What is Connecticut's trauma-informed approach?

Trauma profoundly impacts children and families. Over time, trauma that goes unaddressed can lead to toxic stress that impairs development and causes long-lasting behavioral and physical damage. Untreated trauma has been linked to a wide range of issues later in life, including depression, anxiety, addiction, risk-taking behavior, a greater likelihood of chronic disease, and even early death. In recent years, rates of several mental health disorders among young people have increased significantly, in part stemming from the trauma and isolation associated with living through the COVID-19 pandemic.

Children and families involved with child protection agencies often have experienced trauma. Additionally, the processes of investigation, removal, and placement — routine interventions and functions of any child protection agency — are increasingly recognized as traumatic events in and of themselves. Black and American Indian/Alaska Native youth, who are overrepresented at each stage of the child welfare system, also may be exposed to trauma as a result of long-standing discrimination, systemic inequities, and adverse community conditions.

Child protection agencies have come to recognize the adverse effects of trauma and the critical importance of trauma-informed, healing-centered supports for children and families.

Connecticut's Department of Children and Families (DCF) is an example of a state agency that aims to embed trauma-informed principles and values into all

of its policies, programs, and practices, working to ameliorate the impact of trauma on the children and families it serves.

Centering trauma: Strategies and lessons learned

In 2011, DCF was awarded a $3.2 million, five-year federal grant to integrate trauma practices into all levels of the child welfare system. CONCEPT (the Connecticut Collaborative on Effective Practices for Trauma) engaged multidisciplinary partners,[1] including the Child Health and Development Institute (CHDI) and the Consultation Center at Yale University, to lay the groundwork for what has become a sustained focus on trauma and a statewide trauma-informed system of care. Although the CONCEPT grant has expired, its legacy and lessons continue on.

DCF learned many lessons through the creation and implementation of CONCEPT and through efforts to sustain and integrate it into the development of Connecticut's Behavioral Health Plan for Children, which DCF led following the tragic Sandy Hook Elementary School shooting in Newtown in 2012. The strategies and considerations discussed here hold promise for other child protection agencies interested in systemwide integration of trauma-informed principles.

Generating statewide stakeholder support

DCF's initial approach to developing a trauma-informed system of care was intentionally multi-pronged and integrated into a network of state partnerships. DCF leaders knew they had to gain support from stakeholders both internally (administration and staff) and externally (private providers, schools, and other agencies). A previously established steering committee assessed community readiness and secured community feedback by meeting with and listening to families, faith-based organizations, and grassroots groups across the state. The meetings and feedback helped inform the development of CONCEPT. Four workgroups were established to support rollout and implementation: Screening and Workforce Development; Learning Collaboratives; Policy and Procedures; and Data and Evaluation.

Developing trauma-informed staff at all levels

Due to the diversity and volume of staff and stakeholders that needed to be engaged, cross-training was key. Everyone — commissioners, program managers, providers, constituents, and family advocates — received consistent trauma-informed training. In 2012, DCF began requiring comprehensive trauma training using the National Child Traumatic Stress Network's Child Welfare Trauma Training Toolkit, which is now a pre-service requirement for all new staff. The Child Health and Development Institute established a learning collaborative to bridge gaps and build a common language between DCF and its community partners about trauma-informed care. Designated "trauma champions" provided information to the community through local meetings and communications, and promoted trauma-informed care and activities within DCF offices.

DCF leadership describes the paradigm shift as moving from a "head change" to a "heart change."[2] A turning point in cementing this shift occurred through training staff on the neuroscience of trauma. Participant disclosures occurred in the classroom as staff came to terms with their own personal and secondary trauma. Leadership realized that they had to take care of staff members' emotions that arose both during

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>
> — JODI HILL-LILLY,
> DEPUTY COMMISSIONER OF ADMINISTRATION, CONNECTICUT DCF

training but also in their daily work with children and families. Leaders reviewed and refined the curriculum to incorporate secondary trauma language, created health and wellness teams in all DCF offices, and set up wellness rooms, nutrition groups, and informational speakers. DCF also changed its employee assistance provider to one that was more holistic and proactive in reaching out to staff.

Creating trauma screening and referral procedures

DCF was among the first jurisdictions to begin trauma screening in child welfare. The validated Child Trauma Screen, created by an interdisciplinary workgroup led by the Child Health and Development Institute and Yale, is now utilized to screen all children age 7 and older who are placed into care as part of the agency's "multi-disciplinary evaluation." A second screen for children ages 3 to 6 also has been developed and implemented. In addition, DCF requires trauma screening of all youth receiving court-ordered evaluation, and continues to test strategies for expanding trauma screening to more children involved across the child welfare system.[3] There are trauma-informed screening initiatives in schools, behavioral health settings, and pediatric practices.

After a lengthy review and feedback process, project partners streamlined the screening tool from 60 questions to 10 to increase the likelihood of completion and expand the universe of individuals able to administer the tool. The current tool is structured in an interview format, takes 10 to 20 minutes to administer, has separate child and caregiver versions, and probes trauma history, PTSD, mental health, and substance use. The screening tool is more user-friendly and supports the rapid development of findings that can be used quickly to inform service provision.

The caseworker integrates the child report, caregiver report, and the record review/collateral information, and then enters the information into the Statewide Automated Child Welfare Information System. If appropriate, a standardized mental health referral form is generated using the results of the screening. Staff across all agencies involved in the case have access to the screening results.

IMPACT AND INSTITUTIONALIZATION OF CONCEPT

CONCEPT was developed and designed to be sustainable. Along with specific training and treatment approaches implemented as part of the CONCEPT grant, DCF has incorporated a trauma-informed lens into its mission statement, practices, policies, contracts, and more. These shifts have outlived the CONCEPT grant and continue to evolve as the agency dives deeper into the intersection of racial justice, trauma, and safety science.

During implementation of the CONCEPT grant, DCF:

- Trained more than 9,000 providers and clinicians across many fields on childhood trauma, including the importance of using evidence-based interventions to address trauma symptoms.
- Developed a child-trauma screening tool that can and has been applied across the various sectors and settings that serve children across the state, including child welfare, behavioral health, early childhood programs, education, juvenile justice, and pediatrics.
- Screened trauma symptoms for more than 20,000 children entering care.
- Developed a menu of evidence-based practices to provide effective trauma-informed treatment for children and families.
- Ensured that more than 10,000 children have received evidence-based treatment for trauma, resulting in an 80% reduction in trauma symptoms.
- Adopted a Strengthening Families Practice Model.
- Modified more than 37 different policies and practice guides to better address childhood trauma.
- Hardwired trauma-informed practice into pre-service training for all new employees.
- Adopted a new training curriculum for foster parents: Trauma Informed Partnering for Safety and Permanence — Model Approach to Partnerships in Parenting.

Shifting day-to-day practice

DCF has structured a trauma-informed lens into the day-to-day practice and decision-making of its caseworkers. Whenever a case is open for abuse or neglect in any of DCF's 14 offices across the state, a clinical regional resource team is available to provide consultation to the caseworker. That team is highly skilled and trained in trauma-informed mental health, substance use, and intimate partner violence. Access to this expertise and additional support ensures that workers focus on issues related to trauma as they conduct investigations, make decisions related to removal, and support reunification. DCF Deputy Commissioner Michael Williams emphasized the importance of staff being able to access this resource team throughout their work on every case: "From investigation to case closure, every decision-point should have this lens embedded to ensure we are sensitive to the trauma families have experienced and to make sure we don't inflict more."

Creating a trauma-informed service array

DCF's trauma-informed approach is embedded in its contracted programs, including upstream prevention efforts and various collaborations with the Connecticut State Department of Education. CONCEPT supported training of 30 agencies and more than 600 clinicians to offer Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) and the Child and Family Traumatic Stress Intervention (CFTSI). Project partners, using an implementation science framework, instituted regional, multi-disciplinary learning collaboratives based on a model from the Institute for Healthcare Improvement to disseminate information, increase adoption of trauma-informed processes and therapies, and ensure effective and sustained implementation. The collaboratives, which included practitioners, parents, supervisors, and administrators, helped increase the availability of TF-CBT, embed TF-CBT teams within each agency, and build a sustainable network of providers. Recognizing the importance of a robust service system at various stages of engagement, DCF expanded service options to include: Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems; Cognitive Behavioral Intervention for Trauma in Schools; and Bounce Back.

To track and adjust progress, online surveys collected monthly implementation data from each clinician, and an online scoring system was used to collect child outcome data by each clinician. Evaluators aimed for data collection to be minimal and generated user-friendly reports for staff, which increased data use and helped address initial concerns that the requirements were burdensome. Results revealed a statistically significant improvement in clinicians' attitudes toward evidence-based programs.[4]

Developing trauma-informed policies

DCF leadership developed a policy team, which issued the agency's Trauma-Informed Care Best Practice Guide and applies a trauma and racial justice lens to each agency policy and practice guidance. Instead of inserting routine language, the team reviews each policy and practice, and adjusts content to align with the agency's commitment to trauma-informed care. This process has led to modifications in a multitude of DCF policies and practices to better address childhood trauma, and future ones will undergo the same level of review. For example, policies related to immigrant

> In addition to our service array and day-to-day practice, this is embedded in policy development across the agency. Any proposed new policy, procedure, or protocol is reviewed to ensure that the work we have done to become trauma-informed is reflected.
>
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> DEPUTY COMMISSIONER OF OPERATIONS, CONNECTICUT DCF

children, foster and adoptive services, and transgender youth and caregivers have been revised so that DCF caseworkers consider children's exposure to trauma and how it may affect their current functioning.[5]

Understanding how trauma and racism intersect
In 2020, as DCF was deepening its commitment to racial justice and as trauma became a major focus of clinical practice, the agency began looking more closely at the unique challenges facing children and families in urban settings. This led to efforts to make racial justice an internal commitment and embed it within agency and provider services being offered to families. When agency leadership disaggregated data on the impact of evidence-based practices, there were clear limitations to current interventions that were considered trauma-informed but failed to meet the needs of Black and Latino youth in urban communities. When agency staff talked with young people about those services to try to understand what wasn't working, the youth said they did not feel engaged by or connected to the providers, which often were staffed with white clinicians with life experiences and culture very different from theirs. The youth also expressed a need for opportunities to process not just specific traumatic experiences but the everyday realities of growing up as youth of color in the community.

This led to the launch of the Urban Trauma Initiative, which builds capacity within networks of providers in four urban communities to implement interventions focused on race-based trauma and stress. This work, supported by the Urban Trauma Performance Improvement Center, was launched using American Rescue Act Funding and the Community Mental Health Services Block Grant. The goal is to build enough evidence to eventually make this a Medicaid-reimbursable service. Implementation began in fall 2022.

To learn more, visit Questions from the field at Casey.org.

1 CONCEPT partners included Connecticut Department of Children and Families; Connecticut Center for Effective Practice/Child Health and Development Institute of Connecticut; The Consultation Center at Yale University (evaluators); Yale Child Study Center (CFTSI developer); Dr. Judith Cohen (TF-CBT developer); community providers; family partners; and the National Child Traumatic Stress Network National Center at Duke University.

2 Content of this brief was informed by interviews with Kristina Stevens, Deputy Commissioner, Connecticut Department of Children and Families, and Jodi Hill-Lilly, then-Director of Academy for Workforce Development, Connecticut Department of Children and Families, on April 10, 2018, and a follow-up interview with Michael Williams, Deputy Commissioner of Operations, Connecticut Department of Children and Families, on November 21, 2022.

3 Lang, J., Campbell, K., Vanderploeg, J.(2015). *Advancing Trauma-Informed Systems for Children*. Farmington, CT: Child Health and Development Institute of Connecticut.

4 Connell, C. M., Lang, J. M., Zorba, B., & Stevens, K. (2019). Enhancing Capacity for Trauma-informed Care in Child Welfare: Impact of a Statewide Systems Change Initiative. *American journal of community psychology, 64*(3-4), 467–480.

5 Child Health and Development Institute of Connecticut. (2016). *Building a Trauma-Informed Child Welfare System: Issue Brief #49*.

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