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PART 2



California Child Welfare
Co-Investment Partnership

Trauma and Child Welfare: Strategies for Preventing and Intervening to Promote Healing

[Part one](#) of this two-part issue on trauma, released in June, provided an overview of Adverse Childhood Experiences (ACEs) and other trauma-related concepts, along with data and perspectives, to advance the understanding of trauma and promote resilience and healing.

ACEs are now recognized as a national public health crisis. An October report by the Centers for Disease Control (CDC) analyzed data from more than 144,000 individuals from twenty-five states and found that ACEs are linked to at least five of the top ten leading causes of death. According to the analysis, one in six people across the United States has experienced four or more kinds of adverse childhood experiences. The results suggest that ameliorating the effects of ACEs could potentially reduce chronic diseases, risky health behaviors, and [socioeconomic challenges later in life](#).

As of January 2020, California becomes the first state in the nation to roll out trauma screening in pediatric settings for all children, youth, and families covered by Medi-Cal (California’s Medicaid health care program). Trauma screening holds the promise of the early identification needed to assess, treat, and intervene as well as prevent a child and family’s trajectory into foster care.

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“Our vision for California is bold. We will cut ACEs and toxic stress in half in one generation. To do so we must establish primary prevention and public awareness, deploy broad scale screening, interrupt the inter-generational transmission of ACEs by screening adults — with a particular focus on the prenatal and early parenting years. We must build a strong, coordinated referral system that is accountable and easy to navigate for children, adults, and providers.”

Dr. Nadine Burke Harris, California Surgeon General

“Children and families who have experienced trauma need to heal in supportive family environments. Identifying and addressing ACEs can keep families safely together and connect them with appropriate services and supports, which aligns with the focus of the California Department of Social Services.”

Greg Rose, Deputy Director, Children and Family Services Division, California Department of Social Services

Progress on Trauma Screening Implementation



It is very exciting for California to be at the helm of addressing the public health crisis that unaddressed ACEs have created. This is not just another metric, it is the first step in further serving children and families by acknowledging that the adversity they may have experienced has health implications, and then by connecting children and families with the resources that best serve their needs and build their resilience.”

Dr. Dayna Long, MD, Medical Director, Center for Child and Community Health, UCSF Benioff Children’s Hospital Oakland

The updated categories included in the PEARLS screening tool account for additional trauma-inducing experiences, including:

1. Violence in their neighborhood, community, or school
2. Discrimination
3. Housing insecurity
4. Food insecurity
6. Parent/caregiver with serious physical illness or disability
5. Family separation (foster care, immigration)
7. The death of a parent or caregiver

For the complete set of PEARLS screening tools, visit the Resources section of the [ACEs Aware website](#)

Governor Newsom included \$40.8 million in the Fiscal Year 2019-2020 budget to reimburse providers (pediatricians) using the Pediatric ACEs and Related Life-events Screener (PEARLS) to screen all Medi-Cal eligible children, youth, and caregivers (parents). An additional \$50 million was also allocated (AB 47) to provide training and support for providers with the implementation of the PEARLS. To that end, the Department of Health Care Services (DHCS) and the Surgeon General have launched a website ([ACESAware.org](#)) to provide resources for providers.

The screening tool, PEARLS, was selected based on the recommendations of the multiple stakeholder working group established by AB 340 (Arambula, D-Fresno). PEARLS 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 was designed to identify exposure to childhood adversity and events that may increase a child’s risk for toxic stress and [negative health outcomes](#).

The original ACEs questionnaire, developed by Kaiser Permanente and the CDC, included ten questions that captured whether an adult had experienced as a child any of the following categories of adversity: physical, emotional, and/or sexual abuse, physical and/or emotional neglect, living with a caregiver diagnosed with a mental illness, the incarceration of a relative, witnessing a mother treated violently, living with a caregiver’s substance abuse, and whether parents were divorced. The PEARLS screen added seven new categories (see side bar).

Three versions of the PEARLS tool will be used to evaluate children and teens for a history of exposure to adversity.

- **Child** – Ages 0-11, to be completed by a parent or caregiver
- **Teen** – Ages 12-19, to be completed by a parent or caregiver
- **Teen Self Report** – Ages 12-19, for teenagers to self-report (can also be used with adults)

For adults ages twenty-one to sixty-five, screening is permitted once in their adult lifetime, per provider, per Managed Care Plan, using either the Adult ACEs screener adapted from the CDC Kaiser Permanente Study, or any tool that contains questions on the ten original categories of ACEs.

The ACEs score refers to the total number of ACEs categories experienced, not the severity or frequency of any one category. The higher a patient’s ACEs score, the greater the risk for ACEs–associated physical and behavioral health conditions.

Following the screening and clinical assessment of both the ACEs score and other signs of stress, providers will be encouraged to refer children and their families to services and supports, and will also be encouraged to tailor their medical treatments to the underlying causes linked to the effects of toxic stress and ACEs.

According to ACESaware.org, the response to identification of ACEs and increased risk of toxic stress should include:

-  Applying principles of trauma-informed care including establishing trust, safety, and collaborative decision-making
-  Identification and treatment of ACEs–associated health conditions
-  Patient education about toxic stress and buffering interventions including:
 - Supportive relationships
 - Mental health treatment (if indicated)
 - Regular exercise
 - Good sleep hygiene and high-quality sleep
 - Healthy nutrition
 - Mindfulness practices
-  Validation of existing strengths and protective factors
-  Referral to patient resources including educational materials, community resources, social work, and/or mental health care as necessary
-  Follow-up as necessary.

“When a screening for childhood trauma is done well, it can be transformational for families, as can the subsequent conversations with a well-trusted medical provider. It's critical that, when needed, the screening be followed by a connection to clinical and community services. However, because the field is so emergent, practitioners have to approach screening and the appropriate types of family support with a learning mindset. Providers and community resources will help us understand what's working and what's not.”

Rajni Dronamraju, Associate Director, Charitable Giving, Genentech

Initiatives like the Genentech-funded [Resilient Beginnings Collaborative](#), a learning program dedicated to addressing childhood adversity in pediatric safety net care settings, have informed the implementation of the PEARLS tool. An evaluation of seven Bay Area safety net clinics who participated in the collaborative resulted in a set of recommendations that support not only trauma-informed systems, but also a healing-centered approach. The recommendations include:

- Focus on **integrating** clinical practices that assess and address childhood adversity.
- Transform office and clinical environments to be **trauma and resilience informed**.
- Support partnerships and practices to **create coordinated systems of care**.
- Improve infrastructure and quality of care through **data monitoring and assessment**.
- Connect families with **community resources** and follow up to make sure the family has engaged.



It's ineffective to screen without a plan to respond.

The screening should give providers a sense of what children and families may need to address ACEs or assuage toxic stress, and should be informed by a focus on building resilience. Conducting an ACEs screen is just a starting point."

Jennifer Rodriguez, Executive Director, Youth Law Center



What we assess for will be what we intervene

around. If we only assess for individual ACEs, we miss the bigger picture of community-level trauma that many of our families are up against. It is important that the conversation surrounding ACEs takes into consideration systemic issues like institutionalized racism, as well as what we must do to purposefully counteract the trauma-inducing effects of these forces."

Dr. Joyce Dorado, Co-Founder and Director, UCSF Healthy Environments and Response to Trauma in Schools (HEARTS)

The complex relationship between exposure to ACEs and toxic stress, protective factors, individual vulnerabilities and conversely, individual strengths, make it difficult to determine next steps based on the screen alone.

Screening tools and assessments themselves may be a trauma-informed intervention that can promote healing. Acknowledging adversity in the life of a child and his or her family may be an opportunity for a caring person or mentor to become a supportive and healing presence in the child and family's lives. However, per the ACEs Aware site, because screening and assessment asks families and youth to revisit potentially upsetting parts of their life, it is important for providers to administer screenings in a trauma-informed manner. Being able to refer patients to mental health providers or community resources may serve as a trauma-informed strategy that avoids eliciting feelings of blame or anger and further re-traumatizing patients.

For those children and families whose identified needs may require support or referral to other child serving systems, further assessment tools can inform the question of "Once we screen, what do we do?"

In California's child welfare services system, the [Child and Adolescent Needs and Strengths \(CANS\)](#) assessment is one such tool, which is required by both DHCS and DSS. It supports decision-making, including level of care and service planning for children in the foster care system, which allows for the monitoring and outcome of services. The CANS data can serve as an important foundation for a robust outcomes and accountability system. In child welfare and behavioral health settings, CANS is used as part of the mandated [Child and Family Team \(CFT\) process](#). It uses a rating scale to summarize important areas related to the child's or youth's needs — in school, at work, at home, and in relationships with friends and others. The CANS also captures information on strengths of the child/youth and of the caregivers. Employing this assessment as part of the CFT process means the team (which in addition to the child may include caregivers, social workers, teachers, adult mentors, et al.) can develop a plan to address the child's needs and support their strengths.

Another assessment tool is [the North Carolina Family Assessment Scale for Reunification](#), which [Safe & Sound](#) has adapted in order to measure protective factors. This assessment was initially developed for use in child welfare settings such as home visitation, although it may be used in other settings that provide family services. This assessment has been "Well-Demonstrated" in terms of reliability and validity according to [the California Evidence-Based Clearinghouse](#).

The following chart shows, by age group, the percentage of children and youth in the child welfare population and the signs of stress* that may indicate the need for further assessment.

AGE > % of child welfare population	SIGNS OF STRESS FOR ASSESSMENT	WHY THIS MATTERS
0-5  > 35%	Fearing separation from parents or caregivers Crying and/or screaming a lot Eating poorly and losing weight Frequent nightmares May lose developmental skills	Nationally, 75% of children who die from abuse or neglect are under the age of 3.
6-12  > 21%	Becoming anxious or fearful Feeling guilt or shame about their actions during traumatic situations Having a hard time concentrating Having difficulty sleeping Developmental regression or delays May have frequent stomachaches or headaches	This is a time-sensitive life stage for identifying the impact of ACEs given that 50% of all mental health problems begin by age 14.
13-18  > 31.5%	May feel their actions made things worse Feeling depressed or alone May express fantasies about revenge Developing eating disorders and self-harming behaviors Beginning to abuse alcohol or drugs Becoming sexually active May withdraw from family and friends	Maltreated children are 59% more likely to be involved with the juvenile justice system than their non-maltreated peers.
18-21  > 12%	Drug use Suicidality Avoiding friends and social activities Changes in sleeping habits; tired, low energy Inability to do daily activities or handle problems/stress	Addressing ACEs could reduce the number of adults with depression by as much as 44% .

* Some of the signs of stress for each age group may be present in children with no ACEs, or in children whose symptoms are not related to ACEs. This table is not intended to be used for diagnosis.

SPOTLIGHT

The Attachment Biobehavioral Catch-Up (ABC) Program, developed by Mary Dozier, PhD, and her team at the University of Delaware, is an evidence-based parenting intervention for caregivers of infants and toddlers who have experienced early adversity. The ABC intervention targets parental nurturance. Over the course of ten coaching sessions, ABC coaches help parents recognize the needs that may be causing a child's behavior, and provide positive comments and observations to parents. ABC was shown to improve attachment quality between child and parent, and improved early self-regulation in children, at a relatively low cost. In some of the ABC implementation sites, the cost per family is approximately \$1,000. One coach trained in the ABC technique can see about forty families per year.

Assessments & Interventions

The following table includes interventions that have demonstrated success in mitigating the effects of toxic stress responses. Each intervention is accompanied by the Family First Prevention Services Act (FFPSA) program rating assigned by The Prevention Services Clearinghouse. The ratings, developed in accordance with FFPSA, range from **well-supported**, **supported**, or **promising** for eligibility for federal reimbursement under Title IV-E. For updates on the programs and services under consideration for the clearinghouse, visit <http://familyfirstact.org/>.

INTERVENTION	AGES	FFPSA PROGRAM RATING
<u>Parent-Child Interactive Therapy</u>	0-5 6-12	 Well Supported
<u>Trauma-Focused Cognitive Behavioral Therapy</u>	0-5 6-12	 Promising
	13-18 18-21	 Well Supported
<u>Attachment Biobehavioral Catch-Up for Infants</u>	6-24 months	 Pending Review
<u>Attachment Biobehavioral Catch-Up for Toddlers</u>	24-48 months	 Pending Review

Other programs that are in use but have not yet been reviewed, or the review status is unknown, include: Alternatives for Families: A Cognitive Behavioral Therapy, Wraparound, Trust-Based Relational Intervention, Neurosequential Model of Therapeutics, Child and Family Traumatic Stress Intervention, I Feel Better Now!, Blues Program, Evidence-Based Mentoring.

A Buffering Care Infrastructure

Research increasingly shows that exercise, healthy eating, adequate sleep, connections with caring adults (outside of family), and mindfulness practices can prevent and mitigate stress. Unfortunately, many of these mitigating practices are difficult for children at risk or currently system-involved to access.

As part of a healing approach to trauma, our child and family serving systems should be encouraged to provide resources and opportunities for children and youth to access activities that encourage exercise and connections, and allow them to pursue their interests, such as extracurricular activities like sports, art, dance, civic engagement, etc. in lieu of, or in addition to, clinical services.

Buffering the Toxic Stress Response¹



¹ Source: Burke Harris, Nadine. *The Deepest Well: Healing the Long-Term Effects of Childhood Adversity*. Boston: Houghton Mifflin Harcourt, 2018.

Over the past few years, child welfare has had an increasing focus on preventing system involvement with the support of federal and state policies and programs. ACEs screening has the potential to provide the data, at both an individual and population level, to intensify those efforts.

At the federal level, the Family First Prevention Services Act will provide Title IV-E reimbursement for (secondary) prevention services for those at imminent risk of system involvement, provided the services are evidence-based and well supported, in the following categories: mental health programs, substance abuse treatment programs, in-home parent skill-based programs, and kinship programs.

At the state level, one of the most promising approaches to support families, prevent abuse, and build resiliency are Family Resource Centers (FRCs). The governor recently signed legislation ([SB 436](#)) which establishes in statute an inclusive and clear definition for FRCs and provides new opportunities to expand these critical community support systems for children and families.

Linking state and county efforts, the County Welfare Directors Association initiated a prevention cabinet that meets monthly. That cabinet joined forces with the [Office of Child Abuse Prevention](#) and [Strategies 2.0](#) to conduct a summit in early 2019 that included child welfare leadership from twenty-two counties, and representation from community-based organizations (e.g., Family Resource Centers). Regional efforts are continuing to meet since the summit to develop strategies for public-private partnerships with the goal of strengthening families.

Recently passed legislation ([SB 1004](#)) offers another opportunity for expanding resources focused on prevention. This bill amended the Mental Health Services Act by requiring the portion of the funds in the county plan relating to prevention and early intervention to focus on the priorities established by the commission and authorizes a county to include other priorities, as determined through the stakeholder process, either in place of, or in addition to, the established [priorities](#).

“ Ignoring and denying children and families mental health care is the crisis of our age. By implementing screening to identify children who have experienced ACEs, we have the ability to serve children and families at an earlier point and ensure that we fund and deliver the behavioral health support and community resources that our children and families need to heal on their own terms.”

Assemblymember Dr. Joaquin Arambula

“ The data from the PEARLS as well as any other assessments and outcomes that are tracked for children and families are important. These analytics can inform how counties invest their prevention and early intervention dollars and shape their strategy both with MHSA resources as well as other funding.”

Toby Ewing, Executive Director, Mental Health Services Oversight and Accountability Commission

“ It’s an important step to do the screening, and another thing to ensure that providers are trained to respond, prepared to connect patients to culturally relevant and appropriate services, provide the warm hand-offs, and be able to respond to the concerns that may come up, and especially for immigrant families in this time, expanding the clinic services to include legal partnerships.”

Mayra Alvarez, President, The Children's Partnership

Financing Reforms for Systems Transformation

“Creating a system that prevents trauma and promotes healing requires an examination of our current financing system. Transformation is only possible if we have the fiscal architecture in place to support it.”

Dana E. Blackwell, Senior Director, Casey Family Programs

“We have an arcane eligibility and payment system that requires us to know exactly what is going on with a person and from the first assessment build a treatment plan that doesn’t align with how people and their conditions evolve. Providers should be able to modify a treatment plan in recognition that child and family strengths and needs often change over time due to a variety of client-driven and other factors. We need to reform how we determine eligibility for our services and do fundamental payment reform to make it easier for counties to get families and children the services they need.”

Michelle Doty Cabrera, Executive Director, County Behavioral Health Directors Association of California

The response to ACEs screening for children and families represents a significant opportunity to align financing of our child-serving systems to provide the supports and services to prevent, intervene, and promote healing. There are several sources of financing, as well as reforms in process, which have the potential to result in system transformation.

A significant opportunity in funding mental health care is in the utilization of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. EPSDT is an entitlement; it means any non-federal share dollar the state or county provides to spend on an allowable beneficiary for an allowable service, the federal government must match.

Toward that end, recently passed legislation ([SB 1287](#)) revised the Medi-Cal definition of “medically necessary” for purposes of an individual under twenty-one years of age to incorporate the existing federal standards related to EPSDT services, which will allow for expanded access and coverage for children and families.

Medi-Cal Reform on the Horizon

In October, DHCS released a comprehensive [set of proposals](#), referred to as the California Advancing and Innovating Medi-Cal (CalAIM) initiative. DHCS plans to finalize all proposals for submission to the Centers for Medicaid Services between May and July 2020.

The primary goals of the CalAIM initiative are to:

- **Identify and manage** member risk and need through Whole Person Care Approaches and addressing the Social Determinants of Health;
- **Move Medi-Cal** to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- **Improve quality outcomes** and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

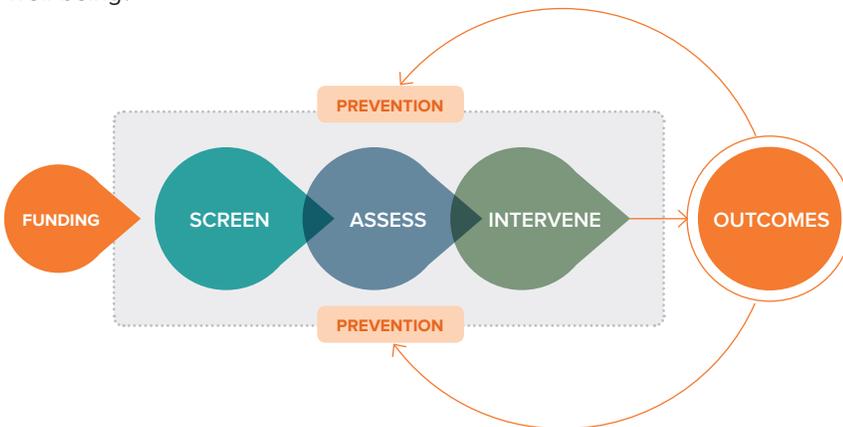
CalAIM proposes the removal of diagnosis as a prerequisite for access to care and shifting to a “level of impairment” model. DHCS will also be developing a workgroup focused on how to better serve the foster care population in Medi-Cal that is scheduled to convene in early 2020 in order to develop a proposal for this important and vulnerable population.

“Medicaid is the tie that binds our fragmented child- and family-serving systems, and we are at an inflection point in state policy that offers an opportunity for a more comprehensive and accountable method to finance and deliver supports and services.”

Alex Briscoe, Principal, California Children's Trust

An Outcomes-Based System for Child & Family Well-Being

Once we screen for trauma, assess, intervene, and finance our child-serving systems, how will we know whether we are improving child and family well-being?



Preventing the impact of trauma and improving overall child well-being is a shared responsibility across all child- and family-serving systems. An outcomes-based system is an effort to improve results for the individuals it serves based on agreed-upon measures with consistent data collection.

Child welfare has a transparent, outcomes-based system with measures that include, for example, time to permanency, reunification, and re-entry, which are reported (quarterly) on the publicly accessible [California Child Welfare Indicators Project \(CCWIP\) website](#), a collaborative venture between the University of California at Berkeley and the California Department of Social Services (CDSS). The project is housed in the School of Social Welfare, and provides policymakers, child welfare workers, researchers, and the public with direct access to customizable information on California's entire child welfare system.

California's education system similarly measures through both federal legislation and state policy mandates, a set of performance-based indicators on the California School Dashboard administered by the California Department of Education (see [dashboard](#)) which provides parents, educators, and policymakers with measures to assess the performance of schools and districts in achieving student and school indicators of progress. And as a result of the Local Control Funding Formula, enacted in 2013-2014, the dashboard now includes education outcomes for children in foster care.

By contrast, behavioral health, an important system for improving overall well-being (including both child welfare and education outcomes), primarily measures use of services, reported as "penetration rates," which do not include indicators of improvement or outcomes.

There are some promising examples from other jurisdictions/states that have developed an integrated outcomes-based approach to provide support and services to children and families, which include data sharing and mandates for periodic assessment allowing for continuous quality improvement.

“ Pursuant to state legislation (AB 636, (the California Child and Family Service Review System), a community of child welfare stakeholders convened by the administration identified a set of outcomes, made them publicly available to be tracked and monitored with the goal of continuous quality improvement. Looking forward, there is a lot to learn from that model for all of our child-serving systems.”

Frank Mecca, Executive Director, Child Welfare Directors Association of California

“ Penetration rates as a systems outcome are important, but it's not a child-based outcome. More important is to measure whether we reduced suffering and increased strengths to buffer against trauma.”

Danna Basson, Director Research and Evaluation, WestCoast Children's Clinic

An Outcomes-Based System for Child & Family Well-Being

“ Looking forward, we could distill a manageable and meaningful set of processes and outcomes that matter the most for behavioral health that also align with child welfare. The state did just that when it applied the child welfare model of outcomes and system improvement to the CalWORKs program.”

Frank Mecca, Executive Director, Child Welfare Directors Association of California

“ Trauma-informed approaches and thereby outcomes are about the systems behavior and impact. Our approach to measuring outcomes should be asking whether our institutions, like schools for example, are ready for young people. It's about school readiness not student readiness. Do staff feel trained, confident, and do they have support from leadership as they provide services and resources for children and families that have experienced ACEs? Most importantly, do students and families think the school is prepared and ready to meet them where they are and move with them?”

Kanwarpal Dhaliwal, RYSE Associate Director

For example, Illinois, through a system known as the [Service Provider Identification & Exploration Resource \(SPIDER\) application](#), and [New Jersey](#), through [CYBER](#), an Electronic Health Record system administered by PerformCare, have set up secure data sharing portals so counties and local providers can measure progress to tailor their resources for specific populations.

To incentivize improvement and accountability, many state systems use performance-based contracting where new provider contracts must include practices that exemplify the system of care's guiding principles. Systems can restructure and re-allocate existing funding to support a performance-based system, as Texas's [Community-Based Care](#) has accomplished.

What outcomes should we be looking for?

For this issue, child welfare and behavioral health care stakeholders were interviewed about what might be included as possible outcomes to measure improvements in behavioral health specifically, and child well-being in general. The following are some of the indicators that were recommended:

- **Symptom reduction** in terms of stress (e.g., whether quality of sleep has improved)
- **Sense of hope** and future orientation
- **Functional improvement** (school attendance, working)
- **Emotional well-being** (reduction in depression and anxiety symptoms)
- **Physical well-being** (reduction in obesity, asthma, etc.)
- **Education outcomes** (school attendance, grades)
- **Reductions in involvement with other systems**, for example, the juvenile justice system

Looking forward, the focus on trauma and prevention is an opportunity to engage leadership and stakeholders from all child-serving systems to develop a set of measures for child and family well-being with the goal of preventing system involvement and reunifying families.

“ We can demystify mental health. Mental health is the capacity for a child to love, to connect, to create, to learn, to play, and to feel.”

Dr. Chandra Ghosh Ippen, Associate Director, Child Trauma Research Program, UCSF

Build the capacity of families and communities to “buffer” the effects of trauma, prevent toxic stress, and promote healing for children

1. **Map resources**

As providers/pediatricians identify needs that go beyond their practice, what resources will be available for their referrals? Some counties/communities may be resource rich, while others have few supports or services available. Using the data collected from providers on needs and resource gaps, California counties might follow the lead of [Nebraska](#), which has developed a Community Opportunity Map that inventories resources with the goal of creating equitable access.

2. **Build capacity in local communities to work “upstream” through collaborative approaches**

Reducing traumatic experiences and building protective factors requires public and private partnership across child- and family-serving agencies, and could be facilitated by federal, state, and county leadership and resource investments, with particular focus on supporting non-clinical interventions with Medi-Cal reimbursement.

3. **Intensify efforts to recruit, train, and retain a trauma-informed workforce for child-serving systems and ensure caregivers, including resource families, are trauma-informed**

Create supports and incentives to improve county and workforce retention and address secondary and vicarious trauma.

4. **Increase, at all levels (state, county, and individual), information sharing across all child-serving systems**

Coordinate and strengthen the network of referral and treatment systems to make them more effective, accountable, continuous, and easy to navigate for children, adults, and providers.

5. **Support new and integrated approaches to improve child and youth well-being**

Build upon the momentum created by the CalAIM proposals and the newly formed Mental Health Subcommittee of the Child Welfare Council to ameliorate the effects of ACEs and toxic stress.

“ We need to shift from a frame that asks how do we fix inequality, to a frame that focuses on creating structural well-being. That means creating systems, policies, practices, and resources, and putting them in places that guarantee people will encounter opportunities to interact with them and be well.”

Shawn Ginwright, Founder and Chief Executive Officer of Flourish Agenda, Inc.

“ Some counties have good programs while others are quite weak and we know that low-income areas, rural communities, and kids of color are underserved. The state needs to establish a statewide system that would, over time, save money by preventing system involvement and consider ‘realigning realignment’ to support child welfare and behavioral health services.”

State Senator Jim Beall

Additional Resources

Progress on Trauma Screening Implementation

- [California 2019-20 State Budget Summary](#) – See page 30 for information on trauma screening funding.
- [ACEsAware.org](#)
- [PEARLS Screening Tool](#)
- [Assembly Bill 340 \(Arambula\): Trauma Screening Advisory Workgroup](#)
- [Bay Area Research Consortium](#)
 - [Center for Youth Wellness](#)
 - [UCSF Benioff Children's Hospital Oakland](#)
- [Centers for Disease Control-Kaiser Permanente ACE Study Questionnaire](#)
- [Genentech Resilient Beginnings Collaborative](#)

Assessment Tools and Interventions

- [ABC Program](#)
- [Alternatives for Families: A Cognitive Behavioral Therapy](#)
- [Wraparound](#)
- [Trust-Based Relational Intervention](#)
- [Neurosequential Model of Therapeutics](#)
- [Child and Family Traumatic Stress Intervention](#)
- [I Feel Better Now!](#)
- [Blues Program](#)
- [Evidence-Based Mentoring](#)

The Family First Prevention Services Act

- [Title IV-E Prevention Services Clearinghouse](#)
- [FamilyFirstAct.org](#)

Focus on Prevention

- [Family Resource Centers](#)
- [The Pediatrician's Role in Child Maltreatment Prevention](#)

Financing Reforms for Systems transformation

- [EPSDT Benefit](#)

Recommendations: Moving Forward

- [Medi-Cal Healthier California for All Proposal \(CalAim Proposal\)](#)
- [California Child Welfare Council](#)



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 six philanthropic organizations (Casey Family Programs, Conrad N. Hilton Foundation, The Ralph M. Parsons 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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