Children's Services
PRACTICE NOTES
For North Carolina's Child Welfare Workers
From the NC Division of Social Services and the Family and Children's Resource Program

Partnering with NC's Mental Health System

Partnering with the mental health system is a key part of achieving positive outcomes in child welfare. Because of their expertise and desire to help children and families heal and thrive, those working in the mental health system are natural partners for child welfare professionals.

"You just can't do child welfare without mental health partnering."
— *Child welfare system stakeholder*

But even in natural partnerships, things aren't always easy. Child welfare professionals sometimes find it difficult to obtain appropriate, evidence-based services for clients. Poor communication and lack of clarity about each other's roles, mandates, and procedures can trip up even the most sincere attempts to work together.

Yet despite the occasional frustrations, these barriers can be overcome. If the recently released final report from the Governor's Task Force on Mental Health and Substance Use (available here: http://bit.ly/1TsryJN) is any indication, in the future our two systems will almost certainly be working together more, not less.

This issue of *Practice Notes* demonstrates that to some extent this future is already here. Through Project Broadcast and many other efforts, child welfare and mental health agencies are searching for new ways to collaborate so they can be stronger, more efficient, and more successful.

We hope this issue of *Practice Notes* will provide you with inspiration and ideas to make your partnerships with mental health deeper and more fruitful for the kids and families you both serve. ◆

New Course for Child Welfare Professionals on Advocating for Mental Health Services

The NC Division of Social Services is pleased to announce the launch of *Advocating for Child and Adolescent Mental Health Services,* a self-paced, on-demand, online course that provides basic information to our state's child welfare workers and supervisors on working with local management entities/managed care organizations (LME/MCOs) to connect children and families to services.

This 2-hour training teaches child welfare staff how to monitor services and build collaborative relationships with LME/MCOs so youth and families can be connected to needed behavioral health services. The course explains how LME/MCOs determine eligibility, outlines the functions of the LME/MCO, describes what to expect from behavioral health providers, and teaches strategies that can be used to advocate for appropriate services for clients.

This course was developed with funding from the NC Division of Mental Health, Developmental Disability, and Substance Abuse by the Behavioral Healthcare Resource Program, part of the Jordan Institute for Families at the UNC School of Social Work.

To Take This Course

Visit ncswLearn.org for a full course description or to take this course. No registration is required. Simply log in to your account and navigate to the "Personalized Learning Portfolio (PLP) / Online Courses" section at http://ncswLearn.org. ◆

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This publication for child welfare professionals is produced by the North Carolina Division of Social Services and the Family and Children's Resource Program, part of the Jordan Institute for Families within the School of Social Work at the University of North Carolina at Chapel Hill.

In summarizing research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.

Let us hear from you!
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Building a Trauma-Responsive Child Serving System in NC

Project Broadcast was launched in October 2011 with a five-year grant from the U.S. Administration for Children and Families (#90CO1058) to help our child welfare system become more trauma-informed. Almost five years later, even though funding is coming to an end, the project's mission will remain a key component to child welfare services in North Carolina.

Why Focus on Trauma?

National studies have shown that adverse childhood experiences (ACEs) lead to increased use of health and human services, poor health outcomes, and early death. In fact, with an ACE score of three (out of ten), at some point in your life you are 2x more likely to become a smoker and 6x more likely to attempt suicide. With an ACE score of four, you are 7x more likely to become an alcoholic and 12x more likely to try suicide at some point.

In fact, there is a "dose-effect" for childhood trauma. As Figure 1 shows, the more ACEs you have, the more likely you are to experience mental health disorders. As Figure 2 shows, ACEs have a dose-effect for physical health outcomes as well. (*Figures reprinted from Putnam, et al. 2015, which is available at www.canarratives.org.*)

Trauma can have a huge impact, but fortunately its effects can be mitigated if we identify trauma early and intervene effectively.

Screening for Trauma

Project Broadcast developed two trauma screening tools for use by child welfare professionals: one for children under age six and one for children age six and older.

These one-page tools help identify potential trauma exposure and functional impairments often associated with trauma, and they help workers decide whether to refer youth for a comprehensive, trauma-informed clinical assessment. The screening form for children age six and older includes four questions the social worker specifically asks the child about physical abuse, sexual abuse, domestic violence and other traumatic events.

These tools have been used widely in Project Broadcast counties. Over the course of 36 months (Jan. 2013 to Dec. 2015), child welfare workers in 12 NC counties completed 9,714 trauma screenings. Because some children were screened more than once, the total number of children screened was 6,651. On average, children screened were 8.39 years old. Slightly more than half (51%) were male. Thirty-nine percent were white, 39% were black, and 13% were Hispanic.

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Figure 1

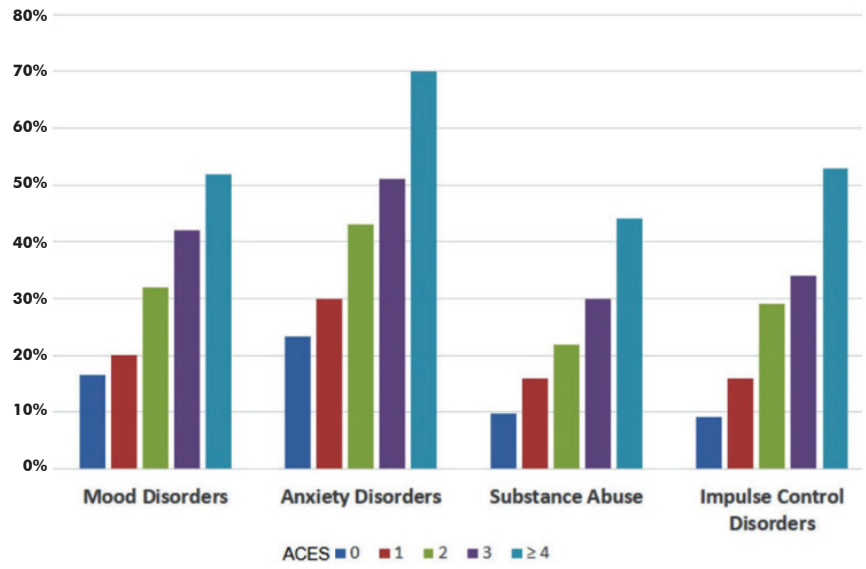
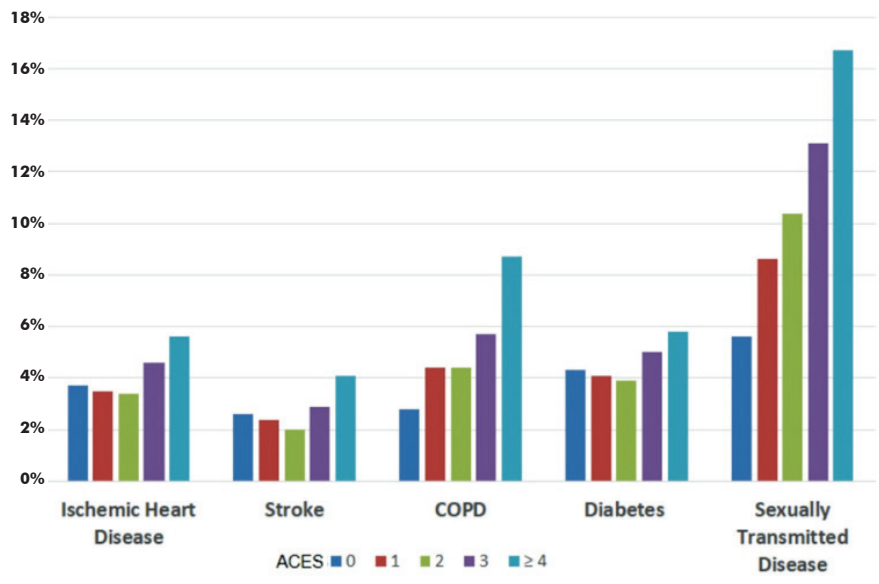


Figure 2



Figures reprinted from Putnam, Harris, Lieberman, Putnam, & Amaya-Jackson, 2015

Trauma-Responsive System

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Twenty percent of the children screened were found to have had three or more adverse childhood experiences. That's more than 1,300 children who are 6x more likely to attempt suicide in their lifetime. This is why the work we do is so important. After we ensure children are safe, we must tend to their well-being so they can become productive, successful adults. We want them to live long enough to know their grandchildren some day.

Among the children screened by Project Broadcast the most common trauma experience was exposure to domestic violence (48%), followed by exposure to drug/substance abuse or related activity (42%).

Children's trauma varied by case type. For example, 54% of CPS in-home and 48% of foster care cases had experienced trauma, compared to 23% for children involved in CPS assessments/investigations. Overall, 30% of children screened had experienced some type of trauma. Of these, 56% were referred for further assessment. (Most of the remaining 44% were already in treatment.)

When children older than six were asked directly about their history, 15% indicated they had experienced physical abuse, 22% had been exposed to domestic violence, 10% had been sexually abused, and 2% had another traumatic event occur. The trauma screening revealed previously unknown information about 113 children. Thanks to trauma screening, we can provide them with services and psychoeducation to help them heal.

The Future of Project Broadcast

The NC Division of Social Services and its partners want to expand Project Broadcast to all NC counties. We want to ensure our entire child welfare workforce has the knowledge and skills they need to identify and respond to child trauma. We also want to make sure all child welfare agencies attend to the secondary traumatic stress needs of employees and have effective working relationships with the mental health community. We want to provide the support needed to make every agency's culture trauma-informed.

We are using learning communities to spread Project Broadcast. The current learning community is training representatives from 12 counties to lead efforts to make their agencies more trauma-informed. This learning community, though it is a year-long process, is only the beginning: becoming trauma-informed is a culture shift for all agencies.

Using learning communities is an exciting new step for the Division of Social Services as well. This is a promising approach to rolling out training and implementing new initiatives. We hope to offer another trauma-focused learning community in spring 2017.

Other Child-Serving Systems

When it comes to our state's vision for making other child-serving systems more trauma-informed, the word "synergy" comes to mind. Synergy is *the interaction or cooperation of two or more organizations to produce a combined effect greater than the sum of their separate effects* (Oxford, 2016).

Today many entities in our state are focused on trauma:

- The Division of Medical Assistance is embedding trauma-informed information into the mental health service definitions;
- The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services is funding the NC Child Treatment Program, which is training hundreds of new clinicians each year (visit www.ncchildtreatmentprogram.org often; new clinicians are added monthly);
- The Department of Public Instruction is leading a School Mental Health Initiative;
- The Department of Public Safety/ Division of Juvenile Justice have implemented trauma-informed assessments, treatment, practices, and policies in their Youth Development and Youth Detention Centers;
- The Department of Health and Human Services is investing in Mental Health First Aid (www.mentalhealthfirstaid.org) which could have a tremendous impact on our entire system; and
- The Governor's Task Force for Mental Health and Substance Use issued many trauma-informed recommendations in May 2016.

After we ensure children are safe, we must tend to their well-being so they can become productive, successful adults. We want them to live long enough to know their grandchildren some day.

Conclusion

It's an exciting time in our state. If we can realize how prevalent trauma is, recognize the signs and symptoms, respond with trauma-informed skills and practices, and avoid re-traumatizing children and families, we will be well on our way to mitigating trauma's negative effects. We can build resilience in children and families, promote protective factors, and heal those who have experienced trauma.

You are part of this exciting time. You can be part of the healing process.

For more information about Project Broadcast or trauma-informed services in North Carolina, please contact Jeanne.Preisler@dhhs.nc.gov. ◆

Trauma-Informed Practice and NC Child Welfare Policy

The increasing emphasis on being trauma-informed can feel like pressure to add another complex dimension to child welfare practice. However, child welfare policy in North Carolina already emphasizes a number of practices that are in line with research recommendations about minimizing the effect of trauma. With the introduction of Multiple Response System (MRS), and with federal laws passed in recent years, child welfare practice has increasingly emphasized partnering with families, listening to the voices of children and youth, and building and maintaining healthy connections. These are all trauma-informed activities and approaches. They're also already part of your everyday practice with families. The table below highlights North Carolina policies that align with key trauma-informed child welfare activities. ◆

Activity	Related NC Policies*	Trauma-Informed Implementation
Maximize child's sense of safety	Safety Planning	Child welfare staff are strongly encouraged to involve parents and their children in safety planning, and to ask questions that help the child describe their concerns and fears as well as the things that help them feel safe. "Seeking first to understand" and taking the "not knowing stance" are also part of understanding the safety needs and protective factors in families.
Coordinate services with other agencies	Child and Family Team Meetings Permanency Planning Action Teams	CFTs are one of the most important techniques we have for coordinating services. Time spent preparing families, community partners, and others for CFTs is essential. Talk early and often about CFTs; have conversations about who will be helpful to have on the team. DSS agencies should be proactive about educating community partners about CFTs on an ongoing basis. This can help spread System of Care (SOC) values, which in turn ensure communities know what the needs are and so take action to get them met.
Use comprehensive assessment of child's trauma history to guide services	CME/CFE Strengths/Needs Assessment Individualized case planning	NC policy requires us to engage children as part of assessments during the provision of CPS services and throughout their involvement with DSS. Particularly in family assessments, the focus should be on getting the big picture, which includes the child's history. Some county DSS agencies find it helpful to consistently ask children a few simple questions to ensure that their trauma histories are fully explored and appropriate services are provided. Child Medical and Child/Family Evaluations also gather trauma history information to guide supportive interventions for children and families.
Support and promote positive, stable relationships	Placement priorities Visitation plans Sibling placement and visits Family notification Reunification efforts Shared Parenting LINKS goal Use of Life Books	Identifying and supporting positive, stable relationships for children is a theme that runs throughout NC policy, from looking diligently for absent parents, to prioritizing placements and frequent visitation with siblings and other kin, to the LINKS goal of ensuring young people leaving foster care have a personal support system of at least five caring adults in addition to professional relationships.
Provide support and guidance to child's family/ caregiver	Involving family in case planning Individualized foster parent training and development	It is possible to do the Safety Assessment in the family's presence without doing it "with" them. The "to, for, and with" frame taught in courses such as *CPS Assessments* effectively engages and empowers all family members to take part in planning for their own safety and well-being. Involvement of foster parents and other substitute caregivers in CFTs and shared parenting is an excellent way to ensure they have the information they need to meet the needs of children in their care. Creating and actively supporting individualized foster parent training and development plans is another way to ensure they see children's behaviors through a "trauma lens" and have the skills they need to respond appropriately.

**This is not a comprehensive list. NC's full child welfare policy can be found at <http://info.dhhs.state.nc.us/olm/manuals/>.*

Collaborating to Improve Mental Health Services for Children Involved with CPS: One DSS Director's Perspective

A Conversation with Richmond County's Robby Hall

Robby Hall, social services director in Richmond County, NC, and his staff have been working closely with mental health providers, Sandhills Center (their managed care organization, or MCO), and community partners to improve mental health access and treatment for the children they serve. *Practice Notes* recently spoke with him about what this effort has accomplished.

What is your approach or process to partnering with mental health?

As a system we really need to focus on the mental health treatment type or intervention level that children involved with child welfare receive. To make a difference, we want to do this for all children, especially those who have been screened in by CPS but are still in the home.

By providing targeted, front-loaded services early on, we're trying to meet families' needs so we can avoid foster care placement and reduce the chance they'll come to the attention of CPS in the future.

How did your agency manage to increase access to mental health assessments and treatment for the children you serve?

We began by holding a provider meeting where we explained our needs related to community mental health access to our providers.

Eventually this led us to offer to host two of our providers on-site at our agency (i.e., co-locate). Under our agreements with them we provide office space, equipment, and take care of their scheduling. It's a great arrangement: we now have on-site therapists who do screening, assessments, and treatment.

We've also heard you're using something called TOP . . .

Yes. Through funding from The Duke Endowment, we have a project with the nonprofit Kids Insight. With them we're using the Treatment Outcome Package, a web-based assessment tool that allows us to track child well-being from the perspective of the child, foster parent, biological parent, GAL, and therapist. The information can then be used in child and family team meetings and for permanency and treatment planning.

In the second phase of this project we can look at all the children's well-being outcomes and see which treatments or providers they had so that we can match future children, based on need, to the provider or treatment that will serve them best. For example, I might have one provider who does great with teenagers and another who does better with young children.

With the kind of data we get from TOP, where a child receives treatment can be tailored to the child's needs and the provider's strengths.

How have providers reacted?

At first I was nervous about how they'd respond. But I've done performance-based contracting before, and providers left the meeting excited about the possibilities of serving children better and excelling within their sphere of greatest ability.

We also showed them how completing the TOP assessment would only take them a few minutes per child. Plus, our agency is footing the bill for it. This helps incentivize evidence-based programming, which we all want to see offered.

How will you continue using TOP?

We're looking for other counties to partner with so we can contract with providers on a larger scale. Larger contracts allow for cost savings that will enable long-term sustainability.

How are you partnering with your MCO?

When I first started as director in Richmond County I met with Sandhills Center directly, and I continue to meet with them. They're open and responsive. I try to meet face-to-face with their director as needed.

Have you engaged other players?

Absolutely. We've held collaborative meetings with other community stakeholders such as law enforcement and school administrators. By having directors or leaders of these organizations at the table we can streamline decision making. This is better than having lots of different front line staff from the different organizations contacting each other and trying to address issues case by case. Since county commissioners are on the boards of the MCO, they sometimes help arrange meetings.

We've also partnered with Community Care of the Sandhills—the health network that connects Richmond County to Community Care of North Carolina (CCNC)—to implement telepsychiatry. We're using this approach for screening and diagnostics in rural areas to reduce wait times and bring down costs. The main focus is on screening children and starting treatment sooner so we can reduce hospitalizations for acute needs. We have funding for telepsychiatry through October 2016. Sandhills MCO has begun talks with Richmond County DSS around TOP, on-site mental health services, and telepsychiatry. ◆

Learn More

Treatment Outcome Package (**TOP**) is a patented behavioral health assessment tool children for ages 3 and up that measures social and emotional well-being over time. TOP is available through **Kids Insight**, a child welfare-focused nonprofit supported by the Annie E. Casey Foundation and The Duke Endowment. To learn more about TOP and Kids Insight, visit http://kidsinsight.org

The North Carolina Child Treatment Program

Helping Child Welfare Professionals Find the Right Mental Health Treatment for Every Child

Child welfare professionals spend a lot of time trying to navigate the mental health system on behalf of families. Most of us have heard the phrase "evidence-based treatment models," or EBTs. We realize there are mental health treatments out there that could make significant improvements in children's lives, but there are challenges in accessing EBTs: how do you know which treatments are likely to help a particular child? And how do you find the right kind of provider when you need one?

The North Carolina Child Treatment Program (NC CTP) is a tool that can help you connect with EBT providers in your county. Founded in 2006, the NC CTP is focused on dissemination of evidence-based mental health treatments for infants, children, and adolescents coping with attachment difficulties, psychological trauma, traumatic bereavement, and behavioral challenges. This focus makes NC CTP a useful partner for county DSS agencies. And conversely, DSS child welfare social workers are critical to NC CTP realizing its mission.

Fidelity Matters

When looking for a specific evidence-based treatment model, it's important to find a clinician who provides the model with *fidelity*, meaning as the model was designed and tested.

For example, one of the most well-studied and effective interventions for children who have experienced trauma is **Trauma-Focused Cognitive Behavioral Therapy** (TF-CBT). There have been at least 12 randomized controlled trials that have shown better outcomes for children and youth who receive TF-CBT compared to other types of treatment or to no treatment (NCTSN, 2012). To have the best chance of improved outcomes, you want to be sure the clinician is providing TF-CBT with fidelity—that is, in the same way it was provided in those studies.

What Is Evidence-Based Treatment?

The Society of Clinical Child and Adolescent Psychology (2016) uses a concise definition of evidence-based treatments: "treatments with scientific evidence supporting them." Other organizations and sites use different criteria to determine when there is enough evidence to consider a treatment evidence-based, or to rank treatments based on the amount of evidence available. You can find the criteria used by California Evidence-Based Clearinghouse for Child Welfare here: http://www.cebc4cw.org/ratings/scientific-rating-scale/

To ensure clinicians provide EBTs with full fidelity, NC CTP provides learning collaboratives that last from one to two years, depending on the model. Clinicians participate in multiple day-long trainings and also receive intensive case consultation. Those who successfully complete a collaborative are included on a roster that can be searched by county at http://ncchildtreatmentprogram.org/

TF-CBT in North Carolina

TF-CBT learning collaboratives have been taking place since 2006. There are currently 373 rostered TF-CBT clinicians practicing across the state. Each month new clinicians complete the learning collaborative requirements and become rostered, so be sure to check the site

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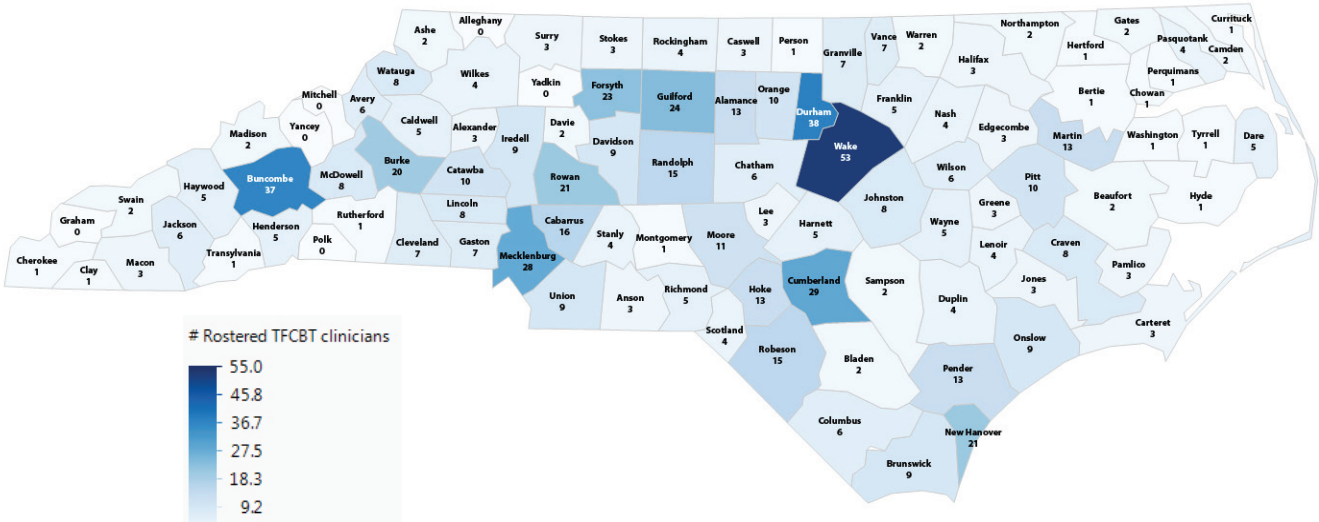
Number of Rostered TF-CBT Clinicians in May 2016, by NC County



Source: NC Child Treatment Program, 2016

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regularly. The map on the previous page shows the number of rostered TF-CBT clinicians in each county as of May 2016.

Children age 3-21 who have experienced traumatic grief or other forms of trauma may benefit from TF-CBT. This therapeutic model helps clients develop the skills to tolerate their trauma memories and manage their symptoms. It also helps clients change how they view themselves, their history, and the world, allowing them to reduce symptoms, heal, and build resilience.

What about Younger Kids?

To participate in TF-CBT, children and teens need to be able to remember and verbally describe their experiences. A common challenge for the child welfare system is that the largest category of children served is those from birth to age 5 (Duncan, et al., 2016). Many of these children are too young or don't yet have the verbal or cognitive skills needed for TF-CBT.

In the past, many people believed infants and young children were too young to be affected by traumatic experiences or exposure to chronic stress. However, we now know young children experience the effects of trauma well before they are able to describe what's happening to them. And of even greater concern, we know that early childhood trauma has a significant impact on children's ability to securely attach to their primary caregivers, which in turn can significantly affect their emotional and cognitive development (NCSTN, 2010).

One of the most exciting developments in North Carolina's mental health system is the spread of an evidence-based treatment model specifically for children from birth to age 5. **Child-Parent Psychotherapy** (CPP) was developed by psychologists Alicia Lieberman and Patricia Van Horn. The treatment is designed for infants and children who have experienced trauma or significant stress, or whose parents have significant stress or histories of trauma. In other words, it is a model with the potential to meet the needs of many families served by the child welfare system.

CPP recognizes that the parent-child relationship is the most important factor in a young child's life, as well as the greatest source of long-term healing and support. As a result, CPP focuses on the parent-child dyad, seeking to create a secure attachment and a caregiver who can remain attuned to and be protective of the child even in the face of adversity. Studies of CPP show that it has been successful in reducing symptoms in both parents and children, and in strengthening attachment (see above).

A new CPP learning collaborative will begin in fall 2016. This means clinicians may be able to accept referrals from county DSS agencies before the end of 2016. Keep your eyes on the NC CTP website (www.ncchildtreatmentprogram.org) for more information.

Child welfare and mental health professionals often find each other's systems challenging to understand and navigate. Working together, DSS and NC CTP can serve as a bridge, helping to find the right treatment and the right provider for each child. ◆

NC CTP Treatment Models: The Basics

Trauma-Focused Cognitive Behavioral Therapy — TF-CBT

- Rated as "1-well-supported by research evidence" and highly relevant to child welfare by the California Evidence-Based Clearinghouse for Child Welfare (CEBC, 2016)
- For children ages 3-21 who have experienced traumatic grief or other forms of trauma
- Up to 24 weekly, 60-90-minute sessions; caregiver and child seen separately and together
- Outcomes:
  - Improvement in PTSD symptoms, depression, anxiety symptoms, externalizing behavioral problems, sexualized behavior problems, shame, trauma-related cognitions, interpersonal trust, and social competence (NCTSN, 2012)

Child-Parent Psychotherapy (CPP) — CPP

- Rated as "2-supported by research evidence" and highly relevant to child welfare by the California Evidence-Based Clearinghouse for Child Welfare (CEBC, 2016)
- For children 0-5 years with symptoms resulting from:
  - Trauma or significant stressors, OR
  - Parents with trauma histories or significant stressors
- Up to 50 weekly, 1-hour sessions; caregiver and child generally seen together but parent seen individually on occasion
- Outcomes:
  - Children: reductions in behavior problems, traumatic stress symptoms, PTSD and depression diagnoses, and co-occurring diagnoses; improvement in sense of self and feelings about caregiver
  - Parents: reductions in PTSD and depression symptoms
  - Parent-child relationship: improved attachment

Sources: Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman, Ghosh Ippen, & Van Horn, 2006; Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011

Evidence-Based Practices in Children's Mental Health

The chart below, reprinted from a guide from the National Alliance for Mental Illness (2007), provides a quick reference for evidence-based psychosocial interventions by diagnosis for children and adolescents. It also lists the medications commonly prescribed for children and adolescents with mental illness by diagnosis.

Diagnosis	Evidence-Based Psychosocial Interventions		* Psychopharmacology
Anxiety	Ages 9–18	Cognitive Behavioral Therapy (CBT)	**Antidepressant medication (Selective Serotonin Reuptake Inhibitors—SSRIs); Benzodiazepines (no controlled evidence, but used in clinical practice).
	Ages 3–17	Exposure Therapy	
	Ages 3–13	Modeling Therapy	
Attention Deficit Hyperactivity Disorder (ADHD)	Ages 3–12	Behavior Therapy (in home and in school)	Stimulant and non-stimulant (Strattera) medications. (FDA requires a patient medication guide alerting consumers of possible serious side effects.)
	Ages 3–16	Parent Management Training	
	The combination of behavior therapy and medication is often most effective in treating ADHD		
Autism	Ages 3–13	Behavior Therapy	Antipsychotic medication has been shown to reduce aggression
	Ages 3–13	Individual and family therapies that target communication skills, interaction skills, and behavior modification.	
Bipolar Disorder	No controlled studies of psychosocial interventions for youth with bipolar disorder have been done. However, behavior therapy, family education, and support benefit youth and families and improve relationships, communication, and coping skills.		Mood stabilizers (Lithium and Valproate—an anti-convulsant medication); Atypical antipsychotic medication; and other medications may be appropriate.
Conduct Disorder/ Oppositional Defiant Disorder (CD/ODD)	Ages 3–15	Parent Training (multiple EBPs for different age groups)	Antipsychotic medication & mood stabilizers. (CD and ODD often co-occur with other mental illnesses so other medications may be appropriate.)
	Ages 9–15	Anger Coping Therapy (targets skill development in school)	
	Ages 6–17	Brief Strategic Family Therapy (BSFT)	
	Ages 13–16	Functional Family Therapy (FFT)	
	Ages 9–18	Treatment Foster Care (TFC)	
	Ages 12–17	Multisystemic Therapy (MST)	
	Ages 12–17	Mentoring	
	Ages 9–18	CBT	
Depression	Ages 9–18	CBT	**Antidepressant medication (SSRIs)
	Ages 11–18	Relaxation Therapy	
	Ages 12–18	Interpersonal Therapy (IPT)	
	Ages 12–18	Family Education and Support	
	The combination of CBT and medication is often most effective in treating major depression.		
Schizophrenia	No controlled studies of psychosocial interventions for youth with schizophrenia have been done. However behavior therapy, family education, and support benefit youth and families and improve relationships, communication, and coping skills.		Antipsychotic medication

Information in the chart is based on reviews by Burns, Chorpita, Chambless and Halloran, Hoagwood, Jensen, Weisz, and the authors of the NAMI Guide (2007).

* Generally, there is limited research on children's medication use, but more research exists on the utilization of ADHD medication.

** The Food and Drug Administration (FDA) has issued a "black box" warning about the increased risk of suicidal thoughts and behaviors in youth being treated with antidepressant medications.

Partnering for Excellence

Working to Improve Services and Outcomes for Children and Families Affected by Trauma

As this issue shows, a lot of energy is being put into trying to improve outcomes for children and families involved with the child welfare system in North Carolina, especially those who have experienced trauma. Partnering for Excellence (PFE), a Duke Endowment-funded effort in Rowan County, is another great example.

History and Goals

Partnering for Excellence began in 2012 when The Duke Endowment provided funding to Benchmarks, an alliance of nationally-accredited human service agencies in North Carolina, to redesign the way the child welfare and mental health systems interact to:

- Provide trauma-informed services to support improved child and family outcomes;
- Reduce costs by helping both systems avoid unnecessary use of high-end services; and
- Reduce the need for future CPS involvement in families currently receiving child welfare services.

The pilot of PFE got off the ground in July 2013 in Rowan County, where the department of social services (DSS); Cardinal Innovations, the county's mental health managed care organization (MCO); and private mental health providers have been collaborating to increase their focus on trauma and the use of evidence-based practices. The Center for Child and Family Policy at Duke University is evaluating the PFE pilot.

The Model

PFE is a different way of doing business for agencies serving child welfare-involved children ages 5-17 and their families. Key elements of the PFE approach include the following.

Initial Trauma Screens. In Rowan County, DSS workers screen all children entering CPS in-home and permanency planning services for trauma exposure. Capitalizing on the good work being done elsewhere in the state, they do this using the trauma screening tool developed by Project Broadcast. This is a one-page questionnaire completed by the DSS child welfare worker after talking with the child, birth parents, foster parents, and any other relevant sources of information about the child.

To date, 90% of young people screened by Rowan DSS as part of PFE have experienced some kind of trauma. Among children in DSS custody, every single one (100%) has screened positive for trauma (Benchmarks, 2016).

Trauma-Intensive Comprehensive Clinical Assessments (TiCCAs). After screening, DSS refers all children with trauma histories for a TiCCA. These in-depth evaluations are done by specially trained private mental health providers. The goal of a TiCCA is to fully understand what the child has experienced and how those experiences have affected and are continuing to affect the child and family.

To conduct a TiCCA, a provider must be trained to deliver Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and have an additional day of training in case conceptualization. PFE clinicians include in the TiCCA holistic recommendations that discuss not only the child's needs for mental health treatment but also school, parenting, pro-social behaviors, and anything else that may be needed.

Integrated Child Plan. The TiCCA helps DSS and its partners start out on the same page. DSS can incorporate information from this assessment into the family services agreement. Just as importantly, it uses this information to make referrals to (and advocate for) the right services and an appropriate model of care for each child. Guided by TiCCA results, the MCO can authorize needed services right from the start. Appropriate services help children heal from trauma and learn coping skills, which have the potential to help them stay in their own homes, stabilize placements,

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The Partnering for Excellence Model

DSS Screening

- DSS social workers screen for trauma in youth ages 5 to 17 in In-Home, Permanency Planning, and cases of abuse
- Children who screen positive for trauma or enter DSS custody are referred for a TiCCA
- Children age 0 to 5 are referred to CC4C through the Public Health Department for trauma and developmental screenings

Mental Health Assessment

- Specially trained TF-CBT clinicians use a protocol and template for assessment
- Focus on primary and secondary trauma
- Use of collaterals
- Holistic, trauma-informed recommendations with a focus on model and not just level
- Enhanced rate and privileging through the LME/MCO

Integrated Child Plan

- TiCCA is integrated into the Family Services Agreement through the child and family team
- DSS strengthens focus on:
  - Youth well-being
  - Coaching CFT facilitators
  - Referrals to evidence-based treatment whenever available

Quality Service Array

- PFE team works to ensure families access quality, evidence-informed or evidence-based front end services in their community
- Collaborative vision of a front end service array
- Focus on trauma training and increased clinical support for those who care for children

Effective Care Management

- DSS, resource parents, the LME/MCO, and private providers engage in activities to improve communication, coordination, and monitoring of child and family treatment

benchmarks
An Alliance of Agencies Helping Children, Adults & Families

PFE

continued from previous page

or expedite permanency.

Quality Service Array. PFE has Rowan DSS, Cardinal, and mental health providers talking about what else the community needs to serve families better. In addition to expanding the number of local TF-CBT providers, since PFE began Rowan has added new parenting courses. The idea is to create a community that is trauma-informed, trauma-aware, and trauma-responsive.

Effective Care Management. A very important dimension of PFE is the model's emphasis on the need for those serving DSS-involved families to work together to improve communication, coordination, and monitoring of child and family treatment. This requires a lot from all parties, including building a strong foundation by attending training together, more formal agreements (such as memorandums of understanding), and committing to participation in ongoing collaborative meetings.

Many of those involved have concluded the added effort is worth it because it helps the mental health and child welfare systems understand each other and their interdependence. As one stakeholder put it, "From a systematic view, you can't do child welfare without mental health partnering" (Benchmarks, 2016).

PFE Outcomes

It's too early in the evaluation of the PFE pilot to talk about the extent to which this effort can help communities achieve the project's long-term goals of improving child and family outcomes, avoiding unnecessary high-end services, and reducing repeat child maltreatment. That said, preliminary evaluation results comparing children before and after PFE came to Rowan County seem promising.

For example, as Figure 1 shows, since the start of PFE there has been a decrease in the percentage of young people diagnosed with ADHD and conduct disorder, while the number diagnosed with PTSD has increased. One explanation for this change is that because providers now have more information about trauma histories, they see children's symptoms and behaviors in a new light.

Figure 1

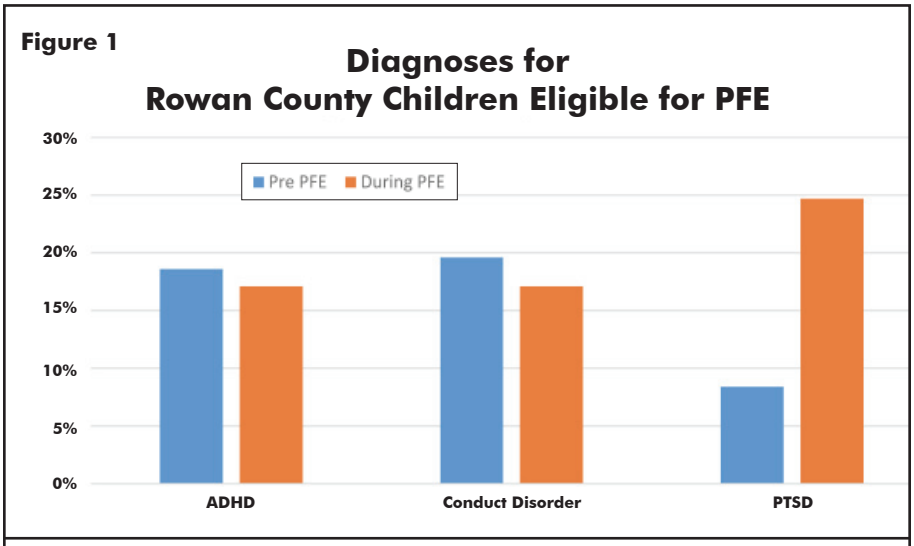
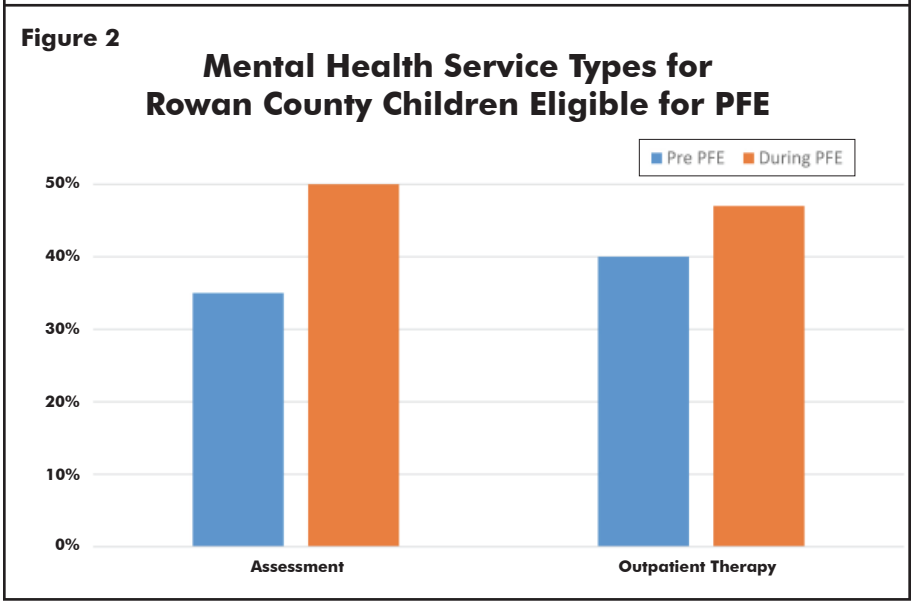


Figure 2



PFE also seems to be having an effect on the mental health services DSS-involved children receive. As Figure 2 shows, since PFE, more children are being assessed and, perhaps because TiCCAs are so thorough, more are receiving outpatient therapies such as TF-CBT.

What's Next

Evaluators will continue to collect information to better understand whether PFE ultimately has the desired impact. In the meantime, Benchmarks and its partners, with the continued support of The Duke Endowment, are beginning to work with additional counties. Cleveland County Department of Social Services and its MCO, Partners Behavioral Healthcare, started implementing the PFE model earlier this year, and the project will likely add at least one more county in the next year.

To Learn More about PFE

For more information, contact Jenny Cooper, the Partnering for Excellence Project Director, at jcooper@benchmarksnc.org. ◆

NC's Five-County Project: Strategies for Successful Collaboration between Child Welfare and Mental Health

Ensuring the safety, permanence, and well-being of children is too big a job for one agency or one service system alone. Success depends on our ability to collaborate across multiple sectors.

Fortunately, there are many groups in North Carolina working to better coordinate services to children and families involved with child welfare. The Five-County Project, which is active in Franklin, Granville, Halifax, Vance, and Warren counties, is one such effort.

The Five-County Project

The Five-County Project seeks to strengthen the system of services and supports for children with behavioral health care needs. The team for this project is made up of representatives from the five county DSS agencies, Cardinal Innovations Healthcare (the area's MCO), schools, juvenile justice, and mental health providers.

After it began in 2013, this multidisciplinary team went through a process of reviewing data, identifying problem areas, and prioritizing strategies to increase placement stability for children in care. In the hope of supporting other cross-organizational efforts, here are some strategies this team has found useful on its journey.

Strategy 1

Identify and focus on a goal with mutual importance

Most parties working with children in child welfare are involved because they care deeply about the well-being of children. It is important to remember that, although we have different roles across organizations, everyone is here for similar reasons.

EXAMPLE: After reviewing relevant data, DSS agencies from the five counties and their managed care organization (MCO) agreed reducing placement disruptions was an important shared concern. They reached this conclusion because they all understood the harmful impact disruptions can have on children. Additionally, everyone had other "pain points" that placement disruptions contributed to, including:

- Missed state permanency goals
- Long evenings or working on weekends
- Foster parent turnover
- Strained relationships with other parties (DSS, MCO, providers) over finding a new placement
- Financial costs of moving a child
- Delays in payment approval, etc.

Although it is necessary and helpful to acknowledge these very real challenges, the group found that frequent reminders about their primary goal kept them from getting sidetracked by struggles with these "pain points."

Strategy 2

Develop an understanding of each organization's role

DSS, MCOs, and providers all serve the same children, but they each have different legal and policy drivers, and may use different terms to discuss the same issues. Understanding everyone's legal and policy constraints helps collaborative groups brainstorm viable solutions instead of blaming each other for the dysfunction.

EXAMPLE: One of the first things the Five-County team did was map each organization's process for referring children to receive mental health assessments and services. This "process mapping" revealed differences in language, documentation, and child and family team (CFT) requirements. This, in turn, helped the team zero in on gaps and identify ways to improve processes.

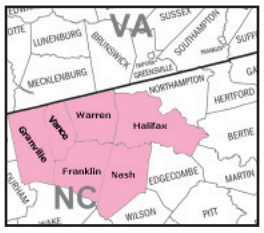
Strategy 3

Play to your strengths using small groups

Everyone involved in a cross-system, collaborative project needs a deep understanding of the problem, the desired outcomes, and the "big" action items needed to achieve those outcomes. For this you need a big group.

Once a solution is identified, however, you need small groups focused on specific tasks. The composition of these small groups matters. So do the parameters of their work: the larger group must always have an opportunity to provide feedback and input on small group efforts. Communication must be two-way.

EXAMPLE: At the beginning of the project the team collected, analyzed, and discussed data related to placement stability to help it decide about goals, outcomes, and action steps. However, it did *not* use a small group to assist with this. As a result, the process took an unnecessary amount of time and frustrated group members, who were ready to move forward with action planning. A lesson learned here was that the process of data mining would have been better delegated to a small group while the larger group focused on other tasks. ◆



The Five-County Project

Launched: 2013

Goal: Strengthen services and supports for children with behavioral health care needs in Franklin, Granville, Halifax, Vance, and Warren counties

Facilitator: Jordan Institute for Families at UNC School of Social Work

Participants: DSS agencies in the five counties, Cardinal Innovations Healthcare, schools, juvenile justice, and mental health providers

Status: The strengthening of relationships across organizations has allowed for action planning in focus areas targeted at impacting placement stability

To Learn More: Contact Sarah Marsh, MSW (marshs@email.unc.edu)

References for this Issue

Benchmarks. (2016). *Partnering for excellence: An innovative model for child and family well-being* [monograph]. Raleigh, NC: Author.

California Evidence-Based Clearinghouse for Child Welfare. (2016). Retrieved 5/18/16 from http://www.cebc4cw.org

Duncan, D. F., Kum, H. C., Flair, K. A., Stewart, C. J., Vaughn, J. S., Guest, S., Rose, R. A., Gwaltney, A. Y., & Gogan, H. C. (2016). *Management assistance for child welfare, work first, and food & nutrition services in North Carolina (v3.2)*. Retrieved 5/18/16 from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: http://ssw.unc.edu/ma/

Ghosh Ippen, C., Harris, W. W., Van Horn, P., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abuse and Neglect, 35*, 504-513.

Lieberman, A. F., Ghosh Ippen, C., Van Horn, P. J. (2006). Child-parent psychotherapy: Six month follow-up of a randomized control trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(8), 913-918.

Lieberman, A. F., Van Horn, P. J., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*, 1241-1248.

National Alliance for Mental Illness. (2007). *Choosing the right treatment: What families need to know about evidence-based practices*. Arlington, VA: Author. Retrieved April 15, 2010 from http://www.nami.org.

National Child Traumatic Stress Network. (2010). *Early childhood trauma*. Los Angeles, CA & Durham, NC: Zero to Six Collaborative Group, National Center for Child Traumatic Stress.

National Child Traumatic Stress Network. (2012). *TF-CBT: Trauma-focused cognitive behavioral therapy fact sheet*. Retrieved 5/21/16 from http://www.nctsn.org/sites/default/files/assets/pdfs/tfcbt_general.pdf

Oxford University Press. (2016). *Oxford dictionaries*. Retrieved 6/01/16 from http://www.oxforddictionaries.com/

Putnam, F., Harris, W., Lieberman, A., Putnam, K. & Amaya-Jackson, L. (2015). *Opportunities to change the outcomes of traumatized children: The childhood adversity narratives* [presentation]. Durham, NC: Authors. Retrieved 6/01/16 from http://bit.ly/1ZdB8lv.

Society of Clinical Child and Adolescent Psychology. (2016). *What is evidence-based practice?* Retrieved 5/18/16 from http://effectivechildtherapy.org/content/what-evidence-based-practice