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Conceptualizing a Trauma Informed Child Welfare System for Indian Country

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Conceptualizing a Trauma Informed Child Welfare System for Indian Country

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Child welfare professionals and their systems are charged with the prevention and treatment of child abuse and neglect. Abuse and neglect amount to traumatic experiences for children, youth, parents, and entire family systems. Especially where children and youth are concerned, the adverse childhood experiences associated with traumatic abuse and neglect may have long term effects that linger and reappear during adulthood. In fact, parents who have histories of adverse childhood experiences are at risk of victimizing their own children, contributing to inter-generational patterns of abuse, neglect, and sometimes complex trauma syndromes (Anda, Butchart, Felitti, & Brown, 2010)

Like the tentacles on a giant octopus, trauma's impacts extend further. Mounting evidence indicates that children's trauma is instrumental in the development of child welfare professionals' secondary traumatic stress (STS). No matter how thorough the training provided to these professionals and despite their efforts to maintain "professional distance," horrifying child abuse and neglect frequently exacts the mental health toll known as STS. When STS festers and grows in child welfare systems, (i.e., it remains undetected and untreated) a tragic situation is in evidence. Child welfare professionals are untreated victims, and their mental health needs reduce and impair their ability to help and support abused and neglected children. When these conditions prevail, STS is a prime suspect for undesirable, preventable workforce turnover, which erodes the effectiveness of entire systems (Caringi et al., 2013).

This emergent pattern involving the trauma accompanying child abuse and neglect, together with child welfare professionals' STS, indicates needs for three kinds of interventions. In no particular order, they are: (1) Research-supported interventions for children and youth—and in some instances their parents and family systems; (2) Research-supported STS interventions for the child welfare workforce; and (3) Systems interventions that build the capacity of child welfare and sister systems (education, mental health, juvenile justice, health) to systematically and collaboratively detect and address children's trauma as well as STS in the workforce.

A trauma-focused, early detection and rapid response system is a centerpiece in such a systems design, and not merely in child welfare. This new detection and response centerpiece must be manifest in each system (e.g., the child welfare system, the juvenile justice system), but also must connect multiple public sector systems. This is complex systems change on a grand scale and it depends on solid partnerships, which facilitate strong effective, sustainable interprofessional collaboration

involving social workers, psychologists, nurses and physicians, educators, and juvenile justice specialists.

Although elements of such a system are in place or ready to be implemented in a growing number of Native American and American Indian communities, comprehensive trauma-informed systems remain works in progress. Moreover, the work that lies ahead is not merely an implementation challenge. This work entails new organizational and institutional designs, and it depends on design-oriented architectures and leadership for their progressive improvement. As with all innovative designs, organizations need to be selectively restructured, and their workforces need to be reconfigured. What is more, workers at all levels must adapt their performances—strategically, coherently, and synergistically as new designs are implemented and tested (Baard et al., 2014).

Perhaps above all, this design work is context-dependent. In other words, place matters, and so do the characteristics of the populations needing to be served alongside the ecologies of child welfare organizations and their community partners. Nowhere are these several particularities more evident than in Indian Country.

The ensuing analysis provides introductory details and a special focus on the design and development of trauma-informed systems in Indian Country. Because place matters (in this case, often-isolated and under-resourced reservation communities) and so do the people needing to be served (American Indian and Alaska Native children), trauma-informed systems for these special people in their somewhat unique locales must prioritize a fourth kind of intervention. Indigenous healing practices with hundreds of years of tradition must be prioritized and incorporated as facilitators for culturally-competent practice and also as safeguards against colonialism (Gray, Coates, Yellow Bird, & Hetherington, 2013). The analysis begins with the context of the child welfare system and a special focus on trauma in Indian Country and the child welfare systems structured to address and prevent it.

Abuse, Neglect, and Trauma: Adverse Childhood Experiences Research

Childhood experiences involving abuse, neglect, domestic violence, out-of-home placement, and homelessness produce chronic traumatic stress. Undesirable short and long-term consequences result, as documented by the Adverse Childhood Experiences research (Anda et al., 2010). Unidentified and untreated trauma has deleterious effects on children's health, school performance, and contact with the justice system. These

developmental barriers foreshadow multiple problems during adulthood, and they are implicated in inter-generational transmission. The economic costs are staggering, and the social consequences are intolerable.

Although every system providing behavioral and mental health services needs to identify and treat children's trauma, the child welfare system, by virtue of its missions, functions, clientele, and resources, must have lead responsibility of systems change. Unfortunately, trauma-informed policies and evidence-based trauma treatments are rare in child welfare systems throughout the United States.

Zooming in: American Indian and Alaskan Native Children in Child Welfare Systems

American Indian and Alaska Native children are disproportionately represented in child welfare systems. They are profoundly impacted by the consequences of historical trauma and are victimized by community and intra-familial violence at much higher rates than their non-native peers. They also face longer adoption times and permanency challenges more any other group. In brief, these children are disproportionately represented, and they are adversely impacted by multiple disparities.

These disparities are certainly shaped by history and the dire social and economic factors present in reservation communities. However, they are also caused and exacerbated by gaps in the service delivery system such as the notable lack of both trauma-informed providers and trauma focused interventions that are culturally appropriate and realistic for use in Indian Country. The disparities are also deepened by unattended issues such as high levels of secondary traumatic stress (STS), especially in tribal Child Protective Services (CPS) workers who typically are among the first responders to reported and documented abuse and neglect. In brief, the transformation of Indian child welfare systems begins with CPS systems and workers.

The Problem in Indian Country

The relevant research demonstrates the need for this transformation in Indian Country. The National Indian Child Welfare Association (NICWA, 2007) reports American Indian/Alaska Native (AI/AN) or "Indian" (for brevity) children are overrepresented in foster care systems. For example, Indian children constitute 52% of South Dakota's child welfare system caseload but only 15% of the population (Administration for Children and Families, 2005), with similar levels of disproportionality in Alaska (51% vs. 20%), Montana (33% vs. 10%), and North Dakota (26% vs. 9%), Indian

children wait for adoption at a level of some 400% longer than non-Indians (Horne, Travis, Miller & Simmons, 2009).

Mental health and child welfare professionals typically report near-epidemic levels of “frequent mental distress” (Zahran et al., 2004) contributing to mood disorders, substance abuse, violence, trauma, and suicide (Olson & Wahab, 2006). A terrible trilogy formed by poverty, historical trauma, and social isolation is implicated as both a cause and a result of vicious cycles involving trauma-inducing child maltreatment, family and community violence, and pervasive unemployment (Yellow Horse Brave Heart, 2003). American Indian (AI) children are twice as likely as their non-Indian peers to be victims of violent crime with corresponding increases in trauma prevalence (Deters, Novins, Fickenscher, & Beals, 2006). Indian children have one of the highest reported rates of intra-familial victimization (15.5 per 1,000) among all ethnic groups in the nation.

Stunningly, these data undoubtedly underrepresent the actual prevalence due to divergent cultural perspectives on what constitutes maltreatment, confusion regarding mandated reporting, archaic data collection systems and stigma. For example, Earle and Cross (2001) assert that 40% of AI/AN child maltreatment cases are not reported. Furthermore, the very systems designed to protect native children are themselves compromised by: the eroding forces of resource limitations, high staff turnover, few opportunities for professional development and self-care, confusing regulations, secondary traumatic stress (STS), and burnout.

Notwithstanding these formidable challenges, AI/AN are able to build on the strengths of their communities in culturally competent ways. Indeed, diverse tribal systems typically demonstrate resilience and have the potential for transformation so they are identical in one important respect. All Child Protective Services (CPS) can, and need to, become trauma-informed systems in which evidence-based, trauma-focused practice with children and families becomes “the new normal.”

Unique Features and Constraints

In contrast to some child welfare systems, Indian child welfare systems must be dovetailed with two other systems. The policy system is the Bureau of Indian Affairs (BIA). The service delivery system is Indian Health Services (IHS) and, in some communities, schools.

The federal policy context also is important. AI/AN tribes and the United States have a unique relationship known as the *doctrine of trust responsibility*. The federal government is required to “provide necessary

economic and social programs to tribes in order to raise the standard of living and social well-being of Indian people to a level comparable to the non-Indian society” (Pevar, 2004). The U.S. Department of Interior, houses the Bureau of Indian Affairs (BIA) and is charged to “provide services (law enforcement, education, human services) directly or through contracts, grants, or compacts to tribes,” BIA serves nearly two million Indian people (www.bia.gov). Our initiative represents one vehicle through which this trust responsibility can be fulfilled.

Indian child welfare systems are complex in other important ways. Relevant legislation includes the Indian Self Determination and Education Assistance Act of 1975 (P.L. 93-638) and Indian Child Welfare Act (ICWA) (P.L. 95-608). ICWA was enacted by Congress in 1978 to preserve tribal culture and address disproportionality issues. At that time, Indian children were 13 times as likely to be in foster care as non-Indian children – irrespective of the actual incidence of maltreatment.

One of ICWA’s original purposes was “to protect the best interests of Indian children by promoting the stability and security of Indian tribes and families.” Under ICWA, tribal courts have exclusive jurisdiction over Indian children living on an Indian reservation. Tribal courts and state courts have shared jurisdiction of an Indian child living off the reservation. Per ICWA, all courts must give preference in placement of an Indian child in a foster or adoptive home first to the child’s extended Indian family, next a family from the tribe of the child, or finally to an Indian family of another tribe before placing the child in home with non-Indian foster or adoptive parents. Across reservations nationally, Tribal CPS operate under the auspices of BIA, but may be implemented by tribes, the state, BIA, or some combination.

Interprofessional Collaboration for a Trauma-Informed System

In order to create a trauma-informed child welfare system, it is imperative to recognize child welfare’ dependence on companion systems such as schools, mental health agencies, health clinics, juvenile justice and the courts, and Tribal Councils, together with these other systems’ dependence on child welfare. To create a trauma-informed system, system and professional readiness are needed to get the conditions right to accept change. This kind of innovation readiness can be called “setting the stage.”

Next, we describe briefly two developmental pathways toward an important progress marker, also called a proximal outcome for systems change. This marker-as-outcome is explicit, shared recognition that stand-alone, specialized professions, their respective organizations, and their

categorical policy systems were not designed to address trauma-related needs, problems, and opportunities. New designs for a trauma-informed system must be grounded in such shared awareness and the subsequent readiness for change it facilitates.

**From Awareness to Readiness and Capacity:
One Pathway to Setting the Stage**

Explicit awareness of interdependent relationships among specialized professionals and other key people (youngsters, parents, families, Tribal leaders) is an immediate priority and therefore, a proximal outcome. That is, when helping professionals and key leaders become aware that no one will be successful without others' strategic, lasting contributions and their own success, readiness is developing for a trauma-informed system. This first awareness-to-readiness path is founded on widespread consensus regarding three inescapable realities:

- Child/family trauma and secondary traumatic stress (STS) in the workforce have pervasive effects, i.e., leaders recognize that trauma's impacts cannot be contained by familiar professional, organizational, community, and family boundaries.
- Because trauma is a cross-boundary phenomenon, cross-boundary solutions-as-interventions are needed. These innovative interventions target current boundaries for professional, organizational and community systems, especially the specializations-as-boundaries that divide good people and their organizations, at times causing them to work at cross-purposes and inadvertently under-cut each other's good work.
- Evidence-based interventions implemented with fidelity by specialized helping professionals in one organization (e.g., social workers in child welfare, clinical psychologists in mental health agencies) are unlikely to improve outcomes for children, families, and organizations, systematically and sustainably, until such time as these interventions are harmonized and synchronized with interventions implemented by professionals in other organizations serving the same children, families, and communities. In fact, there is a high probability that professionals in the several systems will work at cross-purposes, which does not bode well for them or people needing to be served.

Put another way, evidence-based interventions implemented in just one organization are necessary (vital), and they surely are progress markers, but by themselves they are unlikely to improve outcomes

systematically and sustainably until such time as other helping professionals and key community leaders have developed common purposes, recognize that their respective interventions must be harmonized and synchronized, and share accountability for trauma-related outcomes. A trauma-informed system thus hinges on special kinds of collective action.

A Second Pathway to Shared Awareness and System Readiness

The second pathway can be introduced colloquially as “a good news, bad news” headline. The good news is that evidence-based treatments (EBTs) for child/family trauma and STS are available. Here, the challenge is predictable and manageable, although not easy. To meet the challenge, a three-phase process is needed.

Note: The needed work occurs in phases, not steps. It is not a three-step process because it is not linear. The work needs to be planned in interactive phases because the work involves “back-and-forth experimentation” facilitated by evaluation-driven, continuous quality improvement mechanisms.

Phase One. Phase one involves the selection of one or more EBTs. Here it is important that their theoretical and empirical warrants match the population (s) needing to be served, together with the special features of the place (social geography).

Phase Two. Phase two involves focusing on two related, but distinctive priorities related to the EBT(s) selected. The first is *people’s competence*, especially their cultural competence, with the EBT(s). This people-focused, competency development requires leaders to take stock of workforce characteristics and configurations. For example, a highly sophisticated EBT may be out-of-reach for a child welfare workforce without a single MSW social worker.

The second priority is *their sponsoring organization’s capacity* for the EBT(s). Capacity includes, for example, co-requisite data systems, workforce configurations, and overall organizational designs (e.g., departmentalization, role systems, resource allocation systems, etc.). Here, too, organizational audits are needed to determine what it will take to develop all of the co-requisite capacities in one or more organizations for the preferred EBT, especially ones that rely on a continuous supply of valid, reliable, and usable data.

Note the two different units of analysis. People’s competence is one, and an organization’s capacity is the other. It is not possible to have one without the other. A sustainable, high performing, trauma-informed system depends on both.

Phase Three. This phase ushers in a four-part framework about the limitations of current knowledge and the needs of somewhat unique designs in Indian country.

First: Although the stock of knowledge and available expertise is high regarding EBT implementation with fidelity in one profession and in a single, sponsoring organization, the available knowledge is limited and co-requisite expertise is in short supply for interprofessional and inter-organizational implementation. Complexity and novelty are unavoidable because boundaries must be crossed and new bridges built.

Second: As this work proceeds, the characteristics of the workforce, their sponsoring organizations, and the distinctive features of the Native American communities that provide their homes also must be prioritized. Here, it is important to emphasize cautions and warnings regarding standardized “cookie cutter” frameworks premised on faulty assumptions. For example, serious risks and problems arise when it is assumed that all tribal child welfare systems and communities are identical. In the same vein, problems ensue when it is assumed trauma-informed systems configurations developed with mainstream child welfare systems readily transfer to Indian country.

Third: Work directed at a comprehensive, interprofessional and inter-organizational trauma-informed system is not merely a technical problem with known solutions ready to be taken off the intervention shelf. In fact, the development of a trauma-informed system is an adaptive problem, one without easy answers, and requiring *new intervention designs*, not merely the faithful implementation of existing interventions.

Fourth: This work requires learning and knowledge generation “on the fly”, driven by constant monitoring and tailored evaluations, together with adaptive leadership. Leadership is adaptive in two ways: (1) It involves on going experimentation as the new system is designed and implemented, and (2) It involves special professional and organizational safeguards to protect cultural integrity and prevent what amounts to yet another round of colonialism in Indian country (Gray et al., 2013).

The Logic of a Trauma-Informed System

The development of trauma-informed systems in Indian county is complicated work for at least three other reasons:

1. Each tribal community is somewhat unique, which recommends against standardized “cookie-cutter” systems designs.
2. The idea of a trauma-informed system is new to nearly everyone, which means that outside expertise with cultural competence is needed.

3. The work involved is inherently experimental, which recommends adaptive leadership and mechanisms for evaluation-driven learning, knowledge generation, and continuous quality improvement.

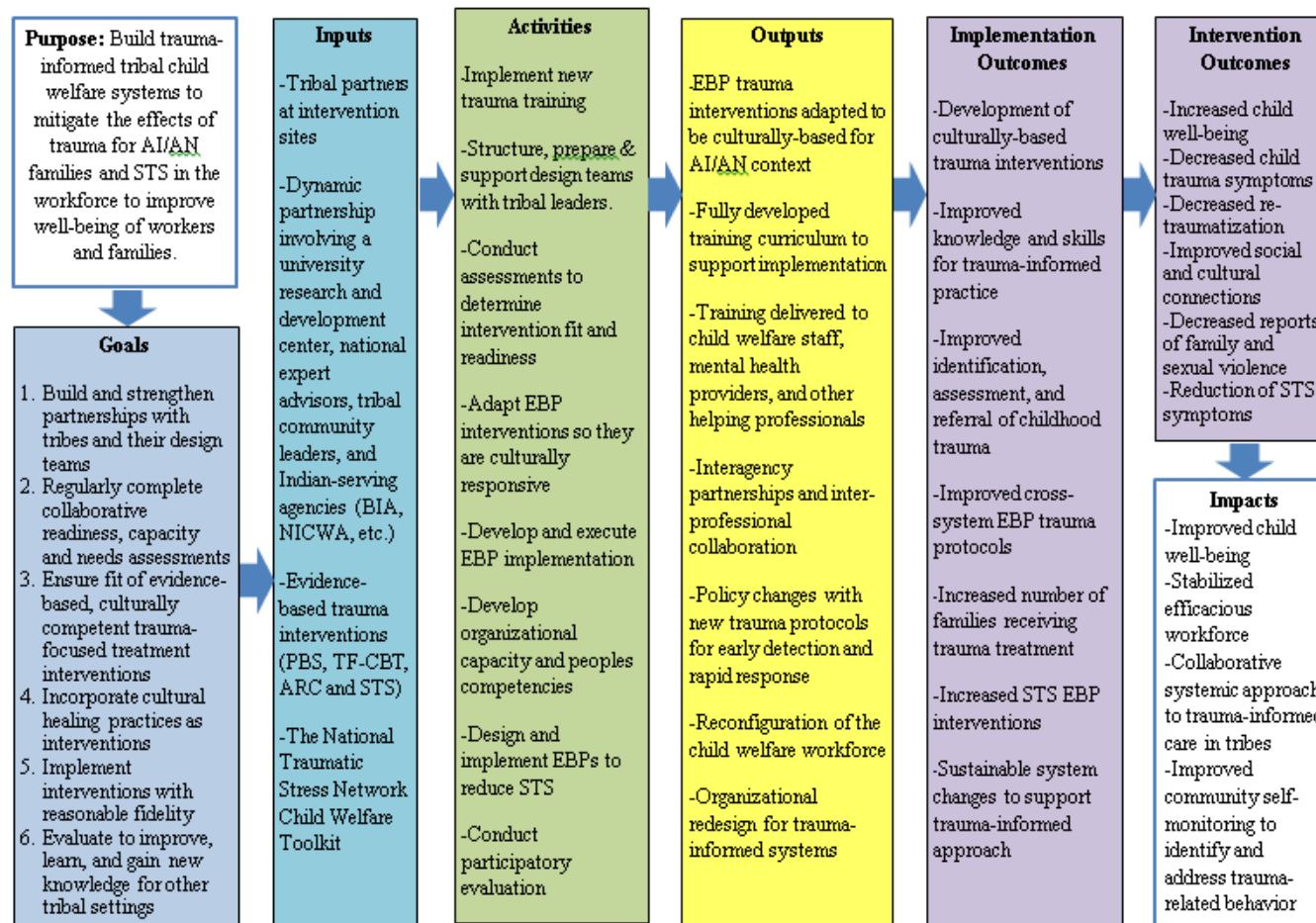
Universities, particularly their faculty from social work and related health and mental health disciplines, have the potential to facilitate the development of these systems. The main idea here is grounded in research. When pioneering systems designs are needed, and multiple diverse partners are involved, intermediary organizations and boundary-crossing leaders are a practical necessity (e.g., Williams, 2012). Intermediary organizations such as universities with sufficient neutrality, capacity, credibility, and legitimacy are needed to recruit, convene, organize and mobilize diverse professionals and Tribal leaders.

Significantly, intermediary, boundary-crossing leaders representing universities, particularly social work units, make this happen, not as authorities, but as facilitators for tribe-specific trauma-informed systems. As we indicate in the next section, these university facilitators are specially positioned to help structure and then facilitate tribal design teams. Proceeding with the assumption that each tribal community is somewhat unique and charged with system development and consisting of representative professionals from child welfare, mental health, health, schools, BIA, etc., these teams also are safeguards for cultural competence and tribal community fit.

Tribal design teams as well as the university leaders working with them, need the equivalent of a map, a compass, and sufficient resources to complete this work (Collins, 2001). In technical terms, they need a logic model to direct and guide their planning. Such a logic model is not a follow-the-numbers, robotic implementation exercise. To the contrary, a logic model provides a planning and implementation scaffold for design teams and systems designers overall. It is, in other words, a structural and operational facilitator for the pioneering work of trauma-informed systems development.

Figure 1 provides an example of such a logic model. We have derived it from a literature review and first-hand experience with the challenging work of structuring design teams and developing multi-component and cross-boundary trauma-informed systems. Predictably, it is selective and incomplete. Using a journey metaphor for the development of a trauma-informed system, this logic model provides an initial compass and map to facilitate the beginning of the journey. The main idea is to revise and enrich it as design teams proceed and as systems development proceeds.

Figure 1.
A Logic Model for the Development of a Trauma-informed System



More than an Implementation Challenge: Collective Leadership for New System Designs

The leadership required for a trauma-informed system thus extends beyond conventional implementation strategies. It can be called “design-oriented.” Design is the accurate descriptor because no one person has all of the answers. Indeed no one person has a complete grip on the problem.

Design-oriented leadership is by necessity collaborative, developmental, and outcomes-oriented. More than one person cannot work alone; this leadership fundamentally depends on design teams, especially tribe-specific teams structured to build trauma-informed systems in their respective Native American community settings. Indigenous expertise is essential in these teams’ design work, and so teams must be structured to include diverse, representative tribal members. Learning and improvement networks among several tribal design teams operating in different communities are also needed.

Starting with Mental Health Partnerships to Develop Trauma-Informed Systems

Comprehensive systems of care designed to address child welfare service gaps in Indian Country must acknowledge the reality that childhood traumatic stress is an underlying causal factor in countless mental health, health, and school learning performance issues faced by Indian children. Adults have some of these same symptoms, including parents of abused and neglected children. When these adults are also affected children’s parents, family-centered interventions need to be added to trauma-informed systems designs (Briar-Lawson et al., 2001), especially those that appropriately and justifiably connect child welfare services with mental health services.

This need for mental health system-child welfare system connection, indeed partnership, is omnipresent. In the child welfare system nationally approximately 85% of children with mental health needs (many the direct consequence of traumatic stress) do not receive services (Burns et al., 2004). Trauma has a profound impact on placement for such children as they are less likely to find permanent homes, more likely to have multiple case managers, and more likely to be placed out of home in order to receive “necessary” services (Smithgall, Gladden, Yang & Goerge, 2005; Hurlburt et al., 2004). These children are likely to receive restrictive, costly services such as juvenile detention, residential treatment, and hospitalization; U.S. House of Representatives, 2004;

Pottick, Warner, Yoder, 2005). Far too often, they are unnecessarily treated pharmacologically (e.g., for Attention Deficit Hyperactivity Disorder (ADHD) or Oppositional Defiant Disorder (ODD) or with harsh discipline (seclusion, restraint) simply because service providers are naïve regarding trauma etiology, trauma triggers, and trauma de-escalation techniques (e.g., Positive Behavior Supports [PBS]).

If Indian child welfare systems are to become trauma-informed and if the attendant changes are to be sustained, systemic efforts must be made to include health/mental health care providers, justice, and educational systems in complementary transformation initiatives that integrate evidence-based trauma-focused treatment.

A Comprehensive Approach to Trauma-Informed Tribal Child Welfare Systems

Systems change in Indian country requires local buy in and sustained external support and resources. A means for communication must be established from the beginning. Here, the Bureau of Indian Affairs (BIA) and Indian Health Services (IHS) can serve as intermediary organizations with convening and organizing power with other professions and their respective organizations.

All interventions must be chosen, adopted, and adapted in collaboration with Tribal leaders. Beyond genuine participation, engagement and empowerment strategies lies a significant need—namely, to honor and incorporate indigenous healing practices, while avoiding “professional-knows-best colonialism.”

Assessment, Planning and Buy-In

Assessment, planning, and buy-in is an essential element to all systems change. Design teams for systems change provide a mechanism for these related processes to occur.

Design teams use *participatory action research methods* to jointly plan, implement, and evaluate complex change initiatives such as trauma-informed systems change (Claiborne & Lawson, 2012; Lawson & Caringi, in press; Lawson, Briar-Lawson, & Petersen, 2001). Tribal Child Welfare is complex and different from community to community. In some cases, the state might be responsible for many aspects of child welfare. In other systems, the BIA or Tribe might be responsible for the work. Regardless of the system, each design team should consist of the top level Tribal Child Welfare leaders, representative managers from the Tribal Child Welfare System, supervisors, front-line caseworkers, agency trainers, and children and parent service users henceforth called “family experts.”

Design teams should be invited to follow a two-part agenda. First, teams work toward consensus on the core, defining elements of a trauma-informed child welfare system. After teams have gained introductory knowledge about trauma-informed interventions and practices and have achieved consensus on the core defining elements, the team will provide guidance on three related priorities: (1) How best to complete the assessments of their respective systems, including how they and their colleagues can participate; (2) A preliminary assessment of the services and organizational structures needed to be reformed and replaced in every CPS unit, including practical questions of when, how, who, and how to reallocate needed resources; and (3) Identification of strengths, facilitators, constraints, obstacles, and barriers, including recommended problem-solving strategies.

After this tribe-specific work has been completed, cross-site, role-alike teams (e.g., all supervisors; all trainers; all family experts; all trainers) provide insider, expert knowledge about how best to proceed with training, leadership development, and technical assistance, including how best to achieve traction and sustainability. These two kinds of team configurations—site specific cross-role teams and role-alike cross-site teams, enable site-specific as well as cross-site answers to practical questions needing to be answered in the first phase of the systems change process.

For example, what new competencies are needed? And, what new organizational capacities are required to implement and sustain evidence-based, trauma-informed clinical practices with children and STS-affected workers? Do specialized tribal CPS units (e.g., CPS, foster care) have special needs and requirements? What training is best? With their work framed in this way, tribe-specific and cross-site design teams will provide evaluation-related guidance and develop participatory strategies for Tribal Child Welfare Systems of Care (SOC).

It is probable that such teams would need to be adapted to fit within existing systems and processes. However, the core principles and practices of design teams should be followed as closely as possible, ideally as described above. Predictably, some tribes will have the capacity to use the model as developed, while others will not. Such is the essence of design work.

Training, Technical Assistance and Systemic Change

The next phase of systems change would be to actively begin the process of training child welfare providers (case workers, foster parents, other

agency staff) in trauma awareness and trauma-focused services according to the unique needs data provided by local design teams.

Potential Trauma-Informed Interventions

Especially in Tribal communities, the nature of the population, the reservation context and place matter. Granting commonalities, unique conditions exist in Tribal communities and must be taken into account when selecting Evidence-based practices (EBPs). Further to this point, the generalizability of EBPs is problematic, not automatic, because no two Tribes are the same. Data gathered in one community simply are not automatically generalizable to the next.

For these reasons and others, it is essential that conditions in local communities be taken into account when selecting EBPs. Further, Tribal partners must have input in the decision-making process; and with a strong proviso that no EBP will be implemented without their approval and with whatever culturally responsive adjustments tribal leaders recommend.

We suggest that Tribal Councils, Elders groups, and community professionals all have valuable and essential information, expertise, and opinions as to the appropriateness of EBPs. Without such consultation, EBP implementation is almost guaranteed to fail because it will not be implemented with conviction and fidelity, and the EBP likely is not a good fit. Most importantly, outsiders with their preferred EBPs must be vigilant about cultural competence so as not repeat the past transgressions by outside experts in Indian Country.

We propose that a formal process of consultation with tribal leaders to secure their input and gain their approval as well as leadership. Once consensus has been achieved, dialogue focused on systems development should include planning conversations regarding the public health pyramid. *Universal* strategies at the base of the pyramid target the entire population with messages and programs aimed at specific health problems. *Selective* prevention strategies target subsets of the total population deemed “at-risk” for health problems. *Indicated* strategies designed to treat specific health problems of individuals who are showing symptoms.

The Importance of Evidence-based, Indicated Interventions

Granting the importance of universal strategies in Indian country, the widespread incidence and prevalence of trauma symptoms recommends an immediate priority for indicated strategies. Indicated strategies with strong research supports are especially important. An excellent resource for such strategies is SAMHSA’s National Registry of Evidence Based

Programs and Practices. The registry provides a starting point to examine evidence based and evidence informed practices. However, all such practices and programs must be vetted, culturally adapted, and approved by Tribal communities and Tribal leaders. The most important ones are described briefly next.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): Designed to treat childhood sexual abuse and trauma for ages 3-18. TF-CBT focuses intervention on the child and non-offending parent or foster parent through individual and conjoint sessions, typically done in outpatient mental health facilities. The goals of the short-term intervention (12-14 sessions) include: to reduce negative emotional and behavioral responses; to correct maladaptive thinking; to increase effective coping skills; to enhance the parent/child relationship; and to enhance personal safety and future growth. Empirical findings demonstrate TF-CBT is useful in reducing symptoms of PTSD, depression, and behavioral difficulties in children (Deblinger, Stauffer, Steer, 2001). Other studies point out parental benefits including a reduction in depression and distress, as well as an increased feeling of being able to support their children (Cohen, Berliner, & Mannarino 2000). TF-CBT has been named a model program by SAMHSA, was selected as a Best Practice for cases of child abuse in the *Kaufman Best Practices Final Report*, and was given the highest level “1” of empirical support by the U.S. Department of Justice.

Attachment, Self-Regulation, & Competency (ARC): ARC is a framework for intervening with children and families who have experienced chronic/complex trauma. The ARC model recognizes that effective relationships between children and important adults (caregivers, teachers, caseworkers) must be trauma-informed and designed to help children regain the trust and consistency lost through previous traumatic experiences. This is accomplished by guiding caregivers through the building blocks of attachment, which sets the stage for the self-regulation designed to help children identify, modulate, and express affect. Finally competency elements promote improvement in developmental tasks, executive functioning, and self-development. ARC has been implemented successfully across multiple settings including child welfare, schools, therapeutic milieu programs, and I.H.S. and community outpatient clinics. Preliminary data indicates that ARC leads to a reduction in symptoms of PTSD, depression, and anxiety, while caregivers reported reduced stress and viewed their children’s behavior less dysfunctional after utilizing the ARC model. Measures will be given pre-test to assess trauma symptoms (CPSS) and signs of depression (CDI). The same measures will be given post-test to evaluate symptoms reduction. The target audience is all of the

staff members in tribal CPS agencies, including foster care providers as well as foster and biological parents.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS): CBITS was originally designed as a 10-12 week group therapy intervention for use in the school setting, targeting the ages of 10-15. A CBITS toolkit has been created to adapt the intervention to be implemented in community-based mental health clinics, foster family agencies, and CPS agencies (Schultz et al., 2010). CBITS is based upon principles of cognitive-behavioral therapy and functions to decrease trauma symptoms of hypervigilance, re-experiencing, avoidance, emotional, and anxiety, while increasing social problem-solving skills, coping strategies, relaxation, and adaptive thinking. Two family sessions, a teacher session, and tips for collaborating treatment with other professionals are written in the CBITS intervention and CBITS toolkit. CBITS is evidenced-based. In a randomized controlled study children in the CBITS intervention group showed a significant reduction in symptoms of PTSD and depression compared to those in the control group (Stein et al., 2003). CBITS has been effectively implemented among diverse populations of children, including Native American children (Morsette et al., 2009). The Life Events Scale, interviews, CPSS, CDI, and Pediatric Symptom Checklist are administered prior to the beginning of CBITS, during the final session, and three months after group completion. The target audience is tribal foster care providers, Systems of Care workers, as well as school counselors.

Secondary (Vicarious) Traumatic Stress Intervention. Figley defines *secondary traumatic stress (STS)* as “the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other, the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995a). Individuals who work with traumatized children in an empathic manner are at risk of developing vicarious trauma symptoms including intrusive flashbacks of their client’s trauma etiology (Pearlman & Caringi, 2009). Training in STS mitigation and management arguably assists the provider in working more efficiently and effectively; we believe STS mitigation also can reduce long term burnout and employee turnover (Pryce, Shackelford, & Pryce, 2007). STS training should incorporate personal, professional and organizational self-care planning options for an audience that includes all training participants in tribal communities.

Positive Behavior Supports (PBS). PBS is a trauma-informed behavior management system that considers inappropriate behavior as an opportunity to teach appropriate social and emotional skills. Children who

have been exposed to trauma typically need extra support in this area. Children are much more able to manage trauma symptoms when provided the structure and predictability of clear rules and adult expectations, consistent boundaries and behavioral accountability. We promote “Trauma-Informed PBS” because it embeds appreciation of how a trauma etiology contributes to behavior problems.

PBS is generally structured around a three-tiered prevention model. Each tier is relevant to child welfare workers and parents who work with traumatized children. The primary tier includes strategies for defining behavioral expectations, teaching behavioral expectations, employing reinforcement systems to acknowledge and increase appropriate behavior, operating a continuum of consequences to respond to inappropriate behavior in a supportive manner, and utilizing data for making decisions. The secondary tier includes screening for all children; using data to identify interventions for at-risk children and monitoring progress; creating systems to increase structure, predictability, and feedback for at-risk children; and utilizing systems to increase communication between adults in at-risk children’s lives. The third tier includes the use of functional behavioral assessment, data to identify individualized interventions, strategies to replace individual problem behavior and increase appropriate behavior, and continuous use of data to monitor progress (Sugai et al., 2000). Each of these elements is integrated within organizational systems consisting of teams which support implementation, application, and sustainability. The target training audience is all staff members in BIA/tribal CPS agencies including foster care providers, foster and biological parents, school systems and Systems of Care professionals.

Finally, the NCTSN *Child Welfare Trauma Training Toolkit* was developed to train CPS workers in the Essential Elements of a trauma-informed child welfare system, childhood traumatic stress, and the values and skills needed to work with children and their parents who have experienced traumatic events. The Child Welfare Toolkit should be used to provide training that will demonstrate how to use this knowledge to support children’s safety, permanency, and well-being. The Toolkit includes an evaluation process that supports further integration of knowledge into practice. The target audience is all BIA/tribal CPS workers.

General Trauma-Informed Technical Assistance

Trauma in children and secondary trauma in service providers are explanatory variables that account for inefficiencies, elevated costs, and avoidable failures in CPS. The development of trauma-informed systems

in Indian Country must include engagement of multiple levels of tribal CPS systems in order to achieve meaningful systemic change. Tribal CPS workers must be trained in trauma-sensitive methods to conduct child removal (e.g., psychological first aid, PBS, fundamentals of suicide risk reduction). In addition, foster, biological, adoptive and grand- parents and shelter staff must be trained in trauma-informed behavior management techniques (e.g., limit setting, defusing and redirecting; Mandt, PBS). The rationale, methods, and local results of these trauma-focused CPS strategies must be presented to agency administrators (tribal, state and BIA). All levels of tribal CPS must learn how to recognize the symptoms of secondary traumatic stress in colleagues and self, and personal, professional and organizational STS mitigation tools.

Enhancing System-Wide Capacities

If tribal CPS systems in Indian country are to become trauma-informed and trauma-focused, if they are to expand their capacities, refine policy and practice and sustain these transformations, then a systems focus on the identification of strengths, weaknesses, stakeholders, and continuous improvement is essential. One way to accomplish this is the process outlined by the Breakthrough Series Collaborative for Child Welfare Workers affiliated with the NCTSN (Conradi, Ko, Tullberg, Langan, & Wilson, 2011). Teams using this model are making changes at the practice level through a process called *Plan-Do-Study-Act* cycles, or action research PDSAs. As each Tribe and Tribal child welfare system is unique, it is essential that a trauma-informed system adopt such a method of continuous quality improvement to assure adaptation for individual community and system needs.

The Importance of Cultural Responsiveness and Culturally-competent Practice

We recommend the selection of interventions for consideration, agency readiness/assessment processes to be utilized and final decisions from local partners about the best interventions for their setting is a sequence highly reflective of the U.S. HHS/ACF's Cultural Competency and Systems Change recommendations from their *Child Welfare Information Gateway* (www.childwelfare.gov/systemwide/cultural).

The cultural responsiveness systems change and training must also be ensured by: 1) the participation of local design teams to include elders, tribal leaders, children, and family members 2) by the critical review of our work by project staff who are themselves American Indian, and 3) by the diversity of perspectives of knowledgeable experts. It is

essential to realize that work on a reservation is doing so under the invitation of a sovereign Indian Nation.

Conclusion

Historically, American Indian communities have long been exposed to "new and improved" training programs. Beyond the marketing hype, many have been expensive, culturally inappropriate, locally irrelevant, and poorly sustained. Most have relied mainly or exclusively on training local professionals. More than 40 years ago, Stokes and Baer (1977) characterized such efforts as "train and hope." Perhaps a more telling and current description could be "drive-by workshops."

As an alternative, we present this comprehensive model to achieve sustained systemic change - corroborated by eight years of preparatory work, rooted in a respect for local wisdom, and informed by the collective expertise of leaders recognized both in and beyond Indian Country. What's more, this work takes stock of the important roles of indigenous healing practices and the central roles of BIA and IHS.

There is nothing simple or easy about this work. In fact, it probably depends on a new generation of specially-prepared, culturally competent change agents. These change agents must be able to cross organizational, professional, and tribal boundaries, building common purposes and shared improvement agendas. They represent a new kind of child welfare leader, one deserving of training and support programs suggested by emergent research and theory (e.g., Williams, 2012).

Only in this way will child welfare achieve the prominence it deserves in a special trauma-informed systems design. The time has arrived for various training agencies and workforce development institutes to prioritize it, together with culturally competent organizational designs in Indian country. One immediate implication provides a fitting conclusion: Indigenous leadership preparation for trauma-informed child welfare systems is a solid facilitator for success. This special leadership helps to ensure system-community fit with cultural competence at the same time that it is a safeguard against colonialism. Above all, it maximizes the probability that primary trauma and secondary traumatic stress victims receive the help and support they need in a timely, effective manner.

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