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PART 1



California Child Welfare
Co-Investment Partnership

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Understanding Trauma to Promote Healing in Child Welfare

For child welfare stakeholders, the concept that children and their families come into our systems bearing the burden of traumatic experiences associated with neglect and abuse is not new. What has evolved over the last couple of decades is the science of ACEs (Adverse Childhood Experiences) and understanding of the long-term physical and behavioral health consequences and high societal costs. [A landmark study](#), and the many since that have supported the initial results, have led to a growing consensus on the need for policies and practices to prevent, intervene, and promote healing.

“The child welfare community is dealing with the most acute and severe cases of childhood adversity. It is absolutely critical for us to focus on primary, secondary, and tertiary prevention; raising awareness; two-generation work; and empowering caregivers. We know that early detection and early intervention improve outcomes.”

Nadine Burke Harris, California Surgeon General

“There is an uncoordinated system of care on the state level. Start by looking at California’s healthcare, education, and juvenile justice systems, and the fact that they have a difficult time working together as a coordinated team to deal with childhood trauma. The systems are also significantly underfunded in terms of providing comprehensive programs to address trauma.”

State Senator Jim Beall, District 15

Key Terms

Adverse Childhood Experiences (ACEs):

Adverse Childhood Experiences (ACEs) is the term used to describe all types of abuse, neglect, and other potentially traumatic experiences that occur to people under the age of 18.¹

Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.²

Historical Trauma: Historical trauma is described as collective trauma that is inflicted on a group of people based on their identity or affiliation related to ethnicity, religious background, and nationality. These experiences can be damaging on a physical and/or emotional level for the community, and the trauma can then be transmitted epigenetically to future generations.³

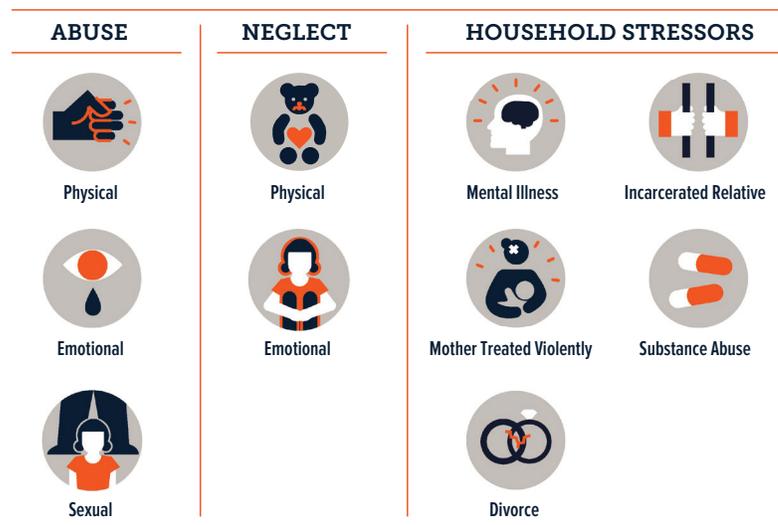
Dose-response: A dose-response relationship is one in which increasing levels of exposure are associated with either an increasing or a decreasing risk of the outcome. Demonstration of a dose-response relationship is considered strong evidence for a causal relationship between the exposure and the outcome.⁴

While adverse childhood experiences are pervasive, the children and families coming into contact with the child welfare system are often those with the most acute, severe, and persistent adverse experiences. Many children and youth not only suffer from neglect and abuse in the home, but are also affected by racism, poverty, and the legacy of **historical, multigenerational trauma**.

What is ACEs science?

ACEs science explores the link between adverse childhood experiences and health outcomes. The concept originated in the landmark [Center for Disease Control / Kaiser Permanente study](#), conducted in San Diego and published in 1998. The study discovered these links by asking adult patients if, as children, they'd had one or more of ten adverse experiences that fell into three types: abuse, neglect, and household stressors.

Adverse Childhood Experiences



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The study found that ACEs, stressful or traumatic events experienced before the age of eighteen years, were found to have a **dose-response** relationship with numerous poor health outcomes as adults, even when controlling for behaviors such as substance use disorder. The physiological phenomenon underlying this is observed in the body's response to adverse experiences, and is known as a stress response, or the "fight or flight" reaction to danger produced [by the surge of adrenaline and cortisol](#). While some amount of stress is normal, severe, sustained, or prolonged exposure to stressors like neglect and abuse can trigger multiple physiological responses in children, which can lead to long-term physical and behavioral changes.

¹ [Centers for Disease Control and Prevention, About Adverse Childhood Experiences](#)

² [Child Welfare Information Gateway, Developing a Trauma Informed Child Welfare System](#)

³ [The New Social Worker, Historical Trauma and Social Work: What You Need To Know](#)

⁴ [Encyclopedia Britannica, Dose-response Relationship](#)

Prolonged activation of the body’s stress response system can lead to **toxic stress**. Exposure to this level of stress can sometimes derail healthy child development.

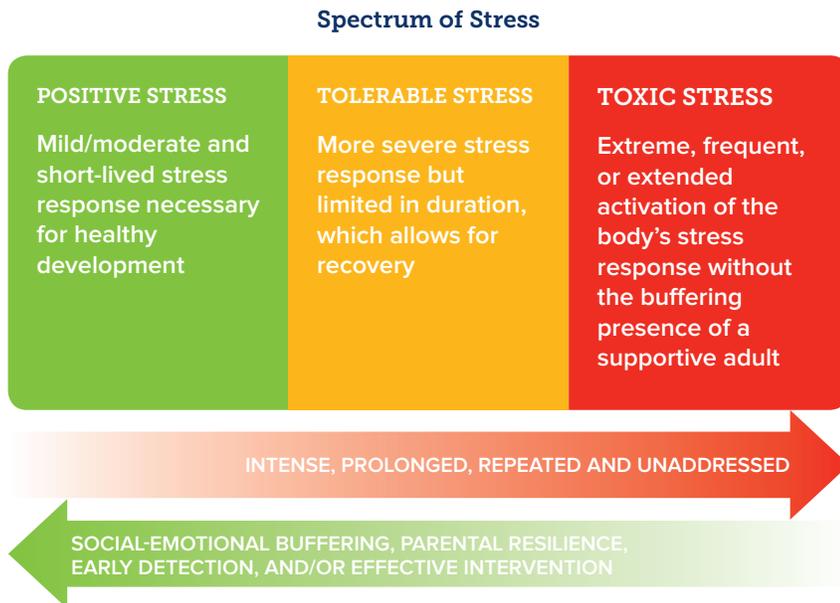
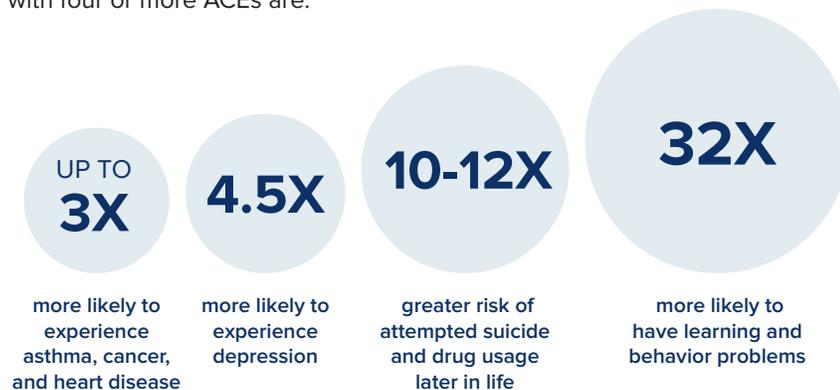


Image Source: Data Report: Hidden Crisis, Center for Youth Wellness (<https://centerforyouthwellness.org/wp-content/themes/cyw/build/img/building-a-movement/hidden-crisis.pdf>)

For example, the CDC / Kaiser Permanente ACEs study showed that children with four or more ACEs are:



Key Terms

Toxic Stress: Toxic stress is a response that can occur when a child or youth experiences strong, frequent, and/or prolonged adversity. In the absence of protective factors, prolonged activation of toxic stress in the body can damage a child’s developing brain.⁵

“Toxic stress comes from traumatic experiences that are longer term than a one-time event and makes a child feel unsafe to the point of going into flight, freeze or fight mode. They are in their survival brain and can’t actually think clearly or perform well in daily tasks, such as those they’re required to do in school. Over time toxic stress can damage their brain’s structure and function, and cause their immune system to become hyper-responsive; this can wear down every system of their body. Child welfare and other systems may not be aware or involved in this cycle because some children don’t act out, they may go quiet and turn inward, and sometimes that’s even more dangerous.”

Jane Stevens, Founder and Publisher of ACEs Connection

⁵ Center on the Developing Child, Toxic Stress

Key Terms

Neuroplasticity: The brain's ability to rewire itself in response to stimuli, and to compensate for damage by reorganizing and forming new connections between intact neurons.⁶

Resilience: The ability of a child to return to their baseline state after a traumatic experience, and therefore not live in a perpetual state of stress response.⁷

Trauma-informed: An organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma-informed care also emphasizes physical, psychological, and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.⁸

ACEs science is about increased likelihood but not inevitability of adverse outcomes

The pernicious effects of prolonged stress are further noted in this [2018 journal article](#) on the development and implementation of a pediatric adverse childhood experiences questionnaire, which reported on the pilot study conducted by the Center for Youth Wellness (CYW), the University of California San Francisco (UCSF), and UCSF Benioff Children's Hospital Oakland (BCHO) Center for Youth Wellness. Per this review, the effects include impairment of executive functioning, changes to the endocrine and immune systems and to genetic regulatory mechanisms, increased risky behaviors, and difficulty with forming healthy relationships. Furthermore, the analysis of various research reports also showed that ACEs have been associated with learning difficulties, Attention Deficit Hyperactive Disorder (ADHD), sleep disturbance, autism, being overweight or obese, exhibiting violent behavior (delinquent behavior, bullying, physical fighting, dating violence, weapon-carrying), and suicide-related behaviors.

The **neuroplasticity** of the brain during early childhood and adolescence makes it particularly vulnerable to adversities. However, this trait also makes this an optimal time for prevention and intervention, to mitigate trauma and promote **resilience**. While the science of adverse childhood experiences can seem highly predictive, intervening with **trauma-informed** care and surrounding a child with protective factors like a stable and caring adult, physical activity, mentoring, and a healthy environment, can mitigate the effects of trauma and help them form new pathways in the brain that do not activate the stress response. For this reason, a trauma-informed approach that promotes resilience and mitigates trauma should be a primary focus of the child welfare system.

In the most basic reframing, instead of asking, "What's wrong with you?"; a more sensitive question would be "What happened to you?". And according to Dr. Bruce Perry, Senior Fellow at The Child Trauma Academy, as the understanding of ACEs increases, it will be important to push past the simple question, "What happened to you?" and ask, "When did it happen?"; "Who was there to help?"; "Who has been there for you since?"; and "Is it still happening?"

Beyond this essential adjustment in interactions with youth and families, there are a variety of policies and practices to help child-and-family-serving systems ensure that their staff are knowledgeable about the signs and responses to trauma (trauma informed), and that the people served feel safe and understood when interacting within the system (trauma sensitive). This level of system-wide commitment minimizes triggering the stresses of adverse experiences and promotes healing. There are also many well supported (some evidence-based) nonclinical interventions including meditation, exercise, and extracurricular activities, as well as age- and culturally appropriate clinical therapeutic approaches that can help promote healing from the effects of toxic stress.

⁶ Nadine Burke-Harris, *The Deepest Well* (New York: Houghton Mifflin Harcourt, 2018), 146.

⁷ Center on the Developing Child, Harvard University, *Resilience*

⁸ The Trauma Informed Care Project, *What is TIC?*

National data

Since the original ACEs study was published in 1998, thirty-nine states and the District of Columbia have collected ACE data, showing that between 55 and 62% of the population have experienced at least one ACE, ten percent have experienced three or more, and between 13 and 17% have an **ACE score** of four or more. In addition, well over half of black children and 51% of Latino children experience one or more ACEs compared with 40% of white children. Data also suggest that LGBTQ and other marginalized populations may experience disproportionately higher incidences of ACEs and are more likely to lack supports, such as strong schools, that can help [mitigate the impact of ACEs](#).

California data

In its report, [Hidden Crisis](#), the Center for Youth Wellness (CYW) reported adults' responses about their childhood experiences and found that ACEs affect every community in California. In some counties, over 75% of residents have at least one ACE. Even in counties with the lowest prevalence of ACEs, one out of every two residents, or 50%, has one or more adverse experiences in childhood. Moreover, rural counties such as Butte, Humboldt, and Mendocino report the highest incidence of individuals with four or more ACEs (over 30%). The CYW estimates that in California, a person with four or more ACEs is nearly thirteen times as likely as a person with no ACEs to have been removed from their home as a child. However, ACE scores seem to be equally distributed across race and ethnicity, as demonstrated by the pie charts below. Therefore, the ACEs data need to be further disaggregated, and other factors need to be explored, to explain the significant over-representation of African American children in California's child welfare system.

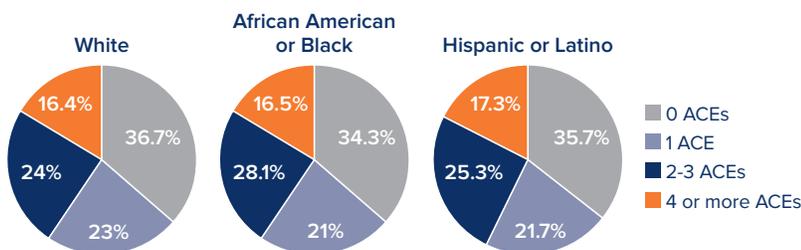
Key Terms

ACE Score: The total sum of the different categories of ACEs reported by participants.⁹

“We know all children in California’s child welfare system have at least two ACEs because they were removed for neglect or abuse, and the act of separation from your family is itself a traumatic experience. Although we may not have the data yet, I am confident that most of our youth have closer to four to five ACEs.”

Frank Mecca, Executive Director, CWDA

Prevalence of ACEs Within Racial/Ethnic Groups in California



Additionally, Kidsdata.org has compiled statewide and legislative district level estimates of [childhood adversity](#) based on caregiver reports using 2016 data. On average, an estimated 16.4% of California children have two or more ACEs, ranging from 13.3% in San Francisco County to 18.1% in Tulare County. The data are limited to forty counties.

⁹ Centers for Disease Control and Prevention, [About the CDC-Kaiser ACE Study](#)

Key Terms

Trauma Screening: Trauma screening refers to a brief and focused tool or process to determine whether an individual has experienced one or more traumatic events, has had reactions to such events, has specific mental or behavioral health needs, and/or needs a referral for a comprehensive trauma-informed mental health assessment.¹⁰

EPSDT: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.¹¹

“ We are excited about PEARLS as a means of identifying kids early for trauma, but when we administer the screen we do not just see them through their adversity. We ask the family about their ‘joy’ – and we document where they found their joy. Then we ask families to prioritize their concerns so we can intervene and connect them with community resources.”

Dayna Long, MD, Medical Director, Center for Community Health and Engagement, UCSF Benioff Children’s Hospital

More Data on the Horizon: Medi-Cal Screening for Trauma Exposure

Assembly Bill 340, passed in 2017, created a statewide advisory group to recommend tools and protocols for **screening** children for trauma as required by the **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** benefit, and in 2019 the group recommended to the Department of Health Care Services (DHCS) that Medi-Cal providers be given the following three options for screening children and youth for exposure to trauma:

1. Use the Pediatric ACEs and Related Life-events Screener (PEARLS) along with the existing Staying Healthy Assessment (SHA), Bright Futures, or another approved Individual Health Education Behavioral Assessment (IHEBA).
2. Use the Whole-Child Assessment, another state-approved IHEBA self-report tool, that screens for exposure to trauma along with the state-required elements of the SHA.
3. Request approval from DHCS to use an alternative tool to screen for trauma that includes, at a minimum, all of the items contained in the PEARLS.

The legislature has approved to add \$45 million to reimburse providers who are conducting the ACEs screens. Also approved is \$60 million over the next three years to train providers to effectively conduct trauma screening protocols.

About PEARLS

This recommended screening tool was developed by the Bay Area Research Consortium on Toxic Stress and Health (BARC), a partnership between the Center for Youth Wellness, UCSF Benioff Children’s Oakland, and the Adversity Bio-Core (ABC) Bank at the UCSF School of Medicine and Pharmacy. The tool is designed to identify exposure to childhood adversity and events that may increase a child’s risk for toxic stress and negative health outcomes. The tool has many significant additional questions to the original ACEs screening, notably that the original ACE item of parental incarceration was broadened to cover additional forms of separation from the caregiver and include examples such as foster care, immigration, and death of the caregiver.

The PEARLS is currently being evaluated to see how both implementation and scoring would be managed prior to the state adoption.

¹⁰ [The National Child Traumatic Stress Network, Screening and Assessment](#)

¹¹ [Medicaid.gov, Early and Periodic Screening, Diagnostic, and Treatment](#)

Once we screen, then what?

Following the trauma screening and “scoring” to determine the extent of trauma exposure, policies and processes are required to determine whether the youth may need a more comprehensive assessment to identify specific needs and strengths and inform a plan for intervention if indicated.

Dr. Dayna Long, who helped lead efforts to develop PEARLS, emphasizes the importance of having protocols to ensure: 1) that everyone knows what is being done for the child and family after the screening, 2) that there is an assessment after the screening is completed, and 3) that there is follow-up if the **assessment** identifies that additional caregiver supports are needed.

In 2018, California mandated that the Department of Social Services and Department of Health Care Services implement evidence-based assessment tools with all children and youth. Both departments identified the Child and Adolescent Needs Survey (CANS), which measures strengths and needs across six life domains, including social-emotional well-being.

Once assessed, children and families should then be linked to appropriate clinical and non clinical services. One important funding support to address needs is the EPSDT benefit, which is a broad entitlement intended to ensure that children and families receive appropriate preventive, mental health, and developmental services. Nearly six million of California’s children are eligible for this benefit, many of whom are living in poverty and potentially impacted by adverse experiences.

Key Terms

Trauma Assessment:

A comprehensive tool or process that includes a clinical interview and behavioral observations designed to gather an in-depth understanding of the nature, timing, and severity of the traumatic events, the effects of those events, current trauma-related symptoms, and any functional impairment.¹²

“**Screening for trauma exposure vs. trauma symptoms is an important distinction. Providing timely services and supports after exposure is to prevent the high likelihood of diagnosable mental illness in the future. The supports and services provided would be different for those just having experienced exposure with no symptoms vs. already showing symptoms.**”

Lynn Thull, Consultant for Mental Health Policy and Practice Improvement, California Alliance of Child and Family Services

“**I believe it’s unethical not to consider trauma as a piece of diagnosing a child. Trauma should be the first piece that’s evaluated: not only for the child, but for the bio parent. We also need to address the trauma that resource parents begin to feel by working with children in this field.**”

Dianna Wagner, Children’s Services Director, Shasta County Health and Human Services Agency

¹² [The National Child Traumatic Stress Network, Screening and Assessment](#)

Facts & Findings



A substantial amount of the trauma experienced by children and youth occurs not only before entering care, but during their time in the dependency system, as well as after they leave care. There are many policies and practices in our system that affect relationships—whether that’s with bio parents, caregivers, friends, community members—that we can address to mitigate and prevent this additional trauma.”

Jennifer Rodriguez, Executive Director, Youth Law Center



You’re already profiling me as a troubled kid and then I’m going to get arrested or I’m going to become that statistic where you’re not caring about my education when you should be worried about what’s going on in my household for me to be that way. And supporting me through that.”

Young person describing being profiled at an early age because of her family background & the neighborhood she grew up in. From “[A Radical Model for Decriminalization](#),” [Young Women’s Freedom Center](#)

In March 2019, Safe & Sound released an [extensive study](#) on the impact of child maltreatment on California’s children, families, communities, and economy. Mapping directly to the primary sources of trauma, the report defined maltreatment as physical, sexual, and emotional abuse, and neglect. The report found that in 2017 nearly 500,000 California children were involved in reports or allegations of child maltreatment, with just over 70,000 substantiated.

All communities have their own factors that could affect the prevalence of child maltreatment, including economic-related indicators such as access to jobs, housing, and services; as well as factors including level of violence, community isolation, and frequency and intensity of natural disasters. California’s widening socioeconomic gap, growing rates of homelessness, sizable immigrant population, and heightened environmental issues are increasing the risk of child maltreatment and the potential trauma for our children and families.



Disproportionate and disparate outcomes in child welfare are a reality that we have grappled with for many years. It is critical that we collectively own the responsibility to both understand and address the root causes of these outcomes, particularly as they relate to both historical and generational trauma, and trauma which is directly connected to present-day racism, discrimination, and/or cultural bias.”

Jackie Contreras, Ph.D., Managing Director, Child and Family Services, Casey Family Programs

Prevention, Interventions, and Creating Healing Systems

The best approach to mitigating toxic stress and subsequent negative health outcomes associated with ACEs is one that prevents traumatic experiences and builds resilience and **protective factors**. This includes those associated with poverty (e.g., food insecurity, housing instability) as well as the adverse experiences for children associated with parental substance use, mental illness, violent relationships, etc. While the science shows that supportive, responsive relationships with a parent or caregiver can also help to buffer a child from the effects of these adverse experiences, helping children and adults build their core life skills—such as planning, focus, and self-control—can strengthen the building blocks of resilience when coupled with basic supports (e.g., housing, living wage work, etc.).

The Center for the Study of Social Policy, as part of its Strengthening Families approach, has developed the [Protective Factors Framework](#) as a set of strengths-based ideas that promote healthy outcomes for families and children. The Framework outlines five protective factors that healthy families share (see below). An important part of prevention is creating culturally appropriate, stigma-free, low-cost community services that enable families to reach out for help to build their knowledge and resources.

- Children’s social and emotional competence
- Parent knowledge of parenting and child development
- Parent resilience
- Families’ social connections
- Families’ concrete supports

The [Strong Start Index](#), launched in February 2019, uses a set of twelve indicators collected at birth from every child in California to map the level of resources that promote resilience for children in a given neighborhood, county, or region. The Index currently uses data from 2016, when a total of almost 500,000 babies born showed an average Strong Start score of 8.8 out of 12, and nearly 20% of babies were below the average score. The [interactive map](#) enables a closer look into the neighborhoods where lower Strong Start scores often indicate a need for greater supports to bolster family resilience and well-being.

Key Terms

Protective Factors: Biological, environmental, and psychological factors that predispose children to positive outcomes in the face of significant adversity.¹³

“Think of immunizations as an analogy to trauma interventions—a preemptive action that is not waiting for an illness. The question is what would that intervention in a trauma response look like to keep someone from experiencing a full-blown illness?”

Kim Lewis, Managing Attorney, National Health Law Program

“Instead of focusing on risk, we flipped the ACEs narrative to develop the Strong Start Index, which measures all the different strengths and assets that a child is born with. It’s not meant to be used on individuals, but to figure out communities that could use funding and targeted prevention services.”

Emily Putnam-Hornstein, Ph.D., Director, Children’s Data Network

¹³ Center on the Developing Child, Harvard University, [Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience](#)

“Using the Strong Start Index, we can use recent, family-level data to understand which neighborhoods need additional resources so we can ensure babies and young children get the services and informal supports they need during this critical time in their development.”

Moira Kenney, Executive Director, First 5 Association of California

“We want to give communities tools to move forward with building protective factors because maltreatment and trauma are not just individual issues, they are community issues. Protective factors can be supporting schools, parks, and family resource centers; workforce policies and parental leave; and social connections.”

Katie Albright, CEO, Safe & Sound

For families with younger children at critical developmental stages, specifically prenatal through the first two to three years of life, proactive initiatives like home visitation programs have incredible promise for the prevention or mitigation of ACEs. These promising programs are not yet widely disseminated, but are receiving growing attention based on the positive outcomes produced. Additionally, there now exist several evidence-based, effective clinical treatments to intervene with children who have experienced trauma and adversity, including Trauma Focused Cognitive-Behavioral Therapy and Parent-Child Interactive Therapy. Each of these programs includes attention to parenting skills and works on establishing behaviors that promote resilience in the child and parent.¹⁴

Policy and Practice Interventions: The heightened attention on screening for adverse childhood experiences and assessing for toxic stress presents an opportunity as well as challenges to adopt the most promising policies and practices. The good news is that many new policies in child welfare, including Continuum of Care Reform (CCR), the Core Practice Model, and child and family teaming, acknowledge as well as include practices that are intended to mitigate the effects of adverse childhood experiences by providing more control for the child and family as well as increasing placement stability and promoting permanency. That noted, there remains the ongoing challenge of implementation and developing both clinical and nonclinical responses that do not define children and families by their adverse experiences, but instead build their resiliency and promote healing.

Figuring out effective ways to heal trauma often only requires looking at how non-system involved children and youth thrive. We know that strong families and supportive communities are foundational and that being engaged in a variety of activities can build lifelong skills, confidence, and resilience. Giving youth in care access to extracurricular activities such as sports, clubs, music, art, dance, and summer camp allows them to develop their strengths and ambitions. A recent policy brief, [Closing the Extracurriculars Gap](#), from Youth Law Center makes the strong case that these activities not only surround children with a supportive network of positive adult role models, but they also teach teamwork, enable youth to uncover hidden talents, and provide the healing endorphins that can help rewire the negative impact of trauma.

¹⁴ [Adverse Childhood Experiences and the Lifelong Consequences of Trauma, American Academy of Pediatrics 2014](#)

Creating Healing Systems: The child welfare system has a significant and central role in ensuring the safety and well-being of children and families that come to the attention of child welfare. That noted, they share this responsibility with many other systems, including the judiciary, behavioral and physical health, education, and provider agencies. For each of these systems, it's essential that the workforce is both trauma informed and trauma sensitive. And beyond the workforce, each of the systems should evolve from what is often trauma-inducing to becoming a vehicle for healing.

Many advocates and practitioners are also working toward responses that **move beyond “What happened to you?” to “What’s right with you?”** and view those exposed to trauma as agents in the creation of their own well-being. Healing Centered Engagement (HCE) comes from the idea that people are not harmed in a vacuum, and well-being comes from participating in transforming the root causes of the harm within institutions. HCE also advances the move to “strengths-based” care and away from the deficit-based mental health models that drive therapeutic interventions.

Healing centered engagement is:

- Explicitly political, rather than clinical. Communities and individuals who experience trauma are agents in restoring their own well-being.
- Culturally grounded, and views healing as the restoration of identity. Healing is experienced collectively, and is shaped by shared identity such as race, gender, or sexual orientation.
- Asset driven and focuses on well-being we want, rather than symptoms we want to suppress. An asset-driven strategy acknowledges that young people are much more than the worst thing that happened to them, and builds upon their experiences, knowledge, skills, and curiosity as positive traits to be enhanced.
- Supports adult providers with their own healing. It's an ongoing process that we all need, not just young people who experience trauma.

Secondary Trauma of the Child Welfare Workforce

In addition to being trauma informed, child welfare workers need to address their own trauma. In a prior [issue of insights](#) we described the role of the child welfare workforce, and the intensity and often trauma-inducing nature of their work. Recent research has also documented secondary traumatic stress (STS), which is the result of exposure to others' experiences. Given the nature of their caseloads, child welfare workers are particularly vulnerable. Left untreated, STS can lead to decreased effectiveness and high rates of burnout and turnover, which can also interfere with the ability to be “trauma sensitive” with the children and families they are trying to support.

“ I don't know if we can heal trauma; we have to empower people to do that. We can create an environment that is not punitive, that supports wellness, and that doesn't make people go to five different places in a week to get the services they need. We can make it easier for them to survive in the world.”

Judge Katherine Lucero, Superior Court of Santa Clara County

“ We must work to prevent our workforce from feeling inadequate and hopeless given the lack of control we have over the situations we face, which is why we need a work environment that values and promotes safety and well-being so we can provide the same for the children and families we serve.”

Melissa Lloyd, Deputy Director, Sacramento County Child Protective Services

Thoughts on Healing for Our Children and Youth

“Our California students spend a good majority of their waking hours at our public schools. It is because of this that our schools have to provide more than a quality education. We have to be a provider of support and resources that will help prevent, intervene, and mitigate the effects of trauma, and we have to coordinate our efforts with child welfare agencies to better support our most vulnerable students.”

Tony Thurmond, California State Superintendent of Public Instruction

“The greatest impact is that trauma destroys relationships between individuals, within families, in communities, in organizations and within delivery systems, which happens proportionately and in relation to sociocultural, historical and structural inequities. The secret sauce to healing trauma is through supporting and nurturing healing relationships at all of these levels. Foster Care must then be inundated with healing practices to counteract the insidious and ubiquitous effects of compounding family trauma.”

Ken Epstein, Leadership Coach, Trauma Transformed

“The workforce is clearly impacted by secondary trauma. This is heartbreaking work—separating families, struggling to reunify them, seeing the trauma before they came into care and the trauma of being in care.”

Diana Boyer, Director of Policy for Child Welfare and Older Adult Services, CWDA

“Just knowing the ACEs scores does not address the problem. If we are not trained, prepared, and funded to utilize the data in a new, effective way, then we have not served the public. We can re-traumatize even more if we don't have an informed approach. Yes, data is important, but before anything different is done, counties need to develop, re-shift, and refund access/services. Judicial officers in particular need to be not just mindful but educated on what trauma means from a clinical standpoint, so that as they face each child and family unit they can understand their reactions.”

Judge Stacy Boulware Eurie, Superior Court of Sacramento County

“Our young people grow up in atmospheric trauma and come to us as a space of atmospheric healing. I want to emphasize that change has to happen with the system, not the individual, the scrutiny has to be on the system. That is the obligation and the opportunity of being trauma informed.”

Kanwarpal Dhaliwal, Associate Director and Co-founder, RYSE Center

“Love, healing, and restoration should be in the law and in the words of government. I call it Institutional Nurturing. It needs to have a human design.”

Macheo Payne, Ed.D., MSW

In recent years there have been many statewide [campaigns](#) as well as community-level efforts to raise awareness of the impact of childhood adversity; promote policies and practices for prevention, early identification, access to interventions, and training to develop a trauma-informed workforce; and initiatives to develop trauma-informed systems. What follows are some specific child welfare focused recommendations:

1. Ensure screening leads to appropriate assessment and interventions. Following a screen for trauma and an assessment for needs and strengths, the child welfare worker and system partners must work with the child and family to develop an age and culturally appropriate plan of services and supports that may include both clinical and nonclinical interventions. Child welfare workers should also explore strategies to assess all children in the foster care system to promote broader access and timeliness to services.

2. Increase access to, and engagement with, behavioral health services under EPSDT. EPSDT is a broad federal entitlement that supports a variety of early intervention services that could help ameliorate trauma. We need to work with behavioral health to align California's EPSDT benefits and services to the intent of the federal law to also include prevention services and supports for children and their families.

“An essential policy objective moving forward is to develop a direct and specific definition of adversity as an EPSDT qualification. Right now you must meet one of seventeen pathological criteria, so we need to expand the definition of medical necessity and see adversity as a qualifying event, and to qualify nonclinical implementation and strategies.”

Alex Briscoe, Principal, California Children's Trust

“We need more guidance from the state about the breadth of the entitlement with EPSDT, as well as a “decision tree” to be more systematic about the type and duration of services required. Otherwise, every county will continue to do their own thing and statewide tracking of what works will be challenging.”

Karen Larsen, Director of HHSA, Yolo County

“The current EPSDT entitlement is not being met by the systems today. We need to make sure that children entitled today get the services that are medically necessary. Broaden it for sure, but make sure that what we are doing today is following the laws.”

Christine Stoner-Mertz, Executive Director, California Alliance of Child and Family Services



Ninety percent of the people we serve come to Family Resource Centers (FRCs) with no court mandate for services. Services are voluntary. FRCs are intentionally created to reduce the stigma of asking for help – they are warm, engaging, and culturally-responsive places built into neighborhoods and communities where everyone feels welcome and can find compassion, comfort, and safety.”

Katie Albright, CEO, Safe & Sound

3. Invest in primary prevention programs to support families and build resiliency.

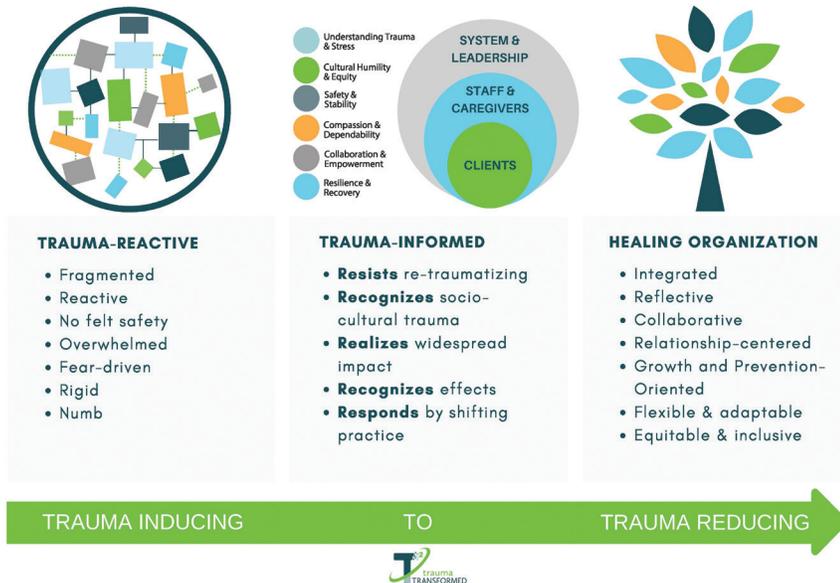
Given the inadequacy of current federal and state funding to support primary-prevention programs, additional investment opportunities are needed to expand many promising efforts in counties and effective local programs such as Family Resource Centers and [Kinship Support Services](#) Programs. [The California Family Resource Association](#) is working with 350+ FRCs across California to establish a unifying definition of FRCs to elevate their work and pave the way for increased state and local government support.

Home Visiting Programs are also a promising prevention tool to support high-risk families. In January 2019, AB 1811 appropriated funding for the CalWORKS Home Visiting Initiative (HVI), which will provide an opportunity to demonstrate the impact of home visiting services with these qualifying families. Additional funding has also been added in this year’s budget for non-CalWORKS, low-income populations to receive HVI services. Looking forward, it will be important to track the impact and connect this prevention service to the state’s efforts to trauma screening and the prevention of child welfare involvement.

4. Implement a performance-based outcome system for behavioral health services.

Healing the children and families who are served by child welfare agencies requires a coordinated effort between the child welfare system and the behavioral health system, including shared outcomes towards improving the health and well-being of those who are served by both systems. However, the behavioral health system currently lacks a transparent, data-informed, outcomes-driven process that identifies strengths and areas of needed improvement.

5. Ensure that child welfare policies and practices are both trauma informed and trauma sensitive in order to become healing organizations, versus trauma inducing systems. This includes providing trauma-informed training as well as support for post-secondary trauma for the child welfare workforce, and trauma training for caregivers and other systems partners (courts, especially delinquency courts supervising probation kids, attorneys, etc.).



“Child welfare workers are experiencing increasing stressors similar to children in the system and losing the ability and time to form relationships with children in foster care that can enhance resilience for both the child and the child welfare workers. The over-focus on compliance and regulatory activities at the expense of developing relationships with children in care hurts both children and child welfare workers.”

Jen Leland, Center Director, Trauma Transformed

The following are websites with studies, briefs and other resources which were referenced in our research for this issue.

ACEs Too High	Harvard University, Center on the Developing Child
American Academy of Pediatrics, the Resilience Project	Prevention Institute, Adverse Community Experiences and Resilience
Centers for Disease Control and Prevention: Violence Prevention: Adverse Childhood Experiences	SAMHSA - National Child Traumatic Stress Initiative
Center for Youth Wellness	The National Child Traumatic Stress Network
Children's Data Network	Traumatic Stress Institute
ChildTrauma Academy	Trauma Transformed
Developing a Trauma-Informed Child Welfare System	University of Kentucky, Center on Trauma and Children
Genentech: The Resilience Effect	We Can Prevent ACeS, Centers for Disease Control and Prevention



California Child Welfare Co-Investment Partnership

The California Child Welfare Co-Investment Partnership is a collaboration of private and public organizations working to improve outcomes in the child welfare system. The Partnership comprises five philanthropic organizations (Casey Family Programs, Conrad N. Hilton Foundation, Reissa Foundation, Walter S. Johnson Foundation, and Zellerbach Family Foundation) and the California Department of Social Services, the Judicial Council of California's Center for Families, Children & the Courts, and County Welfare Directors Association. *insights* is an ongoing publication of the Partnership that examines the links between data, policy, and outcomes for our state's most vulnerable children and families. Download previous editions of *insights* and find out more about the Partnership at co-invest.org.

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