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A QUARTERLY PUBLICATION OF THE NATIONAL CHILD TRAUMATIC STRESS NETWORK

Creating Secondary Traumatic Stress-Informed Organizations

Part Three: Embedding and Implementing STS-Informed Policies

Parts One and Two of this series addressed, respectively, the essential elements of STS-informed organizations and key strategies for building workplace capacity to support staff resilience. This third and final installment looks at formal and informal organizational policies related to self-care practices; methods for identifying the need for these practices; and achieving leadership buy-in to develop STS-informed practices and policies.

Address the Trauma

The Children's Center in Salt Lake City, UT, has adopted an "evolving model" for implementing STS policies, said Brian C. Miller, PhD, Project Director, Trauma Program for Families with Young Children. The model is based on building staff competencies in four core areas: acknowledging the intensity of the work in trauma exposure; developing skills for self-control of rumination; examining the

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A Utah Watercolor Society artist creates art with children in therapy at The Children's Center in Salt Lake City, UT.

Breakthrough Series Collaborative Builds Bridges Between Child Welfare and Mental Health Agencies

The body of research supporting the use of trauma-specific interventions in child traumatic stress continues to grow. However, implementation and availability of these interventions in public welfare agencies has lagged. In 2008 the Network's Child Welfare Committee, together with the service systems and training teams of the National Center for Child Traumatic Stress (NCCTS), generated a plan to accelerate the implementation of trauma-informed practices in public child welfare agencies by fostering stronger partnerships between child welfare and mental health agencies.

The organizers reasoned that by using trauma-informed child welfare practices, children and families in the foster care system would be better served. The way to do this was to bring all the major stakeholders into the process of developing and implementing policies, procedures, and supports for children and stakeholders. The ultimate goal, in alignment with new federal mandates such as the Title IV-E waiver, was this: to increase the probability that children in need of out-of-home placements would remain in a single, stable home after their placement.

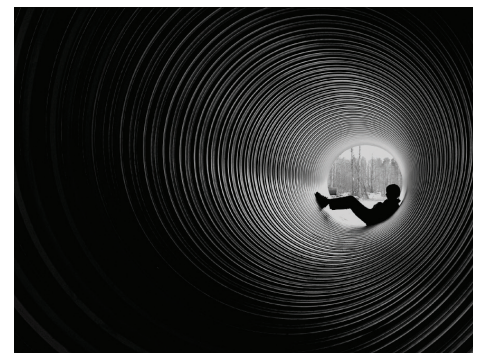
To effect these changes, the NCCTS chose the Breakthrough Series Collaborative methodology developed 20 years ago by the Institute for Healthcare Improvement and the Associates in Process Improvement. Solicitation for applications for

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Sexually Exploited Boys and Young Men Find Community at Supporting Our Struggle

At the age of 16, with a mother who was ill due to surgery and unable to work, "Julian" (not his real name) was having trouble making ends meet. He worked two afterschool jobs to help cover family expenses and his mother's medical bills. But it wasn't enough. As a result of searching Web sites and apps, he was introduced to a gay escort service. "I discovered I could make \$200 to \$1,000 for sleeping with somebody, and I was able to pay the bills," he said. It seemed like easy money, but it came at a steep price: the loss of his self-esteem, safety, and health. After two-and-a-half years as a sexually exploited youth, Julian began using drugs and was living on the streets of Boston.

Julian now considers himself lucky. Last summer, one of his clients asked him if he had been tested for HIV. Julian found his way to the Sydney Borum Jr. Health Center for a blood test and medical attention. The center, known as "the Borum," is a program of Fenway Health, affiliated with Beth Israel Deaconess



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This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Finding Community at SOS *cont'd from pg. 1*

Medical Center and Boston Children's Hospital. The center provides safe, nonjudgmental care for young people aged 12 to 29 years.

During his visit to the Borum, Julian got more than he expected: a referral to Surviving Our Struggle, or SOS, a program of the Trauma Center at Justice Resource Institute developed for boys, young men, and trans-identified individuals who have been victims of commercial sexual exploitation. He was assigned a survivor mentor and offered services including housing, behavioral health and medical care, and preparation for GED testing. He earned his degree and is now an outreach worker with SOS.

"I never knew about SOS and didn't know there was a group for exploited youth," Julian said. "So it was all just by luck. I was just at the right place at the right time."

Under the Radar

The first time Julian attended a My Life My Choice event at JRI with his survivor mentor, Yoyo, he noticed that all the other attendees were female. The program's mission is to educate and empower sexually exploited youth, the majority of whom are female. "What's HE doing here?" one of the women asked. "All the girls were shocked that I was there," he recalled. "They learned that this happens to guys as well."

The incident points up a common misperception about sexually exploited youth, said Steven Procopio, ACSW, LICSW, founder of the 18-month-old SOS program and now a trainer and consultant at the JRI Trauma Center on commercially sexually exploited boys and young men. Procopio noted that since the passage of the Victims of Trafficking and Violence Protection Act of 2000, awareness of commercial sexual



Steven Procopio, ACSW, LICSW, founder of Surviving Our Struggle and trainer and consultant at the Trauma Center at Justice Resource Institute, Brookline, MA.

exploitation has risen, but mainly as it pertains to girls and young women. "Boys and young men are falling under the radar," he said, "because therapists, physicians, juvenile justice, and probation programs are not trained in the issues of sexual exploitation of this population." Accordingly, the incidence of sexual exploitation among boys and young men is underreported, and because they go largely unrecognized, these youth do not receive the services they need.

Procopio and the JRI Trauma Center are aiming to change that situation. Procopio's position is funded in part by the JRI Category II Complex Trauma Treatment Network grant from the NCTSN, as well as by the 2012 National Action Partnership on Multidisciplinary Responses to Polyvictimization, an initiative of the Office for Victims of Crime, U.S. Department of Justice. He conducts training workshops for clinicians, child welfare

staff, and juvenile justice workers on adequate screening to detect possible cases of sexual exploitation. Procopio said it is places like the Borum that can screen for and refer sexually exploited youth, a population at very high risk for HIV and other sexually transmitted diseases.

"I feel if you give back, it will make everything better and stronger, and make the programs more likely to succeed."

"JULIAN," outreach worker for Surviving Our Struggle

A Path to Health

While he was still living with his mother, Julian had disclosed to a family friend what he was doing to earn money. "I think I was asking her in an indirect way for help," he said. That plea backfired. The family friend told his mom, and the tension between mother and son escalated. "She was never okay with me being gay," Julian said. His mother did try to get him into a program that could help him, but the program didn't take, and he returned home. That's when she evicted him. Living on the street and doing drugs sent Julian into a downward spiral.

Once he was connected with SOS, Julian benefited from the program's survivor mentor system. "Yoyo didn't pressure me to stop escorting," he recalled. "But he showed me the steps I needed to take. When I attended events at My Life My Choice, I actually saw other survivors who had gone through this. It was like my own community of people who would understand and not judge."

For those who work with young people – in schools, counseling centers, and walk-in clinics – greater awareness of commercial sexual exploitation could lead to increased referrals of exploited youth to the right resources, Julian said. "Counselors should talk to someone who has experience, like a survivor, and be able to refer youth. This [sexual exploitation] started with me in high school. I feel if somebody had been more aware, it would have helped me in the long run."

Giving Back

Yoyo noted that many of the clients he mentors are around the age he was when he began escorting. "I see myself in them," he said. "It has helped me heal my past a lot." Julian agreed that despite initial anxiety about making public presentations, his outreach work as a safe sex educator in the Boston Public Schools is having the same effect on him. As an HIV-positive person, he also leads a men's health group for JRI Health. "I'm trying to show that there is a community of people who live with this and it is okay," he said. "I'm just giving back for what I have received. I feel if you give back, it will make everything better and stronger, and make the programs more likely to succeed." ■

Creating Secondary Traumatic Stress-Informed Organizations *cont'd from pg. 1*

narrative used to incorporate the pain of trauma work; and questioning the notions of what constitutes effective self-care.

Given the nature of child-serving professions, it is impossible to shield providers from the pain of exposure to trauma, Miller pointed out. A more effective approach is to acknowledge the pain of trauma exposure and be fully open to the reality of the work. "What we increasingly understand about trauma in general is that it is about an unfinished process," Miller said. "If we try to armor ourselves against it and do not acknowledge our sadness, grief, and anger, this creates a low-grade fever that might never resolve."



Marisol Acosta, MEEd, LPC-Supervisor, Program Specialist V with the Child and Adolescent Services unit of the Mental Health and Substance Abuse Division, Texas Department of State Health Services.

To effectively deal with STS in the workforce, agencies must first assess existing needs, said Marisol Acosta, MEEd, LPC-Supervisor, Program Specialist V with the Child and Adolescent Services unit of the Mental Health and Substance Abuse Division, Texas Department of State Health Services.

As part of its Texas Children Recovering from Trauma initiative, Acosta's department is now in the early stages of identifying staff members' needs regarding STS. Acosta is Project Director of the four-year initiative, designed to transform existing children's mental

health services into trauma-informed care. The initiative has been supported by executive leadership since the beginning, Acosta said. The steering committee includes representatives from adult as well as child mental health services, and local advisory committees are comprised of family partners and other stakeholders.

Once the needs assessment is complete, Acosta continued, the department will create STS policies relevant to all staff in the Mental Health and Substance Abuse Division – from top-level administrators to direct-care mental health workers in community settings. All trauma-informed trainings will incorporate an STS component. "We are looking not only at training," she noted, "but also incorporating STS within the context of preventive measures and the creation of a safe healing environment." Use of such tools as the NCTSN's Core Curriculum on Childhood Trauma (see also pg. 4) will facilitate this process, Acosta added. This curriculum incorporates STS and self-care of the provider and direct-care staff into the process of delivering trauma-informed services.

Nuances of Self-Care

Acosta observed that, "there is still a lot of work to be done to create the understanding of STS, as it does not just equal burnout of employees that can be solved with a mental health day off." Miller added that increased attention to STS in the

past two decades has also led to unintended consequences. The covert message behind organizational support of self-care practices (time off, employee assistance programs, on-site yoga, etc.) is that the organization has now done its part, and the providers still experiencing STS are somehow not doing theirs. "We can be most helpful to our clinicians when we not only offer self-care strategies after work," Miller said, "but when we seek to actually change the experience of doing therapy with trauma victims. We can learn skills that allow us a sense of deep involvement with our vocation, so that we do not experience our work as the toxic part of our day, and our favorite self-care strategy when we get home as the good part."

Equipping staff members with appropriate training in trauma-informed treatments, and teaching them the skills of focused engagement, can help the providers deal in the moment with their work, thus avoiding unproductive rumination. Some of the most trying challenges relate to the distress experienced when providers can only witness a child's distress and are powerless to change the child's circumstances. "We don't do well with that," Miller said; it takes coaching for clinicians to cultivate a "gentle balance between feeling empowered and accepting the limits of that power."

Partner and Leadership Buy-In

Miller remarked that many agencies have their hands full just implementing trauma-informed treatments with clients. He said he communicates his center's method of embedding STS processes system-wide to their five other partner organizations under their Category III SAMHSA grant. Because addressing STS is not an additional, stand-alone exercise, implementing STS-informed processes becomes more feasible.

Acosta said that education is an important component of securing leadership buy-in. The process of transforming the Texas Department of State Health Services according to a trauma-informed model is complex, she said, because the agency includes providers who work with adults as well as children. "While everyone in the workforce has different roles, and may serve different populations, they are still impacted by STS, so we are doing work and having conversations about the benefits of supporting the workforce to decrease turnover, increase job satisfaction, and increase the safety of both staff and clients."

Miller said the aim at The Children's Center is to take a proactive approach. "We have got to be proactive in dealing with secondary trauma," he said. "We cannot wait until all we can do is refer [staff] to the employee assistance program." Miller closed by pointing out that professional isolation is a major risk factor for secondary trauma. "As a manager I will be watching to see if clinicians start to isolate themselves. Our ethic for our clinical team is that no one stands alone." ■

To access STS resources developed by the NCTSN Secondary Traumatic Stress Committee, visit www.nctsn.org/resources/topics/secondary-traumatic-stress

Going Beyond Hope: The Exponential Benefits of Network Membership

NCTSN membership had a “tremendous effect” on the resources that Gateway Community Services could offer to area youth, said Alice Conte, who was Director of Child Trauma Services at the Jacksonville, FL, agency during its 2008-2012 SAMHSA grant.

Gateway provides substance abuse and behavioral health services to youth in outpatient, juvenile justice, and residential settings. Conte recalled that when the agency received its grant, the initial goal was to deliver trauma-informed care to a total of 440 youth. To serve this goal, Conte and several Gateway clinicians promptly received training in Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) through an NCTSN learning collaborative.

A needs assessment had also identified a lack of resources in the Jacksonville community at large, Conte noted. That’s when Gateway’s additional goals for the funding period began to gather momentum. The agency set out to promote community awareness of the need for trauma-informed services for children in Northeast Florida. It also focused on facilitating the use of trauma-informed services in other local youth-serving agencies. Toward this end, Gateway sponsored a SPARCS learning collaborative in Jacksonville, inviting 40 clinicians from outside of the

agency; and organized a second learning collaborative, this one on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), for an additional 60 clinicians.

“We found the clinical population here, especially the child guidance and mental health programs, to be very open,” Conte said. “They needed and wanted [more trauma-focused tools], and it became a win-win situation.” She witnessed a wholehearted embrace of Network resources. Full-Service Schools of Jacksonville, funded through United Way of Northeast Florida, now offers SPARCS. A local judge now specifies SPARCS when writing court orders for youth in the juvenile justice system. Impact House, Gateway’s juvenile justice facility, was one of nine participants in a Network learning collaborative with the developers of Trauma and Grief Component Therapy for Adolescents (TGCT-A), to help test and revise the program prior to its Network-wide distribution. Additional testament to the capacity-building efforts of Network membership came in July 2013, when Gateway celebrated the opening of its new childcare center, the Children’s Zone, co-sponsored by the Weaver Foundation.

Since the end of the grant program, Conte has been working with a private education company in Jacksonville that specializes in the needs of developmentally delayed children.

She also sees clients in her private practice. But she felt so strongly about the need for trauma-informed services that she has continued to conduct training for juvenile justice programs using the *Think Trauma* curriculum, and for area family-services personnel using the *Child Welfare Trauma Training Toolkit*. Conte remains active with the city of Jacksonville, now in its third year of a SAMHSA System of Care grant. She has also become an Affiliate member of the NCTSN. Her reasons for continued involvement are clear. “Network membership brought so much to Jacksonville,” she affirmed. “It went beyond our original hope of what we could provide our clients at Gateway.” ■



Alice Conte (center), NCTSN Affiliate member and Think Trauma trainer, with staff members and clients’ children at the Children’s Zone at Gateway Community Services, Jacksonville, FL.

Core Curriculum College – A Problem-Based Learning Experience

The National Center for Child Traumatic Stress recently conducted an intensive two-and-a-half day “college” to train facilitators in the NCTSN Core Curriculum on Childhood Trauma. The sessions took place January 8-10 at the Fordham University Lincoln Center campus, NYC. This was the second college to train facilitators in the Core Curriculum, according to Sara Acharya, MA, JD, LPC, Assistant Director of Education at the NCCTS at UCLA; the first college took place in September 2013. The curriculum, developed by the NCTSN’s Childhood Trauma Task Force, is based on *The 12 Core Concepts for Understanding Traumatic Stress Responses in Childhood*. It uses highly interactive, problem-based learning to enhance clinical reasoning. The learning modules are built around in-depth case studies that help clinicians learn how to apply the 12 Core Concepts.

The January session featured faculty members Virginia Strand, DSW, Fordham University Graduate School of Social Service

(at Westchester); Robert Abramovitz, MD, Silberman School of Social Work at Hunter College; Leslie Anne Ross, PsyD, the Leadership Center at Children’s Institute, Inc., Los Angeles; and Margaret L. Stuber, MD, David Geffen School of Medicine at UCLA. Also in attendance were Robert Pynoos, MD, NCCTS Co-Director; and Christopher M. Layne, PhD, NCCTS Director of Education in Evidence-Based Practice. Fifteen Network sites from throughout the U.S. were represented by pairs of supervisor-level clinicians.

History of the Curriculum

The Childhood Trauma Task force began work on the Core Curriculum at an expert consensus meeting in 2007. The members represented a broad array of Network sites including the NCCTS/UCLA and five Category II sites. The 12 Core Concepts were formulated and endorsed, and clinical vignettes relevant to five categories of age groups,

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Conversations about Historical Trauma: Part Three

Parts One and Two of this series (see *IMPACT* Spring and Summer 2013) explored the complex historical trauma histories that American Indians and African Americans bring to the treatment setting. Part Three explores the experience of other cultural groups including survivors of the Jewish Holocaust, the Japanese American WWII camps, and key events affecting Hawaiians and Pacific Islanders.

Generational Effects of Trauma

Successive generations of individuals who have experienced historical trauma may exhibit different coping skills depending on how much the trauma was discussed or inferred in their families of origin, said Paula G. Panzer, MD, Chief of Clinical and Medical Services at the Jewish Board of Family and Children's Services in New York City. In the Jewish culture, whether the trauma emanated from the diaspora, the Holocaust, the Intifada, or other displacements, children of survivors are often expected to stand for more than just themselves. Panzer recalled a former client, a young mother raised in Israel by a father who had survived the Holocaust and later thrived as a business man. "She was raised with the expectation that there was no room for ordinary challenges to get in her way," Panzer said. For the woman's father, survival during the Holocaust was an all-or-nothing proposition; for her, it became essential to learn more flexible coping skills in order to deal with present-day challenges.



Donna K. Nagata, PhD, Professor of Psychology and Director of Clinical Training in the Department of Psychology at the University of Michigan, Ann Arbor.

Donna K. Nagata, PhD, Professor of Psychology and Director of Clinical Training in the Department of Psychology at the University of Michigan, Ann Arbor, has studied the long-term psychological effects of the WWII Japanese American incarceration on the survivors and their descendants. Japanese Americans were taken from their homes, dispossessed of all their holdings, and branded as untrustworthy and potentially disloyal by their own country. Survivors and descendants

have processed the experience of the camps in complex ways over time. Responses ranging from low self-esteem to avoidance of the trauma have affected offspring, including Sansei (third generation) and even Yonsei (fourth generation) Japanese Americans. Nagata and other researchers have noted profound and long-lasting effects of incarceration on overt family communication and unspoken messages related to ethnic identity, place in society, and awareness of power hierarchies. Although these effects may have lessened with succeeding generations, it is important for clinicians to "be aware that this is a relevant issue that may have ramifications," Nagata said. "How that [trauma] played out within particular families and individuals will vary."

As with any group subjected to historical trauma, reminders of the trauma can frequently surface for Japanese Americans. The calls to round up "suspicious" Arab and Muslim Americans after the September 11 attacks in the U.S. were reminiscent of anti-Japanese sentiment after the attack on Pearl Harbor. For some Japanese Americans, this labeling served to re-voke the experience of being treated like the enemy within their own country.

How Trauma Is Understood

Clinicians should be mindful of how they characterize their clients' trauma, Panzer said. "The impact of disproportionate exposure to threats based upon assumptions such as the race of an individual may lead to incorrect understanding of the impact of trauma," she observed. The impact of the trauma may be experienced in the moment (and over collective moments) as traumatic AND as part of the generational family story, which makes it an historical trauma as well. "What is adaptive in the moment, such as teaching a child how to calmly behave when indiscriminately stopped by police for a search, may be normalized as part of one's cultural adaptation but then differentially experienced as trauma," Panzer said. Accordingly, clinicians need to understand the family message and the individual response.

Edwina L. Reyes, MFT, CSAC, Co-Founder and Vice President of Ho'okō LLC, a counseling center in Waipahu, HI, is a Network Affiliate who formerly did outreach work at a transitional shelter in Wai'anae, HI, in association with Catholic Charities Hawaii (a former NCTSN Category III site). The shelter was serving the influx of Micronesians to the Islands precipitated by the federal government's



Edwina L. Reyes, MFT, CSAC, Co-Founder and Vice President of Ho'okō LLC, a counseling center in Waipahu, HI.

acknowledgment of the devastation caused by nuclear testing in the 1940s and '50s. Eligible to migrate to the U.S. to seek employment, Micronesians often arrived in Hawaii without money and many were essentially homeless, Reyes said. When she first mentioned Catholic Charities' trauma services to the case manager at the shelter, the manager responded that the population did not have trauma. "It wasn't something that they recognized," Reyes recalled.

Seek Resources, Take the Time

Nagata pointed out that, due to the high percentage of outmarriage among Japanese Americans, clinicians are well advised to solicit information about their clients' racial origins. In urban areas of the West Coast where they are more likely to have Japanese American clients, clinicians can seek out information about the WWII incarceration. Many of

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Conversations about Historical Trauma *cont'd from pg. 5*

these cities have Japanese American historical museums. The Denshō Project (www.densho.org) features a free online encyclopedia about the forced removal and incarceration of Japanese Americans during WWII, and more than 1400 hours of archived interviews with survivors.

The diversity of cultures on the Islands demands an attunement to the client's experience, said Reyes' partner Rhesa Kaulia, MFT, Co-Founder and President of Ho'okō LLC. Kaulia stressed the need for providers to seek out and build alliances with local, community-based resources, such as revered pastors, community leaders, or individuals of special respect in the client's life. Although Kaulia herself is a biracial Japanese American married to a Native Hawaiian, she said she strives to "learn from the patients themselves," and does not assume that she understands all the nuances of native and immigrant communities. "Depending on which location they come from,"



Rhesa Kaulia, MFT, Co-Founder and President of Ho'okō LLC in Waipahu, HI.

she explained, "what you know to be true as a general rule for for some Native Hawaiians may not hold true for all." Whether their clients are Micronesian, Hawaiian, Polynesian or Asian, Reyes and Kaulia develop trust with clients using a relational approach, remaining open to them as teachers. Only then can the work of healing from trauma begin. "Even if a client is presenting with depression," Kaulia said, "here in the Islands we spend an even greater amount of time working on building that trust as part of the treatment process."

Clinicians' prior knowledge or expertise can be both a benefit and a limitation for dealing with their clients, Panzer said. "All pathology need not be understood through a trauma lens, and not all trauma must be addressed at once." In addition, time is often at a premium in the public sector. This can restrict the allowance of ample time for self-generated narratives to unfold. To reinforce recovery, resilience and hope, clinicians must avoid assumptions about a family's historical trauma, and first understand what matters in the present for the family; how the family wants to be understood; and what part of their trauma the family members are prepared to address. ■

The NCCTS extends a special thank you to Vivian H. Jackson, PhD, Georgetown University, and the NCTSN Culture Consortium for their conceptualization of and major contributions to this series.

Core Curriculum College *cont'd from pg. 4*

from preschool to late adolescence, were written. In the problem-based learning method, facilitators guide the students through problem-solving rather than rely on didactic teaching; and the "problem" case becomes a vehicle for development of problem-solving skills. Each Core Curriculum case walk-through begins with a scenario in which a child is in psychological distress. Learners are invited to form hunches and hypotheses about the child and the circumstances behind the child's current distress. As information accrues in bits and pieces, as often occurs in the clinical setting, learners pause for reflection and re-evaluation of the case. Similar to previous opportunities offered by the NCCTS, the recent Core Curriculum college entailed lots of preparation. Participants were given specific pre-course activities to prepare for the interactive components. During the session, participants facilitated small group trainings and received feedback from faculty.

Slow Down and Reflect

One of the themes of the Core Curriculum is to teach reflection regarding cases. This aspect of the curriculum impressed Beth Barto, LMHC, Director of Quality Assurance, Project Director, Central Massachusetts Child Trauma Center. She participated along with her colleague, Genevieve Kane-Howse, LMHC, in the January college. "The way the Core Curriculum is organized helps people to be more self-aware," she observed. It "gives clinicians a 'container' and guidance for their reflections," so that they can be more directed as they consider their cases. College participants are required to implement the Core Curriculum on Childhood Trauma when they return to their agencies. Consultations with faculty are available every six

months to assist with dissemination. Evaluations of the efficacy of the training are currently being conducted by the NCCTS in concert with the UCLA Department of Education. Evaluation and testing of the college format will be key going forward, said George "Tripp" Ake, PhD, currently NCCTS Director of Training and Implementation, who also was present at the January college and facilitated one of the interactive cases. "We have to think about the different modes of implementing things such as the Core Curriculum," Ake said, "and the evaluations will be a good way to tell how to get the best return on our implementation efforts."

Having completed the first training at her center, Barto reported that the curriculum was well received by the clinicians. "The biggest dilemma was finishing on time, as folks had so much feedback they wanted to share," she said. The clinicians felt positive about the problem-based learning framework, which allowed them to think critically about their cases. Angel Knoverek, PhD, LCPC, ACS, Director of Clinical Services at Chaddock, a Network Affiliate in Quincy, IL, attested to that effect as well. She participated in earlier field-testing of the Core Curriculum during a 2012 BSC co-led by Abramovitz and Lisa Amaya-Jackson, MD, Duke University Medical Center. Since that time, Knoverek has continued to apply the Core Concepts on a monthly basis at her agency. "The nature of problem-based learning and how cases are conceptualized really helped us slow down and think about a case in a different way," she said. ■

The Core Curriculum on Childhood Trauma is available on the NCTSN Learning Center. For more information, contact Sara Acharya at sacharya@mednet.ucla.edu

Breakthrough Series Collaborative Builds Bridges Between Child Welfare and Mental Health Agencies *cont'd from pg. 1*

the Child Welfare BSC began in 2009, and the BSC took place between October 2010 and September 2012. According to participants, the BSC structure created a rich learning environment and facilitated collaborations that continue to flourish. A newly released report has summed up the two-year effort. Titled *Using Trauma-Informed Child Welfare Practice to Improve Foster Care Placement Stability Breakthrough Series Collaborative*, the report is available free online to Network members and the public. Visit www.nctsn.org/sites/default/files/assets/pdfs/using_ticw_bsc_final.pdf

Thoughtful Collaborative Design

The nine teams selected for the Child Welfare BSC came from throughout the country. Each was led by a public agency, and each was required to have an established partnership with a mental health agency that was providing evidence-based interventions for child trauma. The public agency team members included senior administrators, supervisors, and case workers. Also at the table were mental health agency senior administrators, clinical supervisors and clinicians, as well as foster parents, birth parents, and foster care alumni.

Organizers put a lot of thought into the collaborative change framework, noted Jane Halladay Goldman, PhD, Director of the NCCTS Service Systems Program. That fact was clear to Teresa Chavez, MSW, Children, Youth & Family Supervisor, and to Lori Carlson, Children, Youth & Family Administrator, both from the Arapahoe County Department of Human Services, Aurora, CO. “The requirement for us in Human Services to partner with community mental health showed a lot of foresight from the NCTSN,” Carlson said. The Department of Human Services had already been closely paired with the Aurora Mental Health Center, a Network Affiliate. Kathie Snell, MA, LPC, Deputy Director, Child and Family Services at the Aurora center, recalled that the two agencies had begun talks about participating in the BSC a full two years before the call for applicants arrived.

The participating teams initially tested changes at the practice level using the Model for Improvement, a quality improvement tool that assesses change on a small scale based on Plan-Do-Study-Act cycles.

Practice-level changes (in the Practice Cards section of the BSC report) were organized around five major themes: training and coaching of staff to build knowledge and address secondary traumatic stress; developing and using trauma-focused screening tools; providing information to birth parents and foster parents during case planning and management; increasing the capacity of mental health providers to deliver evidence-based practices; and developing cross-system collaborations by providing joint training opportunities for partners.

Partnerships Strengthened

Snell, Carlson and Chavez all acknowledged that the collaborative demanded intensive effort. “But it was well worth the work,” Chavez said. These providers continue to reap benefits on a weekly basis as their professional relationship has strengthened. “Just last week I dealt with a parent who had a mental health crisis,” Chavez said. “I was able to immediately call Kathie and she helped walk me through the process.” Since the BSC, the Arapahoe County DHS has added another community health partner, the Arapahoe/Douglas Mental Health Center.

“The BSC brought the Department of Human Services and Aurora together around a shared language and shared perspective.”

KATHIE SNELL, MA, LPC, Deputy Director Child and Family Services at Aurora Mental Health Center, Aurora, CO

Halladay Goldman observed that, going forward, the BSC effort dovetails nicely with current federal initiatives under the Title IV-E Waiver Demonstration Project, whose central tenets include increased permanency and trauma-informed care for children in the welfare system. Carlson said that Arapahoe County is now one of nine sites in Colorado selected to participate in the state’s Title IV-E project on Trauma-Informed Screening, Assessment and Treatment for Children, which will roll out this summer. “We are excited to participate,” Carlson said, “and I think our experiences with the Breakthrough Series will help us launch the project and allow us to make trauma-informed practice sustainable.”

George “Tripp” Ake, PhD, currently Director of Training and Implementation, NCCTS at Duke University Medical Center, was Project Director of the Center for Child and Family Health in Durham, NC, when it partnered with the North Carolina Division of Social Services during the BSC. “Like most Breakthrough Series Collaboratives,” Ake said, “this really catapulted North Carolina in a direction of providing more trauma-informed services.” North Carolina has now received funding to implement a five-year project on trauma-informed care throughout the state.

“The BSC was a very positive experience for us,” Snell said of the Colorado team. “Not only did it improve detection of trauma, but it brought us [the DHS and Aurora] together around a shared language and shared perspective.” Ake agreed that the collaborative design allowed both public and mental health agencies to have “safe conversations around the cultural differences in our systems.” ■

Welcome, Attendees

to the annual All-Network Conference of the NCTSN. Our hope is that your time in Falls Church yields new tools and collaborations that will further the Network's mission of serving children and families impacted by trauma. Watch for updates and coverage of the meeting in upcoming issues of *IMPACT*.

Have You Heard?

NCTSN sites in California, Michigan, New York, and Rhode Island are receiving funding from the federal **Administration on Children, Youth and Families** to assist their states in implementing screening, assessment, and service reconfiguration approaches in child welfare systems, with a special focus on trauma and behavioral health needs.

Jeanne Sherman, LMHC, Clinical Supervisor, **Family Service of Rhode Island**; **Susan Erstling, PhD**, Senior Vice President, Trauma, Loss and Children's Services at **Family Service of Rhode Island**; and **Carole Campbell Swiecicki, PhD**, Executive Director of the **Dee Norton Lowcountry Children's Center** in Charleston, SC, are among the faculty and panelists at a conference titled "Adapting TF CBT for Military Children and Adolescents." The conference, presented by Butler Hospital and Family Service of Rhode Island, takes place March 13 at the Butler campus in Providence.

The NCTSN has been actively working with the **National Council of Juvenile and Family Court Judges** on two initiatives. The Network has partnered with the council on a grant sponsored by the **Office of Juvenile Justice and Delinquency Prevention** that is focused on improving juvenile drug courts through the implementation of evidence-based treatment practices. The Network is also supporting the council's "trauma-audit" pilot project aimed at defining and evaluating what it means to be a trauma-informed juvenile court. To date, six juvenile courts nationwide have opened their doors and participated in the audit program. For more information, visit www.ncjfcj.org/update-ncjfcj-trauma-audits or contact Kelly Decker at kdecker@mednet.ucla.edu.

Did You Know?

NCTSN Affiliates in Colorado co-sponsored a free training on Integrative Treatment of Complex Trauma in Adolescents (ITCT-A) with the **University of Southern California Adolescent Trauma Training Center** on February 18 and 19 in Denver.

The Affiliate co-sponsors were the **Aurora Mental Health Center**, the **Kempe Center**, the **Mental Health Center of Denver**, **Laura Template**, **Sara McConnell**, **Evelin Gomez**, and the **Colorado Judicial Branch**. The training was open to all Network members and their community partners. The National Center for Child Traumatic Stress supported this great example of collaboration by providing free CE credits for 330 participants.

The ITCT-A model was developed to assist providers in evaluating and treating adolescents who have experienced multiple forms of psychological trauma. Presenters for the Denver training were USC's **John Briere, PhD**, Center Director, and **Cheryl Lanktree, PhD**, Project Director.

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About IMPACT

IMPACT is a publication of the National Child Traumatic Stress Network (NCTSN). It is produced quarterly by the National Center for Child Traumatic Stress (NCCTS), co-located at UCLA and Duke University. The NCCTS serves as the coordinating body for NCTSN member sites, providing ongoing technical assistance and support.

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Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) brings a singular and comprehensive focus to childhood trauma. NCTSN's collaboration of frontline providers, researchers, and families is committed to raising the standard of care while increasing access to services. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and dedication to evidence-based practices, the NCTSN changes the course of children's lives by changing the course of their care.



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