human Services, 2012). It addresses three critical components of a well-functioning response to the social, emotional and behavioral needs of vulnerable children and their families involved with the child welfare system:

1. universal screening for mental health and trauma symptoms that can assist the decision to refer for clinical assessment and treatment;
2. clinical and functional assessment together with outcome measurement and management; and
3. selection and use of evidence-based interventions (EBI) in response to clinical needs observed in the assessment process that have the potential for relief of symptoms/conditions and improvement in psychosocial functioning.

The figure below depicts how the three critical components are related and lead to better outcomes for children and families. The first step is conducting a reliable and valid universal screening. This screening can both collect information on the trauma and related behavioral health needs for children in child welfare and assist in referring children to a more comprehensive clinical assessment conducted by a mental health provider. Next, this information is used to inform case planning efforts with a focus on activities that support safety, permanency and well-being. This includes the referral of a child to an evidence-based practice or practices to meet the child's unique needs.

A functional assessment, which focuses on assessing a child's functional capacity such as relationships at home and school, can be conducted at any point during this process. It may be conducted by child welfare at the beginning of the case with periodic follow-ups, or within the context of a clinical assessment.

Throughout this process, data are collected for continuous quality improvement purposes including informing the child's progress and providing aggregate level information to contribute to system improvements. Course corrections at both the client level, such as referral to different treatment practices, and at the system level, such as scaling up or down the service array, can be made, as needed.



Implementing the three components mentioned in the first paragraph requires the cooperation and expertise of community child welfare and mental health services systems, data-informed planning, and services at the organizational level. Data informed planning begins with careful selection of target populations and concludes with on-going progress monitoring at both the individual child level and the system level. Additionally, evaluation and outcome measurement are critical to ensuring that improvements in social and emotional well-being, safety, and permanence are achieved and maintained.

Source: Screening, Assessing, Monitoring Outcomes and Using Evidence-Based Interventions to Improve the Wellbeing of Children in Child Welfare, U.S Department of Health and Human Services, Children's Bureau

Protective Factors Can Mitigate the Effects of Trauma[i]

While exposure to complex trauma can adversely affect child development across multiple domains of functioning, the degree of the trauma's impact can change as the child is exposed to different stressors and developmental challenges. Various protective and coping factors, including the child's supportive relationships, self-esteem, and social competency, will affect how each child fares when exposed to trauma. These factors, whether they are individual factors or family and environmental factors, can help buffer the effects of trauma, strengthening the child's resilience and competence across various domains of functioning.

Understanding these protective and coping factors is critical to the child welfare practitioner's ability to respond appropriately to children exposed to trauma, and is key to the implementation of trauma-informed practice. It is the responsibility of caregivers, child welfare practitioners, and other professionals to instill and/or enhance these factors in trauma-affected children to the greatest degree possible and set them on a pathway to healing.

Individual Factors

There are a variety of critical individual protective and coping factors, or traits, that relate to a child's resilience and ability to cope with adverse events such as maltreatment and trauma. Many maltreated children possess some of these traits to some degree. They include:

- **Social supports, or well-developed interpersonal skills, and the ability to secure and maintain a circle of nurturing, supportive adults**. Research suggests that strong interpersonal relationships may provide the best defense in coping with stress or trauma.
- **Involvement in validating experiences**. Children who participate in experiences such as art, music, outdoor activities, and volunteering, are provided opportunities for success and validation, which helps build feelings of worthiness and lessen the effects of trauma.
- **Healthy self-esteem**. A good self-concept and regular experiences of positive emotions promote resistance and resilience to the effects of trauma.
- **Adaptability**. Flexibility in perspective, beliefs, and emotions is a protective factor against adverse experiences.
- **Aptitude**. Resourcefulness and intellectual mastery can help mitigate the effects of trauma.
- **The ability to think rationally**. This ability, which enables children to make sense of the actions of others and brings logical, clear ideas about their experiences to the forefront, is a factor in mitigating trauma.
- **Positive temperament**. A positive temperament provides the ability to see things in as favorable a light as possible and helps children cope with the effects of trauma.
- **Positive beliefs about the world**. Children who perceive the world as fair, safe, and predictable are generally better able to withstand the effects of trauma.

- **Degree of mastery and autonomy**. When children feel that they have a sense of power and control over their lives, they can better deal with traumatic events.

It is important to remember that these protective factors interact differently in different children, and that some trauma-affected children can function fairly competently in some social and emotional areas but not in others.

Family and Environmental Factors

Unlike a child's individual factors, which are protective and coping factors intrinsic to the child, family and environmental protective and coping factors refer to factors that are generally outside of the child's control, such as the available extended support network. These factors, which relate to a child's resilience and ability to withstand trauma, include:

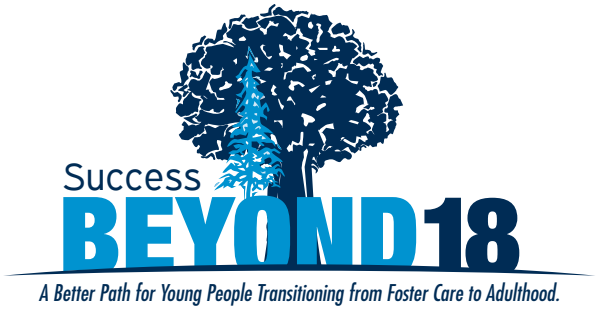
- **Positive attachment and connections to emotionally supportive and competent adults within the family or community.** Parents or other significant adults who can provide emotional support and understanding can significantly increase a child's ability to cope effectively with trauma.
- **Socioeconomic resources.** Children from families with adequate resources are much more likely to have fewer stressors than children from families with inadequate resources, and it is also likely that parents with adequate resources will be more able to provide support and resources that children need to mitigate trauma.
- **Ties to extended family.** These ties can provide a child with additional supportive resources from a trusted network of adults and help mitigate the effects of trauma.
- **Caregiver/parental capacity to provide the child with a secure base and a secure attachment relationship.** A child with a secure attachment will have more cognitive and emotional resources for dealing with trauma than a child with insecure attachments.
- **Caregivers/parents who are able to effectively manage their own response to the child's trauma.** Caregivers who stay calm, supportive of the child, and focused on meeting the child's needs rather than their own provide an important defense against the negative effects of the child's trauma.
- **Caregivers/parents who believe and validate the child's experience.** Knowing that someone understands and cares about what has happened to them greatly increases the child's ability to cope with adversity.
- **Availability of community supports.** Accessible community social organizations that promote healthy child development are valuable resources to children dealing with adverse situations.
- **Communities that send a clear message of behavior and events that are acceptable.** Children and caregivers who recognize clear boundaries of acceptable and non-acceptable behavior feel more supported in dealing with trauma.

These family and environmental protections help mitigate the effects of maltreatment and trauma experiences for a child. However, like individual protections, the family and community

supports are present in different degrees for different children, and their interplay in a specific child is complex and varied.

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

[i] Excerpted from Child and Family Services Reviews Information Portal. Full text available online at: https://training.cfsrportal.org/section-4-trauma-child-welfare-system/2445



Success Beyond 18

A Better Path for Young People Transitioning from Foster Care to Adulthood

(Executive Summary)

May 2013

The Jim Casey Youth Opportunities Initiative's ***Success Beyond 18*** is a national campaign to advance policies and practices designed to set young people transitioning from foster care on the right track for success in family, work and adult life. The overarching objective: To give young people in foster care the same building blocks for success in life and positive experiences that are more often associated with their peers in intact families.

Why now? Brain research shows that we have a second chance to help young people overcome adversity and begin to thrive. Federal funding makes it easier than ever for states to help young people have a strong start at adulthood.

We must act to take full advantage of the extended foster care opportunities provided by the Fostering Connections to Success and Increasing Adoptions Act of 2008 (FCA). No young person should be on his or her own at age 18 -- and they don't have to be. Based on what we know about adolescent and young adult development, services and supports for young people age 18 and older can be designed and implemented to meet their unique developmental needs. The FCA's extended care provisions also serve as a catalyst for redefining and improving services and supports for young people in care beginning no later than age 14. Existing foster care services must continue to improve so that fewer teenagers need extended care, and when needed, the young person is prepared to take full advantage of the post-age 18 opportunities.

With improved outcomes for this vulnerable population, our communities will benefit immediately. Young people who age out of foster care enter the mental health, substance abuse, homeless services and criminal justice systems in disproportionate numbers and at great cost. These costs begin immediately upon young people aging out of care without a permanent family, but can be turned around. For example, if youth transitioning from foster care graduated from high school at the rate of young people as a whole, an estimated 7,000 additional young people would leave care each year as high school graduates; their annual wages would be $8,500 more per year.[1] If young people transitioning from foster care became parents at the rate of their non-foster care peers, there would be 3,000 fewer births, saving society $5,500 for each child through the first 15 years of life.[2] If young people transitioning from foster care were involved in the criminal justice system at the average rate for the population as a whole, 1,950 fewer young people would be annually involved in the "deep end" of the criminal justice system,

1. Alliance for Excellent Education, 2007.
2. Jim Casey Youth Opportunities Initiative, 2013.

saving society $2.5 million in arrest, incarceration, probation and parole costs.[3] By intervening now, we need not wait decades for the return on investment – sound investments in the success of this population promise to pay off and pay off relatively quickly.

Across the country, we know who these young people are and we have the opportunity to act. The three policy and practice goals of ***Success Beyond 18*** provide a foundation for concrete action on the part of states, tribes, and other jurisdictions in meeting their needs. Based on research, experience, and what young people have told us, these three goals can transform systems of foster care services and supports and achieve positive outcomes for adolescents and young adults in care.

Success Beyond 18 **Goal 1.** Extend care for young people beyond age 18 to at least 21 and do it right by ensuring services and supports are offered based on the unique developmental tasks of this life stage and their legal status as adults.

Success Beyond 18 **Goal 2**. Fully promote youth engagement in case planning and decision-making for all young people in foster care age 14 and older.

Success Beyond 18 **Goal 3**. Provide quality oversight that ensures that developmentally appropriate supports and services lead to positive life outcomes for all young people in foster care, beginning no later than age 14 and continuing through extended voluntary care to at least age 21.

What will the campaign achieve?

- Preparation of young people in foster care from early adolescence onward to successfully transition from adolescence to young adulthood.
- An increase in the number of young people in foster care who leave care to permanent families before they reach age 18.
- Dramatically improved outcomes for young people who need extended voluntary care as a result of new opportunities.
- Enhanced well-being of all young people in foster care age 14 and older across all developmental domains.

"By the time I turned 17, I was burnt out on the system and its demands, and I feel that if I was simply included in the conversation that I would not have had to go through half of what I did. Communication is one of the key things that must happen for the best decisions to be made, yet communication is also the number one thing we forget."

– Eddye Vanderkwaak

Adolescence is a critical transition period that is marked by a tremendous pace in growth and change. Young people physically and sexually mature, move toward social and economic independence, develop identity, and build intellectual capacities. Outside the world of foster care, parents are significant sources of support, guidance, communication, and learning opportunities. Young people in foster care typically lack the very benefits that parents provide to their children throughout adolescence and young adulthood. When young people in care approach the age of 18 without permanent, committed families, they suddenly face the prospect of being on their own at an age when even well supported young people rarely can "make it." They have not been gradually prepared from early adolescence onward for adult roles, and their options are to leave care or to continue in a foster care system designed to serve children, not legal adults.

Success Beyond 18 **Goal 1**. *Extend care for young people beyond age 18 to at least 21 and do it right by ensuring services and supports are offered based on the unique developmental tasks of this life stage and their legal status as adults.*

3. Jim Casey Youth Opportunities Initiative, 2013.

This goal addresses the need to provide young people in foster care with supports and guidance that are developmentally appropriate as they enter and continue through the developmental stage of emerging adulthood. For those young adults who need extended services and supports, the program must be designed and implemented the right way to ensure that young people will utilize extended care and experience positive outcomes. States can take steps to support young people's successful transitions from adolescence to young adulthood by extending the availability and enhancing the quality of foster care for young people age 18 to at least age 21. Specifically, states can:

» Undertake a collaborative process with young people and other stakeholders in designing extended care.

» Leverage federal funding made available through the FCA to expand foster care with federal support to age 21.

» Take advantage of new options under the federal law to design services and supports that align with what we know is best from developmental science and best practice, including: options for supervised independent living arrangements that are developmentally appropriate; allowing voluntary departures from care and re-entry as young people "test out" independence and learn from experience; allowing young people to enter into voluntary placement agreements that create a contract between young people and the foster care agency; and providing direct foster care maintenance payments to young adults.

» Maximize participation of young people in extended care by defining the federal eligibility criteria broadly within the federal scope.

***Success Beyond 18* Goal 2.** *Fully promote youth engagement in case planning and decision-making for all young people in foster care age 14 and older.*

This goal addresses the need to support young people in fully engaging in their own case planning and in making decisions that affect their lives. Through active engagement in case planning and decision-making, young people can take advantage of crucial opportunities to develop resilience and growing levels of autonomy; practice making decisions and taking on increasing levels of responsibilities for themselves; and build and strengthen the social capital that is essential for healthy development through adolescence and adulthood. States can improve outcomes for young people in foster care by ensuring that young people direct their own personalized case planning process. Specifically, states can:

» Prepare young people to take leadership roles in directing their own personalized case planning by fully engaging them by age 14 in the planning process and preparing them to take a full leadership role in their case planning at age 18.

» Actively engage individuals that the young person has designated to participate in his/her personalized case planning and require the active engagement of family members and caregivers who are playing a "parenting" role in the young person's life.

» Require that case planning focus on relationship-building for the young person.

» Require that for any case where client-directed case planning for a young person age 14 and older is not implemented, the reasons be clearly documented in the young person's case record.

» Develop mechanisms to regularly ascertain the level of young people's preparation, involvement, empowerment and satisfaction with their case planning process and the outcomes that are being achieved with and for them.

***Success Beyond 18* Goal 3.** *Provide quality oversight that ensures that developmentally appropriate supports and services lead to positive life outcomes for all young people in foster care, beginning no later than age 14 and continuing through extended voluntary care to at least age 21.*

This goal addresses the essential need for oversight of the foster care system as it provides developmentally appropriate foster care services and supports to young people from age 14 through age 18 and beyond. For the relatively small number of young people who need extended care, oversight is essential to ensure that services and supports are responsive to them in their new legal status as adults as well as to their continuing development as emerging adults. Quality oversight can be achieved by taking the following steps for all young people who are in foster care ***or*** extended voluntary care:

» Ensure that the scope of inquiry by the oversight body (the court or an administrative body) includes the young person's well-being needs as well as their safety and permanency needs.

» Provide self-advocacy education and training to support young people, including those with higher needs or developmental disabilities.

» Develop mechanisms to regularly ascertain the level of young people's preparation, involvement, empowerment and satisfaction in administrative and judicial hearings.

Specifically for young people beginning at least at age 14 and continuing to age 18, courts can also:

» Provide client-directed legal advocacy based on the young person's expressed desires and needs.

» Require by policy and court rules that young people in foster care ages 14 and older have meaningful opportunities to attend and actively participate in their court proceedings.

Specifically for young people ages 18 to at least age 21 who are eligible for extended voluntary care, states can:

» Ensure accountability through well-designed oversight venues that recognize the developmental strengths and needs of young people with respect to services, supports, and supervision; the responsibilities of both the young person and the foster care system while the young person is in extended care; and the outcomes that are to be achieved for each young person. The venue may be the court or an administrative body.

» Develop intermediate and graduated interventions to ensure that young people at risk of expulsion from foster care are first provided with supports and services that target situational challenges and unforeseen crises.

» Create client-friendly procedures and easy-to-use forms for young adults who have exited from foster care and petition the court or agency for expedited re-entry into extended care.

The three interrelated policy and practice goals of ***Success Beyond 18*** provide a framework for states, tribes and other jurisdictions to take concrete steps to meet the needs of young people beginning at age 14 and continuing until at least age 21 through a transformed system of developmentally appropriate foster care services and supports. These young people are in our care now, and within a few years – or even less – they face an uncertain future for which they are not developmentally ready and for which they have not been prepared. We now have the opportunity, federal support and the knowledge to do better for them. Now is the time . . . and now is the time to do it right.

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January 2010

EXTENDING FOSTER CARE TO AGE 21: MEASURING COSTS AND BENEFITS IN WASHINGTON STATE

Every year, between 400 and 500 foster youth in Washington State turn 18 and "age out" of the foster care system. Compared with other youth making this transition, foster youth have fewer resources and family supports to guide them on the path to adulthood. In 2006, the Washington State Legislature authorized the Department of Social and Health Services (DSHS) to allow up to 50 youth per year to remain in a foster care placement until age 21, while enrolled in college or vocational training. The Legislature also directed the Washington State Institute for Public Policy (Institute) to . . .

> *"conduct a study measuring the outcomes for foster youth who have received continued support. . . . The study should include measurements of any savings to the state and local government."*[1]

In 2008, the Institute completed a preliminary report which described the characteristics of early enrollees in the Foster Care to 21 program (FC to 21), their persistence in the program, and how they compared with other youth who exited foster care during the same period.[2]

This report describes outcomes for youth who enrolled in FC to 21 between July 2006 and September 2008, and compares outcomes to similar youth exiting licensed foster homes prior to 2006. The cost savings associated with the following outcomes are presented:

- College enrollment,
- Public assistance receipt, and
- Arrests.

In addition to these outcomes, we also compare the birthrates and employment levels of FC to 21 participants to similar youth.

SUMMARY

The 2006 Legislature passed 2SHB 2002, establishing a three-year program for up to 50 youth per year to remain in foster care until their 21st birthday while attending a post-high school academic or vocational program. This program, commonly known as Foster Care to 21 (FC to 21), began enrollment in July 2006; this report describes an evaluation of outcomes for the program youth to date. As of October 2009, 239 youth had applied to FC to 21 since the program's inception. Among eligible applicants, 184 foster youth enrolled in the program between 2006 and 2009.

FC to 21 Participants

- *Youth enrolled in FC to 21 were more likely than other youth exiting licensed foster homes to:*
  - *be female,*
  - *be in a dependency guardianship at age 18,*
  - *have a GPA of 3.0 or greater,*
  - *graduate from high school or receive a GED,*
  - *attend college in the year after graduation; and*
- *Less likely to have:*
  - *run away from a placement since age 13,*
  - *spent time in juvenile detention since age 13.*
- *Of youth we could follow for at least one year, nearly half remained in FC to 21 for a full year or more.*

Comparison With Non-Participants

The evaluation examined outcomes for FC to 21 participants compared with outcomes for a matched group of foster youth who graduated from high school before the FC to 21 program was available.

- *Compared to similar foster youth, FC to 21 enrollees:*
  - *attended college for a longer period in the first two years after high school graduation,*
  - *received food stamps for fewer total months; and*
  - *were less likely to be arrested for a misdemeanor or felony crime.*
- *Employment and birth outcomes were not significantly different between groups.*

Benefit-Cost Findings

Based on observed increases in college attendance and reductions in crime and duration of food stamp receipt, we found the program to be cost-beneficial over the long-term, particularly for program participants.

[1] 2SHB 2002, § 4 (1), Chapter 266, Laws of 2006: Foster Care Support Services

[2] L. Schrager (2008). *Foster Care to 21: Enrollment trends after two years.* Olympia: Washington State Institute for Public Policy, Document Number 08-12-3901.

The Duke Endowment Child Care Strategy

Our mission is to help abused and neglected children:

- **reach appropriate developmental milestones**, and
- **prepare for adulthood**, so that they are educated, employable, connected (civically, spiritually and to family); have access to stable housing and health care; and avoid unwanted pregnancy, substance abuse and criminal activity.

Our objective is to drive child welfare to greater accountability for child well-being. We work in two distinct areas:

1) prevention and early intervention – helping to keep families together by addressing causes that may contribute to child abuse and neglect; and,

2) out-of-home care – improving care that produces documented child well-being.

PREVENTION AND EARLY INTERVENTION

Our strategy for our work in prevention and early intervention is to disseminate programs that have the highest practical level of evidence. Ideal funding opportunities include those that:

- Replicate proven interventions that are supported by strong evidence.
- Receive sufficient support to ensure proper implementation.
- Enjoy approval and targeted funding from the public sector (e.g., DSS, Mental Health, and Juvenile Justice) and other private funders.

We **monitor our progress against this strategy** by tracking the number of children and families served by TDE-funded evidence-based practices and, eventually, by collecting aggregate data to ensure that outcomes are in line with previously documented findings.

Prevention and early intervention grants vary in scale and scope. Examples include:

- Replicating Nurse Family Partnership and Healthy Families, both of which are well-researched home visiting programs for young children and mothers.
- Funding statewide and regional efforts to train mental health practitioners and therapists in evidence-based therapies.
- Helping develop the Durham Family Initiative (aka Durham Connects), a decade-long, community-wide effort to achieve a measurable reduction in child abuse and neglect rates.
- Underwriting the infrastructure needed to replicate effective parent education programs, such as Incredible Years and Strengthening Families program.
- Helping child advocacy centers (CACs) reduce the trauma associated with allegations of child sexual and physical abuse.
- Supporting Big Brothers Big Sisters through mentoring programs that strengthen academic and behavioral competencies.

OUT-OF-HOME CARE

Placement options for abused and/or neglected children who are removed from their home range from family foster care to residential treatment. Our strategy for improving the conditions and effectiveness of out-of-home care has four distinct but related components:

1. *Assure that every child is properly assessed prior to entering care.*
   Implementing a standardized assessment across the state(s) should reduce the number of moves a child experiences in care, improving system efficiencies and minimizing trauma.
2. *Reduce the number of providers serving children in care only to those that meet high quality standards.*
   Less than 50% of DSS placements are to families or beds operated by accredited providers.[1] Too many providers in the field deprive the high quality ones of sufficient referrals, revenue and economies of scale needed to sustain effective services.
3. *Encourage high quality providers to offer a wide array of services.*
4. *Develop "post-permanence" services.*
   Services would help to reintegrate children back into families (whether biological, kinship or adoptive), improving the family's capacity for parenting and capitalizing on gains achieved while the child was in substitute care.

We **monitor progress against this strategy** by measuring:

- The adoption of standardized assessment tools.
- Increased referrals to high quality providers.
- Expanded services offered by high quality providers.
- The provision of post-permanence services that, ultimately, receive state reimbursement.
- Aggregated data of improved child well-being collected by public and private agencies.

Examples of grants in this area of work include:

- Introducing the Treatment Outcome Package assessment tool to Wake and Cumberland counties.
- Piloting the Project for Excellence in Rowan County to map a process for integrating child welfare (DSS) and mental health (Managed Care Organizations) services.
- Evaluating and disseminating "post permanence" services in Catawba and four surrounding counties.
- Replicating evidence-based treatment protocols.
- Developing and adapting new therapeutic foster care models (e.g., Rapid Resource and Together Facing the Challenge).

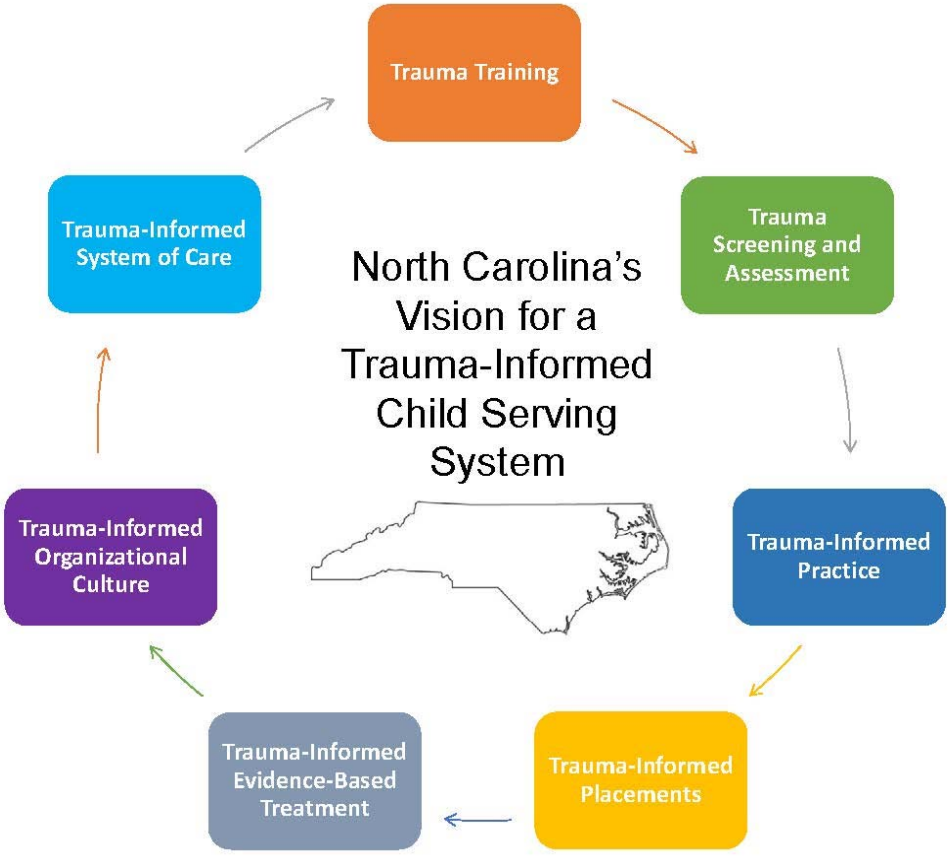
For more information, please contact The Duke Endowment at 704.376.0291 and www.dukeendowment.org

[1] According to TDE's definition of quality, which considers accreditation, leadership, service array, use of evidence based interventions, tracking of outcomes, etc.

PROJECT BROADCAST
Trauma-Informed Practices in the North Carolina Child Welfare System

TRAUMA LENS

April 2015



"Children are harmed in the context of relationships. Some one did something. Children also heal in the context of relationships. So it is up to us to build a system where every person, during every interaction with children, knows how to promote healing."

- Donna Potter, LCSW

FIVE BROAD GOALS

- Develop a Trauma-Informed Workforce
- Increase Availability of Trauma-Informed, Evidence-Based Treatments
- Increase Access to Trauma-Informed Services
- Develop a Well-Being Trauma Passport — A Way to Exchange Critical Child Level Information
- Develop Trauma-Informed Policies and Procedures Across Child Serving Systems

Project Broadcast is funded through the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant # 90CO1058 (FFY 2011-2016)

Trauma Screening

In January 2013, Project Broadcast began piloting a trauma screening process with select staff from nine demonstration counties. Two one-page screening forms were created to capture possible trauma exposure and social/emotional/ behavioral issues often associated with trauma histories. One version was designed with children under the age of 6 in mind, and the other was designed for children ages 6 to 18. The older children were to be asked about their trauma histories directly.

The goal was to begin screening all children who entered foster care as of October 2013, but counties were also free to implement screening in other programmatic areas. This table shows a breakdown of the number of trauma screening forms entered as of 4/12/15 by county, by form type. A total of 5,228 trauma screening forms have been received during a 26 month period, averaging 200 per month.

County	Under 6	6 to 18	Total
Buncombe	197	278	475
Craven	47	137	184
Cumberland	532	853	1385
Hoke	210	322	532
Pender	123	133	256
Pitt	2	14	16
Rowan	8	43	51
Scotland	18	35	53
Union	290	640	930
Wilson	490	831	1321
Unknown	13	12	25
Grand Total	**1930**	**3298**	**5228**

Behind the Numbers

It should be noted that this number does not represent 5,228 unique children as children are rescreened at various intervals. It is also worth noting that these counties have a wide variation in the number of children they serve (ranging from 29 children in custody to 773 children in custody). Additionally, there is wide variation in how counties have implemented screening (some focusing on all children, some focusing on just assessment and investigative cases). Therefore, a low total number of screening forms received does not indicate the county is not screening adequately. There is a wide variation on how successful counties have been at integrating trauma screening into their casework practice. Some have been successful while others are currently receiving consultation and technical assistance to improve their processes.

The following table shows that half of the trauma screens received (n=2636) were completed on cases in the assessment or investigation phase. This trend is the same for both younger and older children (47% and 52% respectively).

Case Type	Under 6	6 to 18	Total	Under 6	6 to 18	Total
Assessment/Investigation	908	1728	**2636**	47%	52%	**50%**
Foster Care/Out-of-Home	731	1074	**1805**	38%	33%	**35%**
In-Home Services	135	226	**361**	7%	7%	**7%**
Other	31	59	**90**	2%	2%	**2%**
Unknown	125	211	**336**	6%	6%	**6%**
Grand Total	1930	3298	**5228**	100%	100%	**100%**

Trauma Training

RESOURCE: The National Child Traumatic Stress Network's "Child Welfare Trauma Training Toolkit"

- Project Broadcast conducted a Learning Collaborative with nine demonstration counties
- Project Broadcast conducted on-site training to all staff in another county
- Several local Departments of Social Services have also trained their staff using this curriculum
- Project Broadcast conducted several webinars to reinforce key learning areas

As a result of trauma training, each child welfare agency will:

- Increase Focus on Psychological Safety
- Increase Focus on Secondary Traumatic Stress
- Begin Trauma Screening and Referrals to Evidence-based Treatments
- Understand How To Advocate or Effective Mental Health Treatment
- Develop Collaboration with System of Care Providers

Embedding Trauma Principles Throughout All Trainings

A concerted effort has been made to embed trauma information into all applicable child-welfare curriculums. While many more curricula are currently being reviewed, the following trainings have been developed or revised to help us develop a trauma-informed child welfare workforce.

- Assessing and Strengthening Attachment
- Child Development and the Effects of Trauma
- Child Forensic Interviewing
- Life Books: Motivating the Memory Keepers
- Responding to Sexual Abuse
- Trauma-Informed Behavior Management for Child Welfare
- Trauma-Informed Partnering for Safety and Permanence: Model Approach to Partnerships in Parenting

Additionally, in the Fall of 2015, counties will be offered the chance to become trainers of the National Child Traumatic Stress Network's "Child Welfare Trauma Training Toolkit" and begin implementing trauma screening in their county.

Training Resource Parents

Many Foster, Adoptive, Kinship and Therapeutic Parents across the state have benefited from training in the National Child Traumatic Stress Network's "Caring for a Children Who Have Experienced Trauma: A Workshop for Resource Parents". This 16-hour curricula, often referred to as RPC, is designed as an in-service training for those parents who already have a placement.

The Center for Child and Family Health has developed trainers (or facilitators) to conduct this training in many of the nine demonstration counties. Another cohort of trainees will be selected in the Fall to join in a Learning Community to become RPC Facilitators.

We believe this curriculum has a power impact on parents and will ultimate have positive impact on placement stability and foster parent retention rates. Evaluation of these efforts are underway.

What Does Screening for Trauma Tell Us?

The older children are asked four questions about their traumatic exposure. Those questions solicit information about physical abuse, domestic violence, sexual abuse, and other traumatic events.

375 screens indicated exposure to sexual abuse; 906 screens indicated exposure to domestic violence; 583 screens indicated exposure to physical abuse and 94 screens indicated exposure to other traumatic events. 101 screens indicated that by asking these questions directly, the agency was able to identify new information not previously known to them. 66% of these screens had been receiving services either in foster care or in-home services. This reinforces the need for the screening process.

When we look across all possible trauma exposure types, domestic violence and substance abuse rise to the top as seen by the chart below.

Exposure Type	Under 6	6 to 18	Total
Basic physical needs not met	331	566	897
Emotional maltreatment	151	525	676
Exposure to community violence	31	132	163
Exposure to domestic violence	625	1129	1754
Exposure to drug/substance abuse or related activity	585	1037	1622
Exposure to school violence and/or severe bullying	6	165	171
Homelessness	149	258	407
Immigration trauma	7	23	30
Incarceration and/or witnessing arrest of primary caregiver	221	503	724
Multiple separations from or changes in primary caregiver	324	740	1064
Natural disaster/war/terrorism	2	14	16
Other	88	184	272
Physical maltreatment or assault	142	475	617
Serious accident/illness/medical procedure	82	98	180
Sexual maltreatment or assault/rape	56	389	445
Traumatic death of a loved one	60	338	398

EVIDENCE-BASED TREATMENTS

ncchildtreatmentprogram.org

- Attachment and Bio-Behavioral Catch-up
- Child and Parent Psychotherapy
- Parent and Child Interaction Therapy
- Trauma-Focused Cognitive Behavioral Therapy
- Structured Psychotherapy for Adolescents Responding to Chronic Stress

For more information, please contact:

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benchmarks
An Alliance of Agencies Helping Children, Adults & Families

Partnering For Excellence

- Improved social-emotional and global functioning
- Decreased use of intensive, restrictive MH services
- Decreased MH expenditures – Medicaid
- Decreased entry into foster care/DSS custody
- Increased placement stability
- Decreased CPS re-assessments

DSS Screening

DSS workers will screen for trauma for children 5-17 yrs old in In-Home Services and foster care.

Children who screen positive or enter DSS custody are referred to a TF-CBT rostered provider for a trauma-informed comprehensive clinical assessment (TiCCA).

Young Children 0-4 will be referred to CC4C through health department for trauma and developmental screening, and referral to Early Intervention.

MH Clinical Assessment

TiCCA clinicians are TF-CBT rostered by the Child Treatment Program, will "test" a Trauma-Informed CCA protocol, and will be privileged by Cardinal to receive an enhanced reimbursement for the TiCCA.

Effective Care Management

DSS, resource parents, Cardinal Innovations, and PFE provider partners will engage in activities to improve communication, coordination, and monitoring of child and family treatment.

- DSS
- Resource parents
- Cardinal Innovations
- PFE provider partners

Integrated Child Plan

Recommendations from both the child and caregiver CCAs will be integrated into CFT meetings and the DSS Family Services Agreement.

DSS will strengthen focus on child well-being goals:

- Expand youth well-being goal planning in family service plan
- Training/coaching for Child and Family Team facilitation
- Focus on ensuring children and caregivers referred to evidence-based treatment whenever possible

Quality Service Array

DSS and PFE partners will *intentionally* work together to ensure that child welfare children and families access quality, evidence-based/evidence-informed, front-end services in the community whenever possible.

- Collaborative vision of a front-end service array for child welfare children and families and work to build that array over time.
- Focus on trauma training and increased clinical support for resource parents.

Partnering For Excellence Initiative Overview

Partnering For Excellence (PFE) is an initiative, funded by The Duke Endowment, to improve the behavioral health and well-being outcomes for children served by Rowan County's child welfare system. Through a partnership between Rowan County Department of Social Services and Cardinal Innovations Health Care Solutions, the PFE Initiative will ensure that children between the ages of 5 – 18 who receive DSS In-Home Services or DSS Foster Care Services:

- Are screened for exposure to and symptoms of psychological trauma;
- Receive timely, trauma-informed comprehensive clinical assessments (TiCCAs) from qualified behavioral health practitioners;
- Receive trauma-focused, evidence-based behavioral health treatment such as Trauma-Focused Cognitive Behavioral Therapy to reduce trauma symptoms and support recovery; and
- Live in a community which is dedicated to an increased understanding of the impact of trauma.

To achieve these goals, Rowan County DSS and Cardinal Innovations are instituting practice, policy and funding changes within their respective organizations. In addition, Rowan County DSS and Cardinal Innovations intend to partner with a select group of behavioral health providers to ensure that the target population of children is able to receive these outlined services in a timely and coordinated manner. These select providers, working as a team with Rowan County DSS and Cardinal Innovations, will demonstrate a commitment to high quality services, fidelity to identified models of care, and effective communication and care management with DSS, Cardinal Innovations, and other System of Care stakeholders.

PFE was implemented in Rowan County in February 2014. To date, 184 children have entered the "pipeline." Youth have been screened and referred for TiCCAs as needed. 100% of youth in DSS custody and 91% of youth in In Home Family Services have screened positive for trauma using the Project Broadcast Screening Tool. TiCCAs have focused on holistic recommendations as well as referral to specific, evidence-based models of care. Rowan County DSS and Cardinal Innovations have partnered to bring trauma training to the community. Rowan County DSS has also created a program to sustain the training of NCTSN's Resource Parenting Curriculum in order to ensure that children are placed with foster parents who are knowledgeable about the impact of trauma.

While it is too early in the pilot to share data outcomes, there are exciting anecdotal outcomes, including:

- Clinician confirmed concerns with reunification as appropriate goal. CFT reviewed and agreed to change the goal to adoption/guardianship thus moving the youth towards permanency more quickly.
- Clinician recommended a temporary end to visitation to assess a child's needs; by the time the assessment was complete, the parent was no longer engaged with DSS and the child was spared an additional broken relationship.
- Youth who was not able to disclose sexual abuse at the CAC scored high on the BSI; through rapport building and a vigilant clinician, the youth felt safe enough to disclose and law enforcement was able to begin their work prosecuting.
- Trauma trainings fill to capacity within a day and include school system employees, GALs, DJJ employees, the CAC employees, private providers and DSS.

- Social workers attend the TiCCA appointments and clinicians gather information from them first in order to respect their time constraints.
- DSS Administrator and MCO Care Coordinator Supervisor are able to work proactively instead of waiting for a crisis.
- DSS is more likely to invite clinicians to CFTs.
- DSS social workers are using more trauma informed language during discussions and applying trauma knowledge to family members.
- County dollars were saved due to a better understanding of utilization management and medical necessity (data being collected/analyzed currently).
- Cardinal Innovations distributed article about PFE to the General Assembly.
- No youth who received PFE services has been placed higher than Therapeutic Foster Care.

Through PFE, we have also learned many lessons about how to create a more integrated, trauma informed community and better partnerships between a local DSS, MCO/LME, and private providers. Some of those lessons learned include:

- Train everyone in trauma informed care - all levels of employees.
- An increased focus on placement stability is necessary by all team members in order for a youth to complete treatment.
- Team members should review the TiCCA together and a MCO/LME representative is very beneficial to the social workers to help interpret these as well. Co-location of a MCO/LME Care Coordinator at the local DSS facilitates this process.
- Internal supervision and peer supervision is critical in implementing new models. It is hard for private agencies to straddle "business as usual" and being a fully trauma informed environment with enhanced services.
- Support in all team agencies must come from administration, and the commitment to making the necessary administrative changes are both crucial.

For any questions regarding Partnering for Excellence, please contact Jenny Cooper, Project Manager at jcooper@benchmarksnc.org or (704) 490-3898. Thank you for your interest!

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

Lessons Learned from Implementing the Resource Parenting Curriculum with Foster and Adoptive Parents

George S. Ake III, PhD

Recent studies show that as many as 702,000 youth in care were identified as maltreatment victims (USDHHS, 2009) and that for many children in care there is a reciprocal relationship found between behavior problems and placement changes (Aarons et al., 2010). These studies suggest a need for more effective interventions targeting children's behavior along with better training and support for resource parents (including foster, adoptive, therapeutic, and kinship) in order to manage children's emotional and behavioral problems and to increase placement stability.

The Child Welfare workgroup within The National Child Traumatic Stress Network (NCTSN; www.nctsn.org) developed and piloted a new tool to help address the need for training and support of resource parents. This tool is called Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents, also referred to as the Resource Parent Curriculum (RPC). RPC was developed to help resource parents who may be parenting children with complex trauma histories and equally complex behaviors and emotions.

At the Center for Child and Family Health (CCFH), we began facilitating RPC as part of our proposal to SAMHSA for our NCTSN Community Treatment Services Center grant. Our main goals in selecting RPC were to:

1. help resource parents understand how exposure to traumatic incidents as well as placement disruptions can impact children's emotions and behavior,
2. provide concrete strategies for parents to use with children in their home,
3. help parents try to depersonalize some of their child's reactions to trauma reminders, and
4. educate parents to advocate for their children needing trauma-focused treatments. Our staff facilitators were selected based on their extensive experience in training other professionals to implement evidence based treatments for child trauma victims and their families.

While we understood the value of RPC and believed that it was well designed, I am not certain that any of us really were prepared for the magnitude of positive changes that it would soon bring. Here are a few of the lessons we learned from resource parents, child welfare workers, and our training faculty.

Resource Parents

Overall, resource parents taught us that their involvement in RPC helped them understand how approaching problem behaviors with a trauma lens was more effective than their previous approaches. They commented that they wished they had participated in RPC earlier and that resource parents should be required to complete this training as part of their in-service requirements given the number of children in care with trauma histories and the perceived lack of information about how to address it. While parents came in with very different levels of information and understanding about their children's history, most of them left the group having a greater appreciation for how children's experiences could impact their current behavior. In addition, parents generally reported that participating in RPC helped to alleviate their feelings of isolation and frustration while helping to empower them to advocate for trauma-informed services for their family.

Parents reported seeing positive changes in their day-to-day approach to parenting and many attributed this change to adjustments they made to accommodate their children's trauma histories. For example, one couple withdrew their child from water sports due to their new understanding of trauma triggers and their child's history of having previous caregivers who used water as part of their abusive discipline. Another couple felt like they had failed as parents of an adopted adolescent prior to RPC, but felt "enlightened" and more hopeful at the end of the group because they understood how their child's complex trauma history might be connected to difficulties establishing relationships with others. They also reported that meeting other parents with similar situations was encouraging throughout the group and, hopefully, following the group.

Child Welfare Professionals

The North Carolina Division of Social Services (DSS) has been a tremendous partner in making RPC a possibility for resource parents as part of a larger effort to make NC's child welfare system more trauma-informed. Many of these groups were held in county DSS offices, and the workers who were present for the groups commented that RPC made a difference and that they benefitted from hearing how to talk with parents about trauma.

> Resource Parent Curriculum was developed to help resource parents who may be parenting children with complex trauma histories and equally complex behaviors and emotions.

Training Faculty

After implementing this curriculum once in an eight-week group format with a trauma-informed mental health clinician and a foster parent or foster care alumni co-facilitator, we all were positive that this was the best platform to serve resource parents. Each group we have done has been more successful than the last as we have incorporated quality improvement activities and built on lessons learned. Currently, CCFH has a full time RPC trainer and through various funding sources plans on having completed a total of 57 groups between 2011 and 2016.

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Glossary of Terms

From Child Welfare Information Gateway, Children's Bureau[i]

child abuse and neglect
Defined by the Child Abuse Prevention and Treatment Act (CAPTA), as, at a minimum, any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act that presents an imminent risk of serious harm. While CAPTA sets Federal minimum standards for states that accept CAPTA funding, each state provides its own definitions of maltreatment within civil and criminal statutes.

child protective services (CPS)
The social services agency designated (in most states) to receive reports, conduct investigations and assessments, and provide intervention and treatment services to children and families in which child maltreatment has occurred. Frequently, this agency is located within larger public social service agencies, such as departments of social services.

child welfare services
A continuum of services, ranging from prevention to intervention to treatment, for the purpose of protecting children and strengthening families to successfully care for their children, providing permanency when children cannot remain with or return to their families, and promoting children's well-being. Services should be family-centered, strengths-based, and respectful of the family's culture, values, beliefs, and needs.

differential response
An approach that enables child protective services (CPS) to differentiate its response to reports of child abuse and neglect based on several factors, including the level of risk associated with the report, indicators of child safety, and the family's need for services and support. Differential response is an area of CPS reform also referred to as "dual track," "multiple track," or "alternative response."

evidence-based practice
Involves approaches to prevention or treatment that are validated by some form of documented scientific evidence. This includes findings established through controlled clinical studies, but other methods of establishing evidence are valid as well.

fictive kin
People not related by birth or marriage who have an emotionally significant relationship with an individual.

foster care
A service for children who cannot live with their custodial parent(s) or guardian(s) for some period of time. Children in foster care may live with relatives, unrelated foster parents, or with

families who plan to adopt them. Foster care is intended to be short-term, with the focus on returning children home as soon as possible or providing them with permanent families through adoption or guardianship. For purposes of Federal reporting and funding, the term also describes non-familial placement settings including group homes, residential care facilities, and supervised independent living.

group home
Residence intended to meet the needs of children who are unable to live in a family setting and do not need a more intensive residential service. Homes normally house 4 to 12 children in a setting that offers the potential for the full use of community resources, including employment, health care, education, and recreational opportunities. Desired outcomes of group home programs include full incorporation of the child into the community, return of the child to his or her family or other permanent family, and/or acquisition by the child of the skills necessary for independent living.

guardianship
The transfer of parental responsibility and legal authority for a minor child to an adult caregiver who intends to provide permanent care for the child. This can be done without terminating the parental rights of the child's parents. Transferring legal responsibility removes the child from the child welfare system, allows the caregiver to make important decisions on the child's behalf, and establishes a long-term caregiver for the child. In subsidized guardianship, the guardian is provided with a monthly subsidy for the care and support of the child.

independent living program
A program that provides older children and eligible youth in out-of-home care with independent living services to help prepare them for self-sufficiency in adulthood. They can receive these services while they are living in any type of out-of-home care placement (such as kinship care, family foster care, or residential/group care). Youth receiving independent living services can be working toward achieving any of the permanency goals (such as reunification, adoption, or guardianship), or they may be heading toward emancipation from (aging out of) foster care to adulthood on their own. Independent living services generally include assistance with money management skills, educational assistance, household management skills, employment preparation, and other services.

kinship care
Kinship care is the full time care, nurturing, and protection of a child by relatives, members of their Tribe or clan, godparents, stepparents, or any adult who has a kinship bond with the child. This definition is designed to be inclusive and respectful of cultural values and ties of affection. It allows a child to grow to adulthood in a family environment.

multidisciplinary team
A group of professionals and possibly paraprofessionals representing a variety of disciplines who interact and coordinate their efforts to diagnose, treat, and plan for children involved in

the child welfare system. They may also be referred to as a "child protection team," "interdisciplinary team," or "case consultation team."

out-of-home care
An array of services, including family foster care, kinship care, and residential group care, for children who have been placed in the custody of the State and who must reside temporarily away from their families.

permanency
A legally permanent, nurturing family for every child and youth. As defined in the Child and Family Services Reviews, a child in foster care is determined to have achieved permanency when any of the following occurs: (1) The child is discharged from foster care to reunification with his or her family, either a parent or other relative; (2) the child is discharged from foster care to a legally finalized adoption; or (3) the child is discharged from foster care to the care of a legal guardian.

permanency planning
A process through which planned and systematic efforts are made to ensure that children and youth are in safe and nurturing relationships expected to last a lifetime. Permanency planning involves time-limited, goal-oriented activities to maintain children within their families of origin, including kin, or to place them with other permanent families through adoption or guardianship.

placement stability
Ensuring that children remain in stable out-of-home care, avoiding disruption, removal, and repeated placements that have harmful effects on child development and well-being. In the Federal Child and Family Services Reviews, placement stability is one of the four composites used as the basis for national standards for Permanency Outcome 1: Children have permanency and stability in their living situations.

protective/promotive factor
Strengths and resources that appear to mediate or serve as a buffer against risk factors that contribute to maltreatment. These factors may strengthen the parent-child relationships, ability to cope with stress, and capacity to provide for children. Protective factors include nurturing and attachment, knowledge of parenting and of child and youth development, parental resilience, social connections, and concrete supports for parents.

resilience
The ability to adapt well to adversity, trauma, tragedy, threats, or even significant sources of stress. Parental resilience is considered a protective factor in child abuse and neglect prevention. Resilience in children enables them to thrive, mature, and increase competence in the midst of adverse circumstances. Resilience can be fostered and developed in children as it involves behaviors, thoughts, and actions that can be learned over time and is impacted by positive and healthy relationships with parents, caregivers, and other adults.

resource family
Includes foster/adoptive parents, foster parents, and relative or kinship caregivers.

safety plan
A casework document developed when it is determined that a child is in imminent or potential risk of serious harm. In the safety plan, the caseworker targets the factors that are causing or contributing to the risk of imminent serious harm to the child and identifies, along with the family, the interventions that will control the safety factors and assure the child's protection.

serious emotional disturbance
A term used to identify children and youth who persistently exhibit behaviors that indicate severe emotional and/or behavioral disorders. One who is classified as having a serious emotional disturbance is eligible for special health and special education services under the Individuals with Disabilities Education Act.

structured decision-making
An approach to child protective services that uses clearly defined and consistently applied decision-making criteria in screening for investigation, determining response priority, identifying immediate threatened harm, and estimating the risk of future abuse and neglect.

substantiated
An investigation disposition concluding that the allegation of child maltreatment or risk of maltreatment was supported or founded by State law or State policy. A child protective services determination means that credible evidence exists that child abuse or neglect has occurred.

system of care
A process of partnering an array of service agencies and families that work together to provide individualized care and supports designed to help children and families achieve safety, stability, and permanency in their home and community. The term originated in the mental health field.

therapeutic foster care
Intensive care provided by foster parents who have received special training to care for a wide variety of children and adolescents, usually those with significant emotional, behavioral, or social problems or medical needs. Therapeutic foster parents typically receive additional supports and services.

transition, independent living, and self-sufficiency services
Those programs, services, and opportunities intended to support young people in out-of-home care to develop to their full potential; contribute to their schools, programs, and the community; and succeed in work, family, and community life as adults.

trauma
An event or situation in which a child's fundamental needs for physical safety and emotional security are not met.

unsubstantiated (not substantiated)
An investigation disposition that determines that there is not sufficient evidence under State law or policy to conclude that a child has been maltreated or is at risk of maltreatment. A child protective services determination means that credible evidence does not exist that child abuse or neglect has occurred.

well-being
The result of meeting a child's educational, emotional, and physical and mental health needs. Well-being is achieved when families have the capacity to provide for the needs of their children or when families are receiving the support and services needed to adequately meet the needs of their children.

This document was prepared in conjunction with the 2015 NC Family Impact Seminar, Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money*, held May 6, 2015, at the North Carolina General Assembly.*

[i] The full list of this glossary of terms is available at: https://www.childwelfare.gov/glossary/glossarya/

List of Relevant Acronyms

ACEs: Adverse Childhood Experience(s)

ACF/ACYF: Administration for Children (Youth) and Families

CCA: Comprehensive Clinical Assessment, and Ti-CCA (Trauma-Informed CCA)

CFT: Child and Family Team (Meeting)

CMS: Center for Medicare and Medicaid Services

CPS: Child Protective Services

CQI: Continuous Quality Improvement

DMA: Division of Medical Assistance

DMH/DD/SAS: Division of Mental Health/Developmental Disabilities/Substance Abuse Services

DSS: Department of Social Services

EBP: Evidenced Based Practice

EBT: Evidenced Based Treatment

IIH: Intensive In-Home Services

LME/MCO: Local Management Entity/Managed Care Organization

MRS: Multiple Response System

NC-CTP: Child Treatment Program

PFE: Partnering for Excellence

PRTF: Psychiatric Residential Treatment Facility

SAMHSA: Substance Abuse Mental Health Services Administration

SED: Serious Emotional Disturbance

SOC: System of Care

This list is excerpted from an acronym list created by Project Broadcast.

Other Resources Relevant to the 2015 North Carolina Family Impact Seminar

Helping Kids in Foster Care Succeed:
Strategies for North Carolina to Strengthen Families and Save Money

Note: This is a partial list of relevant resources.

On the North Carolina Foster Care System:

NC Foster Care System: A County-Administered Social Work Perspective
http://www.ncleg.net/documentsites/committees/BCCI-6617/02-18-2014/NC%20Foster%20Care%20System%20-%20RH.pdf

On the Wicked Problems of Child Welfare:

Federal legislative responses to Wicked Problems:
http://wickedproblems.web.unc.edu/files/2014/03/GrandChallengesFederalLegislatuiveAuthorityCrosswalk.pdf

On the Cost of Ignoring Child Well-Being:

The Economic Value of Opportunity Youth
http://www.civicenterprises.net/MediaLibrary/Docs/econ_value_opportunity_youth.pdf

On Youth Aging Out of Foster Care:

Transitional Aged Youth with Barriers: Supports Needed to Achieve Self-Sufficiency
http://www.publicconsultinggroup.com/humanservices/library/white_papers/documents/Transitional_Aged_Youth_With_Barriers_White_Paper.pdf

Connected by 25: A Plan for Investing in the Social, Emotional and Physical Well-Being of Older Youth in Foster Care
http://www.fostercareworkgroup.org/media/resources/FCWG_Well-Being_Investment_Agenda.pdf

On Policy Options to Improve Well-Being of Children and Youth in Foster Care:

Evidence in Support of Interventions to Address Childhood Trauma and Maltreatment
http://wickedproblems.web.unc.edu/files/2014/03/SR_Child-Maltreatment-Comparactive-Effectiveness-Review-Summary1.pdf

Summary of State Child Welfare Waiver Demonstration Projects:
http://wickedproblems.web.unc.edu/files/2014/03/Active-waiver_summary_table_2014.pdf

Application of Evidence-Based Therapies to Children in Foster Care: A Survey of Program Developers
http://www.apsacny.org/wp-content/uploads/2014/11/APSAC_Advisor_Vol_26_1-pp27-34.pdf

Short Videos on the Impact of Maltreatment on Life Outcomes:

Toxic Stress Derails Health Development https://www.youtube.com/watch?v=rVwFkcOZHJw

The Impact of Early Adversity on Development https://www.youtube.com/watch?v=chhQc0HShCo

Building Adult Capabilities to Improve Child Outcomes https://www.youtube.com/watch?v=urU-a_FsS5Y

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Duke | CENTER for CHILD and FAMILY POLICY

The Center responds to requests from policymakers and practitioners for overviews of scientific research and other information on topics related to children and families.

The Center is affiliated with the Sanford School of Public Policy and the Social Science Research Institute at Duke University.

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- **Children's Mental Health**
- **Youth Problem Behaviors Including Violence and Substance Abuse**

Non-Partisan Research and Expertise on Key Policy Issues

North Carolina Education Research Data Center

(*housed at the Center for Child and Family Policy*)

The Data Center provides researchers with access to education data, inspiring a wealth of cutting-edge, policy-relevant research. Areas of research include the minority achievement gap, school accountability and choice, the impact of plant closings in North Carolina on student outcomes, the shortage of qualified teachers, academic performance of at-risk children, and problem behavior in schools.

The Data Center houses information collected by the North Carolina Department of Public Instruction, dating to the mid-1990s. Data includes:

- Records on North Carolina's more than 1.48 million public school students, including test scores, suspension and dropout status, and course enrollment.
- Information on the state's nearly 94,000 teachers, including degrees obtained and licenses acquired.
- Records for the 2,500+ public schools in North Carolina including categories such as demographic makeup, End of Grade test scores, dropout rates, and school status under the state's accountability model.
- District-level data including financial status, incidents of violence, and demographics.

Non-Partisan Research and Expertise on Key Policy Issues (cont'd)

Family Impact Seminars

Since 2005, the Center has convened the annual North Carolina Family Impact Seminar (NCFIS).

Family Impact Seminars:

- Address topics chosen by legislators;
- Provide educational, non-partisan presentations, discussions, and briefing materials for state policymakers and others;
- Feature experts in research, policy, and practice who provide objective, solution-oriented information on a particular issue;
- Draw on research to inform policy, while paying particular attention to the impact on children and families.

Seminar Topics Since 2005

- Employment Strategies
- Childhood Obesity
- School Suspension
- Evidence-based Policy
- Dropout Prevention
- Juvenile Justice
- Children's Mental Health
- Medicaid Cost Containment

http://childandfamilypolicy.duke.edu/engagement/policy-and-practice/nc-family-impact-seminars/

Program Evaluation Services

Center staff have extensive experience in evaluation research relevant to children, families, public education, and other areas, including:

- Developing and implementing evidence-based interventions that track participants longitudinally to assess change over time;
- Working closely with state and local agencies that serve children and families;
- Conducting focus groups and carrying out other qualitative evaluation research strategies;
- Developing Web-based data collection systems;
- Developing surveys and other measurement instruments; and
- Managing and analyzing large, complex datasets.

The Center also has significant capacity for translating research results in ways that inform policymakers about evidence-based programs for children and families.

http://childandfamilypolicy.duke.edu/engagement/working-with-nonprofits/evaluation-services/

School Research Partnership Office

The Duke University School Research Partnership facilitates faculty research and interventions in schools and responds to external requests for research to inform school policy and practice. It also matches school district and community agency partners with students who conduct research and policy projects. This exchange provides students with real-world experience and provides partners with research that informs their work.

http://childandfamilypolicy.duke.edu/engagement/school-research-partnership/

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Seminar Speakers:

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Helping Kids in Foster Care Succeed: Strategies for North Carolina to Strengthen Families and Save Money
A Briefing Report prepared for the North Carolina Family Impact Seminar

Editors: Mandy Ableidinger, Jenni Owen and Brandi Thomas

North Carolina Family Impact Seminar briefing reports and other Center for Child and Family Policy publications are accessible on the Center's Website: www.childandfamilypolicy.duke.edu.