Fostering Futures

Key Findings and Lessons Learned from the Second Phase of a Trauma-Informed Care Transformation Initiative

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Prepared by:
Monica Idzelis Rothe, Jackie Aman, and Sera Kinoglu

451 Lexington Parkway North | Saint Paul, Minnesota 55104
651-280-2700 | www.wilderresearch.org

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Acknowledgments

This report reflects the contributions of the Fostering Futures Evaluation Committee, including Dr. Lynn Sheets (Co-Principal Investigator), Dr. Kelly Hodges (Co-Principal Investigator), Carol Howard, Andrea Spagnoli, Judie Hermann, Bonnie MacRitchie, Kimberly Wild, Karen Johnson, Fredi-Ellen Bove, Christine Norbut, Sharday Lewis, Dr. Heather Paradis, Elena Romani, as well as Laurie Lambach.

Wilder Research staff contributors include:

Mark Anton
Jenny Bohlke
Walker Bosch
Monzong Cha
Jen Collins
Marilyn Conrad
Michelle Decker Gerrard
Thalia Hall
Madeleine Hansen
Henry Hollis
Sera Kinoglu
Heather Loch
April Lott
Dan Swanson
Pa Nhia Yang

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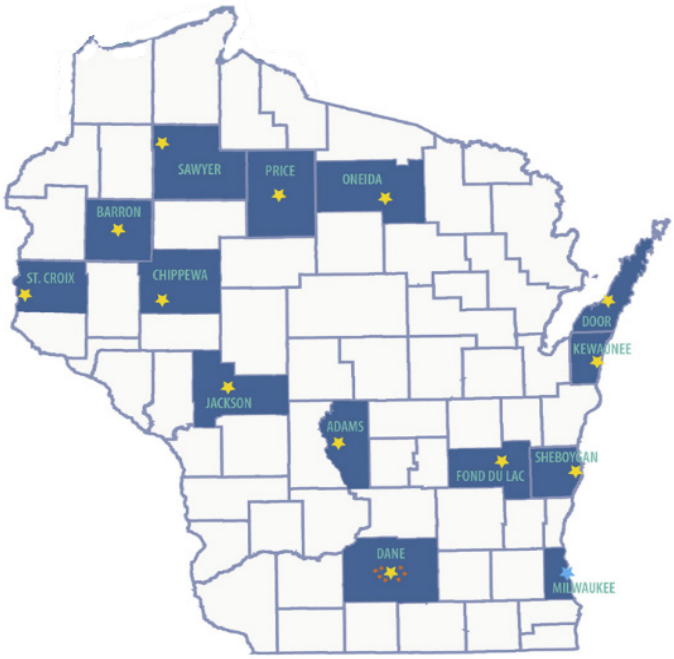
Executive summary

Background

The Fostering Futures (FF) initiative was developed in response to research about the negative impact on a child's healthy growth and development caused by chronic traumatic stress. Stress or adverse experiences during childhood can cause poor health outcomes in adulthood. Families and workers who are involved with the child welfare system are particularly vulnerable to these stresses. The FF approach focuses on implementation of trauma-informed (TI) principles into the work of child- and family-serving systems of county and state governments in Wisconsin. In addition, FF's theory of change suggests that policy and systems changes that advance TI principles will result in improved health and well-being of Wisconsin's children and families.

This report and evaluation focuses on Phase II of FF (May 2015-October 2017). Aligned with the Wisconsin Trauma Project, Phase II builds upon community-prioritized needs identified in the first phase of FF's work (January 2013-April 2015), a pilot phase in which 3 communities received facilitated peer learning on trauma-informed care (TIC). The participants of the Phase II learning community include 21 groups, or Core Implementation Teams (CITs), representing 14 county-based human service agencies and 7 state agencies. It is anticipated that Phase III of FF will launch in early 2018, which will include new members of the learning community and continuing coaching/technical assistance for the current teams.



Each Core Implementation Team in Phase II received training and technical assistance related to trauma-informed care by the National Council for Behavioral Health (NCBH) and Fostering Futures staff. This included: participating in trainings on Adverse Childhood Experiences (ACEs) and trauma-informed care (TIC); conducting organizational self-assessments; identifying trauma-informed care domains for change-making; and developing and implementing action plans.

Methodology

The evaluation aimed to capture how teams implemented the initiative and its impact on trauma-informed care systems change within the participating agencies. The evaluation utilized instruments pre-selected by the National Council for Behavioral Health (NCBH) and the Fostering Futures Steering Committee, as well as tools/methods created specifically for Fostering Futures, including:

- **The Organizational Self-Assessment (OSA)** which measures the degree to which an organization reflects trauma-informed care principles.
- **The Professional Quality of Life Scale, version 5 (ProQOL 5)** which assesses the negative and positive effects of helping others who experience suffering.
- **The Performance Measurement Tool (PMT)** which measures CIT progress in creating systems change within their organization.
- **Core Team Quarterly Reports** that summarize each CIT's team meetings and attendance, key accomplishments, challenges, and outreach activities.
- **The Participant Feedback Survey** which measures perceived changes in CIT member attitudes, knowledge, practices, and beliefs related to trauma-informed principles.
- **Focus groups** with representatives from the county-based teams, state agencies, and parent/consumer participants to learn about participant experiences with Fostering Futures, the impact of their work, and suggestions for the future.

Key findings

A mixed methods evaluation approach was used to assess the implementation of this work and the outcomes achieved by teams in Phase II. Several key themes emerged from the evaluation which highlight the extent of participants' work and their level of commitment to becoming trauma-informed; the successes achieved within county- and state-level agency workforces across the state; and the early indications of and potential for broader impact on consumers and organizational policy.

High levels of participant engagement

- Core Implementation Teams met regularly and maintained steady attendance throughout the first year. This included participation at all levels, including executive leaders, who attended the majority of state and county Core Implementation Team meetings, as well as parent/consumer representatives, who - while somewhat limited in number - expressed satisfaction with their experience on the Core Implementation Teams and reported feeling involved, heard, and validated by their CIT colleagues.

- Core Implementation Teams also engaged in a range of outreach activities during the year, most notably collaborating or meeting with courts/ judicial teams and presenting their Core Implementation Team work to staff (more common among county teams), as well as implementing TIC education or trainings for their staff (more common among state teams).

- Participants also overwhelmingly agreed that their Core Implementation Teams would continue to meet to advance the work even after the formal learning community comes to an end.

Transformed agency workforces

- One of the biggest accomplishments reported by initiative participants was getting their agency staff trained on concepts like TIC, ACEs, and related topics. As a result of these trainings, many agency staff not only demonstrated increased *knowledge* about these issues, but increased *engagement* in their work and a sense of *empowerment* to adopt leadership roles and advocate for change when it comes to trauma-informed care.

- Many participants on both the county and state teams reported that the dynamics within their agency had changed since the initiative began. At several agencies, staff noted that they are generally more collaborative and supportive of one another as a result of the increased agency-wide focus on TIC.

- In general, participants expressed a heightened awareness about the impact of trauma on individuals and said that they were modifying their own interactions as a result. For example, significantly more county and state team participants were integrating trauma-informed principles into their interactions with colleagues at the end of Phase II compared to before they began participating in the initiative.

A foundation for change at the policy and consumer levels

- While Core Implementation Teams routinely cited numerous accomplishments and various changes to agency practices, few Core Implementation Team leaders reported formal changes to actual agency *policy* during the year. There were some notable exceptions, however, that indicate shifts in agency-wide *practices*. For example, multiple agencies modified their hiring and recruitment process to be more trauma-informed (e.g., by asking about a job candidate's experience working with individuals with trauma histories); implemented systems to track and analyze their performance on one or more trauma-informed care domains; and identified ways to assess the comfort and safety of their environment by the end of Phase II.

- On the parent/consumer level, there were anecdotal reports by initiative participants that consumers were beginning to notice the effects of this work; some families described positive changes in their relationship with social services, as well as improvements to agencies' physical spaces.

These findings suggest a strong basis for additional growth in these areas in the coming years, if commitment to the work remains high.

Future opportunities

Lessons learned from the implementation of this work with members of the Phase II learning community offer several opportunities for strengthening the implementation and impact of Fostering Futures going forward, including:

- Consider ways of enhancing the coaching/technical assistance provided and offer concrete tools and supports when possible, such as specific strategies and tools
- Provide clarity around the goals, process, and expectations in the early stages so participants are clear about the type and amount of work expected
- Offer support to Core Implementation Teams around including meaningful parent or consumer representation on their teams
- Identify opportunities for sharing and cross-agency collaboration, such as an initiative-wide gathering, so teams can learn about one another's work and share resources
- Tailor the content and strategies to fit the work of the county and – especially – state agencies who do not provide direct services to consumers
- Assess the quantity and utility of surveys and other tools administered to Core Implementation Teams to maximize their effectiveness and to limit survey fatigue
- Include assessments of longer-term changes in future evaluations, such as staff turnover and retention rates, agency-level policy and procedural changes, and outcomes for parents/consumers

Participating Core Implementation Teams:

County teams:

– Adams County Health and Human Services Department
– Barron County Department of Health and Human Services
– Chippewa County Human Services
– Dane County Department of Human Services
– Door County Department of Human Services
– Fond du Lac County Department of Social Services
– Jackson County Department of Health and Human Services
– Department of Children and Families
– Division of Milwaukee Child Protective Services*
– Kewaunee County Department of Human Services
– Oneida County Department of Social Services
– Price County Health and Human Services
– Sawyer County Health and Human Services
– Sheboygan County Health and Human Services Department
– St. Croix County Department of Health and Human Services

State teams:

– Department of Children and Families (DCF)
– Department of Corrections (DOC)
– Department of Health Services – Public Health (DHS-PH)
– Department of Health Services – Long-Term Supports (DHS-LTS)
– Department of Veterans Affairs (DVA)
– Department of Workforce Development (DWD)
– Wisconsin Economic Development Corporation (WEDC)

* DCF-Milwaukee is a state-administered division, rather than a county-administered agency.

Introduction

Project background

The Fostering Futures (FF) initiative in Wisconsin was developed in response to research about the negative impact on a child's healthy growth and development caused by chronic traumatic stress. Stress or adverse experiences during childhood can cause poor health outcomes in adulthood. Families and workers who are involved with the child welfare system are particularly vulnerable to these stresses. The FF approach focuses on implementation of trauma-informed (TI) principles into the work of child- and family-serving systems of county and state governments, with the goal of improving the safety and well-being of children and their families touched by the child welfare system. FF's theory of change suggests that policy and systems changes that advance TI principles will result in overall improved health and well-being of Wisconsin's children and families.

This report and evaluation focuses on the most recent phase of FF – **Phase II** (May 2015-October 2017) – in which FF contracted with the National Council for Behavioral Health to provide training and technical assistance to a learning community, utilizing their 7 Domains framework. The learning community in Phase II was comprised of 14 county human services teams and 7 state agency teams that began work in April 2016 following a statewide Request for Applicants in October of 2015. Phase II builds upon community-prioritized needs identified in Phase 1 (January 2013-April 2015), or the Pilot Phase, in which 3 communities – The Harambee neighborhood of Milwaukee, the Menomonee Tribe, and Douglas County, WI – received facilitated peer learning on trauma-informed care from consultants, funded by the Healthier Wisconsin Partnership Project (HWPP). Phase II is also the culmination of feedback and learnings that emerged from seven listening sessions led by Wisconsin's First Lady, Tonette Walker, in 2012 and Summits held in May 2015. The Summits in Wausau and Madison provided education about implementation science and trauma-informed organizational transformation with the goal of generating excitement about the next phase of Fostering Futures. Furthermore, the partnership with and support from the Waupaca community in Wisconsin was instrumental in advancing FF's work; partners in Waupaca assisted with outreach and provided ongoing support and coaching to participating teams. See Appendix A for a timeline of events related to the development and launching of Fostering Futures.

FF is currently aligned with the Wisconsin Trauma Project. The Trauma Project introduces evidence-based trauma treatment into the child welfare service array (Trauma-Focused Cognitive Behavioral Therapy [TF-CBT] training); provides trauma-informed parenting training to resource and biological parents; and offers organizational and system training, consultation, and technical support in order to build a more trauma-responsive system of care through collaboration with FF. County and Tribal Human Service agencies were offered the opportunity to apply to participate in the component or components that would most benefit their system.

Project participants and activities

As noted above, teams participating in Phase II of FF represent a mix of county-based human service agencies and state agencies. The participants of the Phase II learning community (the focus of the current evaluation) received training and technical assistance related to trauma-informed care by the National Council for Behavioral Health (NCBH). Using a learning community model, NCBH provided one year of peer learning to the participants, including individualized coaching. Teams received information and training on Adverse Childhood Experiences (ACEs) and trauma-informed care; conducted organizational self-assessments; identified trauma-informed care domains for change-making; and developed and implemented action plans. Participants were encouraged to participate in national monthly webinars on various topics, three individual team coaching calls and two group calls with a designated coach from NCBH, and three in-person learning community meetings or Summits over the course of the year. Teams were asked to develop a Plan for Change in three domains: (1) create a trauma-informed workforce; (2) redesign safe and secure environments; and (3) engage in performance improvement and evaluation.

County and tribal human service agencies across Wisconsin applied to participate in Phase II of the initiative; state teams were invited to participate by the governor's office. In total, the learning community was comprised of 21 groups, or Core Implementation Teams (CITs), representing 14 county-based human service agencies and 7 state agencies (Figure 1).

It is anticipated that Phase III of FF will launch in early 2018, which will include new members of the learning community and continuing coaching/technical assistance for the current teams.

1. Map of county and state agencies participating in Fostering Futures Phase II

Note. DCF-Milwaukee is a state-administered division, rather than a county-administered agency.

Core Implementation Teams (CITs) were to include approximately 8 to 12 individuals, although the actual size of teams varied from county to county, agency to agency. County teams were expected to include a team leader; 3 to 4 staff members (management and workers); a person to collect, analyze, and disseminate data; 1 to 2 consumers with lived experience in the child welfare system in that county; and 1 executive representing a locally contracted provider of services. State teams were to include a team leader; a mix of managers and staff-level individuals; a person to collect, analyze, and disseminate data; 1 to 2 consumers with lived experience of the system; and 1 executive of an external agency that contracts with the state agency.

The 21 teams began participating in the learning community in April 2016. Participation in the NCBH learning community continued for one year until April 2017. Teams will receive technical assistance and support from their NCBH coach through October 2017. Teams will also receive support and guidance from Fostering Futures leadership during their second year of participation in the initiative (Phase III).

Evaluation overview

Wilder Research was contracted by Fostering Futures to conduct an evaluation of Phase II of this initiative, which includes the activities of the learning community. The purpose of the evaluation of Fostering Futures is to capture how participating teams implement the initiative and to measure the impact of the interventions on trauma-informed care systems change within each participating agency. The evaluation aims to document the implementation process and capture changes in one or more of 3 TIC domains: physical environment, workforce, and quality improvement processes informed by consumers.

The hypothesis is that by the end of Phase II, participants will have gained knowledge and the necessary skills to have made measurable improvements within their agencies toward trauma-informed transformation in at least one of the 3 TIC domains.

Organization of the report

The report that follows presents a summary of the methodology used to conduct the evaluation, the outcome results, lessons learned from the implementation of FF with the learning community in Phase II, and conclusions and recommendations to consider for Phase III.

Methods

This report uses information gathered through a variety of tools – both instruments pre-selected by the National Council for Behavioral Health (NCBH) and the Fostering Futures Steering Committee and tools/methods created specifically for Fostering Futures. The evaluation team used a mixed methods approach to learn about the implementation and impact of the initiative. All research tools, protocols, and consent forms were submitted to relevant Institutional Review Boards and granted exemption in March 2016. Data collected through the evaluation is presented in aggregate, with the exception of de-identified quotations that were selected to demonstrate overarching themes.

Tools were administered to state and county Core Implementation Teams (CITs), with select tools also being administered to a Cross-section of colleagues selected by each CIT. NCBH and Fostering Futures staff encouraged CITs to identify a Cross-section group (i.e., other staff within their agency or department not directly participating in the initiative) to gain an external perspective on the impact of their efforts at each agency. To create the Cross-section groups, CITs identified colleagues from within their organizations, in a variety of roles, who would be impacted by the Fostering Futures work. In total, 13 of 14 county CITs and 3 of 7 state CITs identified a Cross-section of colleagues from their agency.

Figure 2 summarizes the purpose, administration, and response rates for each of the tools. More detailed information on the methodology is available in Appendix B.

2. Summary of evaluation tools

Tool	Description	Tool administration
▶ Organizational Self-Assessment (OSA)	Measures the degree to which an organization's policies, procedures, practices, and environment reflect the core principles and values of a trauma-informed care organization	Electronic surveys sent to: – State CIT members in April 2016 (83% response rate) and March 2017 (52% response rate) – County CIT members in April 2016 (92% response rate) and March 2017 (63% response rate) – County Cross-sections in September 2016 (29% response rate) and April 2017 (25% response rate)
▶ The Professional Quality of Life Scale, version 5 (ProQOL 5)	Assesses the negative and positive effects of helping others who experience suffering and trauma by measuring an individual's compassion satisfaction, burnout, and compassion fatigue	Electronic surveys sent to: – State CIT members in April 2016 (78% response rate) and March 2017 (50% response rate) – County CIT members in April 2016 (88% response rate) and March 2017 (64% response rate) – County Cross-sections in August 2016 (44% response rate) and March 2017 (39% response rate) – State Cross-sections in August 2016 (45% response rate) and March 2017 (40% response rate)
▶ The Performance Measurement Tool (PMT)	Measures CIT progress in creating systems change within their organization	Electronic surveys sent to: – County CIT leaders in April 2016, August 2016,and February 2017 (100% response rate for all) – State CIT leaders in April 2016, August 2016,and February 2017 (100% response rate for all)
▶ Quarterly Team Reports	Summarizes each CIT's team meetings and attendance, key accomplishments, challenges, and outreach activities	CIT leaders asked to electronically submit reports every 3 months in Phase II. (83% response rate – 70 out of a possible 84 reports received)
▶ Participant Feedback Survey (PFS)	Measures perceived changes in CIT member attitudes, knowledge, practices, and beliefs related to trauma-informed principles	Administered in-person to all CIT members who attended the April 2017 Summit; sent electronically in April 2017 to all other CIT members – State CIT members: 68% response rate – County CIT members: 52% response rate
▶ Focus groups	Structured discussions about participant experiences with different facets of Fostering Futures, the impact of their work, and suggestions for the future	Conducted 3 separate focus groups in April 2017 with: – County CIT members (12 attendees representing 12 county CITs) – State CIT members (5 participants representing 4 County CITs) – Parent/consumer representatives from County CITs (6 attendees representing 6 County CITs)

Note. The Organizational Self-Assessment (OSA), the Professional Quality of Life Scale (ProQOL 5), and the Performance Measurement Tool (PMT) were selected by the National Council for Behavioral Health as a part of their ongoing work with each CIT and the coaches who provided support to each team. The Quarterly Team Reports, Participant Feedback Survey, and Focus Group protocol were tools created for the Fostering Futures initiative by Wilder Research in collaboration with the Fostering Futures Evaluation Committee. The Cross-section was asked to participate in the OSA and the ProQOL only as the other tools are specific to the activities of the CITs.

Limitations

The following section summarizes limitations that should be considered when interpreting the evaluation data. It should also be noted that it can often take years to observe certain changes or outcomes in initiatives focused on systems-change such as Fostering Futures. Therefore, because the evaluation findings presented here reflect a one-year period, it is possible that not enough time has passed for some changes or improvements to be detected or that certain tools lacked sufficient specificity or sensitivity to detect change.

Quarterly reports

The analysis of each Quarterly Core Team Report showed that team leaders filled out these reports to varying degrees of completion and occasionally interpreted questions on the report in different ways. In addition, some teams did not fill out many reports and, thus, this analysis may not accurately represent the entirety of activities carried out by those CITs.

Performance Measurement Tool (PMT)

As a tool intended to serve as a basis for conversation between teams and their coaches, the PMT was created with programmatic – rather than evaluative – goals in mind. While the PMT does offer helpful information about changes in practice, systems, and processes in each agency over the course of the year, its response categories are not mutually exclusive and thus results can be difficult to interpret. In addition, only one team member (typically the team leader) completes the tool. Teams are instructed that this individual should have the best knowledge of the overall work of the team or seek feedback from team members on answers to specific questions they do not have information about. Despite these instructions, the perspectives of the rest of the CIT may not necessarily be reflected in the results. Finally, turnover in the CIT leader role resulted in multiple people completing the PMT at different points in time, so the results are not always comparable. Given these constraints, the PMT results were used primarily to verify, support, or add nuance to themes found through other evaluation tools.

Organizational Self-Assessment (OSA)

Similar to the PMT, the Organizational Self-Assessment (OSA) was created for programmatic purposes by the National Council for Behavioral Health. The length and complexity of many questions on the OSA made it difficult to concretely interpret results at the individual question level. Thus, this report used results at the domain level to extract meaning from the OSA.

In addition, many members of state CITs felt the OSA focused on direct services and was not as applicable to their work at the state level. As a result, some participants admitted repeating their responses from baseline at the follow-up assessment. In addition, several county teams chose not to participate and none of the three state Cross-sections received the OSA, given these issues.

Finally, a matched statistical analysis was used to measure change from the initial OSA to the follow-up OSA, meaning that only those respondents who participated in the OSA at both time points were included in the analysis. Therefore, this report does not include the results of those that only completed the OSA at one time point and may not be representative of all CIT members and Cross-section participants.

Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL 5)

Similar to feedback provided about the OSA, some CIT members found the ProQOL 5 to be too clinical in nature given the type of work they do. They felt that the assessment focused on those in "helping professions" and was less relevant to non-direct service oriented professionals, especially at the state level.

In addition, a matched statistical analysis was used to measure change from the initial ProQOL 5 to the follow-up ProQOL 5, meaning that only those respondents who participated in the ProQOL 5 at both time points were included in the analysis. Therefore, this report does not include the results of those that only completed the ProQOL 5 at one time point and may not be representative of all CIT members and Cross-section participants.

Parent/consumer involvement

While the design of Phase II included the involvement of parents and consumer representatives on each CIT, many teams struggled to find and maintain this involvement over the course of the year, especially state teams. The limited number of parent and consumer representatives involved in the initiative overall, and even less so in the evaluation, makes results non-generalizable.

Outcome results

The following summarizes the key findings that emerged from the evaluation of the second phase of Fostering Futures. Key findings generally reflect themes that were present across multiple data sources. When county and state team results were similar, they are presented together. When there were differences, they are presented separately.

Key accomplishments

Transformed agency workforces

- Agencies have provided staff training on TIC, ACEs, and related topics, resulting in increased knowledge of and engagement in trauma-informed practice
- Work environments have become collaborative; there is more communication, consideration, and trust among colleagues
- Staff are using trauma-informed principles in their interactions with one another, trying to respond with less judgment and more compassion

In general, counties reported improvements in their agencies' efforts to build a trauma-informed workforce, create safe and secure environments, and establish ongoing performance improvement. Overall comparisons of the initial and follow-up OSA assessment results showed that county team members felt they improved across all seven domains of trauma-informed care assessed by the OSA. The highest overall ratings by counties on the initial assessment were in the domain related to the provision of best practices in trauma-informed care (Domain 4), while the lowest were in the domain related to the practice of evaluation and performance improvement (Domain 7) (Figure 3).

On the follow-up assessment, county participants generally gave notably higher ratings when compared with ratings on the initial assessment. The biggest increases in average ratings from the initial assessment to follow-up assessment were in the domains related to having a trauma-informed workforce (Domain 3), creating safe and secure environments (Domain 5), and conducting performance improvement and evaluation (Domain 7), the three domains of focus for this initiative (Figure 3).

OSA results from county Cross-section respondents showed minimal increases between the initial and follow-up assessments for these domains. However, Cross-section respondents tended to rate their county agencies higher overall in each domain, giving average ratings of 1.66 to 2.36 on each domain on the initial assessment (Appendix C, Figure C1).

3. Overall comparison of county CIT scores on the initial and follow-up OSAs

Domain	Initial average score (April 2016)	Follow-up average score (March 2017)	Difference between Initial and follow-up average score
Domain 1: Early Screening and Comprehensive Assessment of Trauma (N=59)	1.12	1.75	0.63***
Domain 2: Consumer Driven Care and Services (N=59)	0.74	1.35	0.61***
Domain 3: Trauma-Informed, Educated, and Responsive Workforce (N=57)	0.83	1.84	1.01***
Domain 4: Provision of Trauma-Informed, Evidence-Based, and Emerging Best Practices (N=59)	1.24	1.92	0.68***
Domain 5: Create Safe and Secure Environments (N=57)	1.09	2.03	0.94***
Domain 6: Engage in Community Outreach and Partnership Building (N=58)	1.11	1.68	0.57***
Domain 7: Ongoing Performance Improvement and Evaluation (N=56)	0.55	1.53	0.98***

Note. The rating scale for each question ranged from 0 to 4, where 0=we do not meet this standard at all, 1=we minimally meet this standard, 2=we partially meet this standard, 3=we mostly meet this standard, and 4=we are exemplary in meeting this standard (we have much to offer other grantees). Differences in overall domain scores between the initial OSA assessment and the follow-up OSA assessment were analyzed using a paired samples test, and are significant ***p<.001.

State agencies maintained or reported minimal gains in building a trauma-informed workforce and establishing ongoing performance improvements. When comparing the CIT results of initial and follow-up OSA assessments, state members generally reported a lesser degree of improvement in each domain when compared with county team results, although they maintained or slightly improved in each domain. More notable gains were made in domains related to ongoing evaluation (Domain 7) and creating a trauma-informed workforce (Domain 3) – two of the three focus domains (Figure 4).

4. Overall comparison of state CIT scores on the initial and follow-up OSAs

Domain	Initial average score (April 2016)	Follow-up average score (March 2017)	Difference between Initial and follow-up average score
Domain 1: Early Screening and Comprehensive Assessment of Trauma (N=17)	1.10	1.20	0.10
Domain 2: Consumer Driven Care and Services (N=18)	0.74	0.90	0.16
Domain 3: Trauma-Informed, Educated, and Responsive Workforce (N=23)	0.88	1.69	0.81***
Domain 4: Provision of Trauma-Informed, Evidence-Based, and Emerging Best Practices (N=19)	0.93	1.15	0.22
Domain 5: Create Safe and Secure Environments (N=20)	1.04	1.40	0.36*
Domain 6: Engage in Community Outreach and Partnership Building (N=17)	0.96	1.21	0.25
Domain 7: Ongoing Performance Improvement and Evaluation (N=57)	1.10	1.99	0.89***

Note. The rating scale for each question ranged from 0 to 4, where 0=we do not meet this standard at all, 1=we minimally meet this standard, 2=we partially meet this standard, 3=we mostly meet this standard, and 4=we are exemplary in meeting this standard (we have much to offer other grantees). Differences in overall domain scores between the initial OSA assessment and the follow-up OSA assessment were analyzed using a paired samples test, and are significant at *p<.05 and ***p<.001

Individual CITs showed substantial improvements in all OSA domains. At the team level, comparisons from the initial OSA to the follow-up OSA revealed that 43 percent of county teams increased by at least 1 point on a scale of 0 to 4 in the domain related to creating safe and secure environments (Domain 5), while 43 percent of state teams increased in domains related to consumer driven care and services (Domain 2), trauma-informed workforce (Domain 3), and performance improvement and evaluation (Domain 7) (Figure 5). At least one CIT showed a 1-point improvement from the initial to follow-up assessment in every trauma-informed care domain. Results suggest that during Phase II, CITs feel that their organizations have made notable progress when it comes to adopting trauma-informed principles.

5. Number of CITs reporting at least a 1-point increase from the initial OSA to the follow-up OSA

Domain	County CITs (N=14)		State CITs (N=7)	
	Number	%	Number	%
Domain 1: Early Screening and Comprehensive Assessment of Trauma	1	7%	2	29%
Domain 2: Consumer Driven Care and Services	4	29%	3	43%
Domain 3: Trauma-Informed, Educated, and Responsive Workforce	4	29%	3	43%
Domain 4: Provision of Trauma-Informed, Evidence-Based, and Emerging Best Practices	4	29%	1	14%
Domain 5: Create Safe and Secure Environments	6	43%	2	29%
Domain 6: Engage in Community Outreach and Partnership Building	4	29%	1	14%
Domain 7: Ongoing Performance Improvement and Evaluation	3	21%	3	43%

Note. The rating scale for each question ranged from 0 to 4, where 0=we do not meet this standard at all, 1=we minimally meet this standard, 2=we partially meet this standard, 3=we mostly meet this standard, and 4=we are exemplary in meeting this standard (we have much to offer other grantees). For this analysis, the Milwaukee County Department of Children and Families was considered a county team.

County and state team members reported changes in personal awareness and interactions with others. According to findings from the Participant Feedback Survey and focus groups, as a result of the initiative, participants expressed a heightened awareness about the impact of trauma on individuals and said that they were modifying their own interactions as a result. Specifically, the survey showed that significantly more county and state team participants were integrating trauma-informed principles into their interactions with others at work compared to before they began participating in the initiative (Figure 6; see Appendix C, Figures C31-C33 for the full set of survey results).

6. Changes in use of trauma-informed principles in interactions with others, Participant Feedback Survey: County and state teams (means)

Items	County CITs			State CITs		
	N	Before initiative	After initiative	N	Before initiative	After initiative
I integrate trauma-informed principles into my interactions with others at work.	79	2.9	3.6***	44	2.7	3.5***
I frequently consider the findings from ACEs research in my interactions with others.	77	2.5	3.3***	45	2.1	3.1***
In my work, I use a toolbox of skills to actively engage and build positive relationships with staff, clients, and/or families.	78	3.1	3.6***	45	3.0	3.4***

Note. Respondents were asked to indicate the extent to which they agreed with each statement **before** participating in Fostering Futures and then **after** participating in Fostering Futures. The scale was: 1=strongly disagree, 2=somewhat disagree, 3=somewhat agree, and 4=strongly agree. Differences from before the initiative to after the initiative were tested using a paired samples test. All differences are statistically significant at ***p<.001.

By keeping in mind that the people they work with and/or serve may be dealing with trauma, which may be at the root of their behavior, participants described that they were now mindful of how they were responding to others, and trying to do so with less judgment and more compassion. In fact, using a trauma-informed lens and being mindful about trauma was the most common response among participants when they were asked on the Participant Feedback Survey to identify the biggest impact of the Fostering Futures initiative. This was also echoed in the focus groups.

> *"It has changed the framework in which I perceive encounters with people, both in and out of work. Instead of being frustrated after a challenging interaction, my go-to reaction is now that of empathy and compassion; what may have happened to that person to make them react that way. It has helped me to assume good will of people who may be acting in a deviant or confrontational way. This mindset has helped me to be more patient, understanding, and willing to find different solutions/approaches to meet the needs of people." [Participant Feedback Survey]*
>
> *"Being trauma aware requires deliberate thoughts and thinking. For me it doesn't always come naturally so I have to practice to make it a part of my day to day work." [Participant Feedback Survey]*
>
> *"Definitely seeing cases from a new lens - looking out for beyond what's in your face, using a trauma-informed lens throughout." [Focus group]*
>
> *"It makes you take a breath and think about it as opposed to just walking through it – understand how it's impacting yourself as well as people you work with." [Focus group]*
>
> *"For me, I was more aware of trauma in more egregious situations. But now it's recognizing trauma in less obvious cases, knowing it's there and acknowledging that." [Focus group]*

Initiative participants also saw an increased awareness of TIC at the organizational level by the end of Phase II. Beyond increasing their own individual awareness of TIC and modifying their individual behavior, participants saw significant increases in their awareness and understanding of their *organization's* trauma-informed care practices. According to results from the Participant Feedback Survey, by the end of the year, significantly more participants said they: a) understood the extent to which their organization was trauma-informed, b) observed recent changes in their organization to become trauma-informed, and c) could identify additional ways in which their organization could become *more* trauma-informed. Specifically, both county and state teams showed more than a 1.0 increase in their average rating on these items from the initial assessment to follow-up on the 4-point scale (Figure 7; see Appendix C, Figures C31-33 for the full set of survey results).

7. Changes in awareness of TIC at the organizational level, Participant Feedback Survey: County and state teams (means)

	County CITs			State CITs		
Items	N	Before initiative	After initiative	N	Before initiative	After initiative
My organization has made changes to support trauma-informed care principles.	78	2.4	3.6***	45	2.2	3.3***
I have a clear understanding of the degree to which my organization is trauma-informed.	77	2.1	3.4***	45	1.9	3.2***
I can identify areas in which my organization can become more trauma-informed.	77	2.6	3.7***	44	2.4	3.6***

Note. Respondents were asked to indicate the extent to which they agreed with each statement **before** participating in Fostering Futures and then **after** participating in Fostering Futures. The scale was: 4=strongly agree, 3=somewhat agree, 2=somewhat disagree, and 1=strongly disagree. Differences from before the initiative to after the initiative were tested using a paired samples test. All differences are statistically significant at ***p<.001.

These results indicate that the initiative successfully attuned participants to how their own organizations were adopting trauma-informed practices and principles, as well as opportunities for further integration of TIC into their organization.

> *"It got our organization talking and meeting about TIC." [Participant Feedback Survey]*
>
> *"I think that Fostering Futures has the potential to change how we do "state system" work. I think it will attract and retain better employees." [Participant Feedback Survey]*
>
> *"Helping to move the program forward, it is clear that we need to spend more time training staff how to ask for what they need." [Participant Feedback Survey]*

Training resulted in a more educated, engaged, and empowered workforce. One of the biggest accomplishments reported by initiative participants was getting their staff trained on concepts like trauma-informed care, ACEs, and related topics. PMT results show that at least seven additional agencies provided training on compassion fatigue to their agency staff and felt they had developed the basic knowledge and awareness of TIC within their workforce by the end of Phase II (Appendix C, Figure C28). In addition, staff training efforts were the most commonly cited accomplishment for both county and state teams on their Quarterly Reports. According to focus group participants and the Quarterly Reports, trainings were well-attended and included staff at various levels and within various departments of the organization. As a result of these trainings, many staff are not only more knowledgeable about these issues but are feeling more engaged in their work and empowered to take on leadership roles and advocate for change when it comes to trauma-informed care.

> *"We had trainers come in 2 weeks ago and spend the day going over social justice issues and trying to help [staff] have a better understanding of what's going on nationwide and in [our jurisdiction] and interact with families dealing with those issues. It's the fact that they are feeling more included. Office associates are running our work groups now. They are more empowered, they were not in a leadership role before. Some are putting on their resumes to say I've taken a leadership role in a statewide initiative." [Focus group]*
>
> *For us, staff feel more empowered in this experience. We're trying to make sure they're aware that we want them to be involved." [Focus group]*
>
> *"Getting everyone in the agency trained on trauma was great and having people just get together and be trained on something substantive—a very important process for our work." [Focus group]*
>
> *"We scheduled a Trauma Informed Care Awareness training developed by [agency] for all staff to attend. The second training is being expanded to include staff from other bureaus. By including members outside our bureau, we are initiating exposure and outreach to the larger division." [Quarterly Report]*

Connecting with Broader Agency Staff

Teams said they connected with colleagues at their agency not directly involved with the CIT by:

- Sharing information back and keeping them up-to-date on CIT activities and progress – through e-newsletters/ memos, and occasionally in-person meetings
- Gathering their input and ideas through surveys or open discussion
- Making regular announcements and providing tips and resources around TIC to keep it "in the forefront of everyone's minds"
- Collecting feedback about the CITs work and its implementation of trainings or policies

Participants described a more collaborative and supportive workplace culture as a result of the initiative. According to findings from the Participant Feedback Survey and the focus groups, many participants on both county and state teams report that the dynamics within their agency have changed since the initiative began. In addition, PMT results showed that CITs broadened their work to include staff external to the CIT in workgroups (Appendix C, Figure C30). At several agencies, staff noted that they are working together more and are generally more supportive of one another as a result of the increased focus on TIC.

"It's really brought staff together. Having committees of people with different personalities. I think everybody's more sensitive to each other just in their interaction with coworkers." [Focus group]

"More satisfaction with work, personally. Less stress for staff, better communication." [Participant Feedback Survey]

"It has energized me in my role as leader and given my work a renewed sense of purpose and urgency. It has brought our recently merged agency around a unifying vision and philosophy." [Participant Feedback Survey]

"We're seeing more collaboration… In our presentation, what we've found through this process [is that] we have many new workers and not everyone knew everyone – we needed to focus on people knowing each other. One of our committees took the initiative of doing that and working across teams. People just bring food and eat together. One team has adopted another unit and does fun things for them… last week [someone] brought in donuts and coffee and a sign saying "you donut know how much we appreciate you." We call them random acts of kindness. I think everybody is more supportive and more aware – if you look like you're having a hard time, someone will reach out and ask what's going on. I think our coach said this – it's not that people are giving you a hard time, they're having a hard time. We have adopted that. That can be staff to staff or staff to client. This whole project has helped us with that – you're not really a jerk, something is going on in your life." [Focus group]

> *"We have all levels [on our Core Team] - section chiefs, administrators – you can sit down and talk it out. That's having a slow impact on just how workers talk with the suits or how suits talk with program managers. It's a slow burn. It's having a nice change. One of the things we struggled with is trust between all of staff. 'Administration is doing it because they don't like us' – but it's a matter of transparency. There's been a marked change since we started but we have a long way to go." [Focus group]*

- Although there were few changes to agency policy during Phase II, some agency-wide practices became more trauma-informed (e.g., hiring and recruitment practices)
- Anecdotally, there were reports that consumers began to see the effects of this work, describing more positive relationships with social services and improvements to the physical environment

A foundation for change at the policy and consumer levels

CITs improved various facets of their hiring and recruitment processes by the end of Phase II. Compared to initial PMT results, 11 additional CIT leaders reported that their agencies asked about a job candidate's experience working with individuals with trauma histories and added trauma-informed care principles and practices to new employee training at the time of the mid-point or follow-up PMT. In addition, seven agencies reported that they now mentioned a preference for individuals with a trauma-informed care background in job advertisements by the end of the year (Figure 8).

8. Comparison of PMT results related to hiring and recruitment process improvements

	CIT leaders that responded "YES" to each statement					
	Initial PMT		Mid-Point PMT		Final PMT	
	Number	%	Number	%	Number	%
Our interviews for clinical staff include questions related to their understanding of or experience with working with individuals with trauma histories. (N=19-20)	5	25%	8	42%	16	80%
Our orientation program for new employees includes training on trauma-informed care principles and practices. (N=21)	2	10%	12	57%	13	62%
Our organization's job advertisements include a preference for experience with or knowledge of TIC. (N=21)	1	5%	5	24%	8	38%

Note. Given inconsistencies in CIT leader responses and limitations of the PMT tool when used for evaluation purposes, the number of CIT leaders that responded "Yes" to each statement was calculated by combining those that responded, "Yes, we started this prior to the learning community," and "Yes, we started/expanded this since we joined this learning community".

The impact on consumers is starting to be felt. While most of the changes that have occurred as a result of this initiative have happened among workforce staff, there is some preliminary, anecdotal evidence to suggest that the impact of this work is starting to be experienced by consumers as well. Some participants reported that consumers have started commenting on positive changes in their relationship with social services, as well as improvements to the physical spaces in which they operate (Participant Feedback Survey, focus groups). Some of the consumer representatives themselves noted these changes as well. This will be an important area to assess for growth in Phase III.

> *"We've had consumers make comments about how comfortable the waiting area is now – we had someone fall asleep in there! The ones that attended the parent training were very appreciative." [Focus group]*
>
> *"The families we serve see a change in our environment, in how they are treated, and in how they are engaged in their own care and treatment. They have increased voice and choice." [Participant Feedback Survey]*
>
> *"I can see how things are improving. As a consumer, as a foster parent, as part of the team. When I became a foster parent [many] years ago, they talked about trauma happening but it was 10 minutes of training. Now it's a whole day. I've learned so much about secondary trauma in the last couple of years which I wished I would have known [many] years ago. Now, how they ask questions, go about things [differently]; everything is improving." [Focus group]*

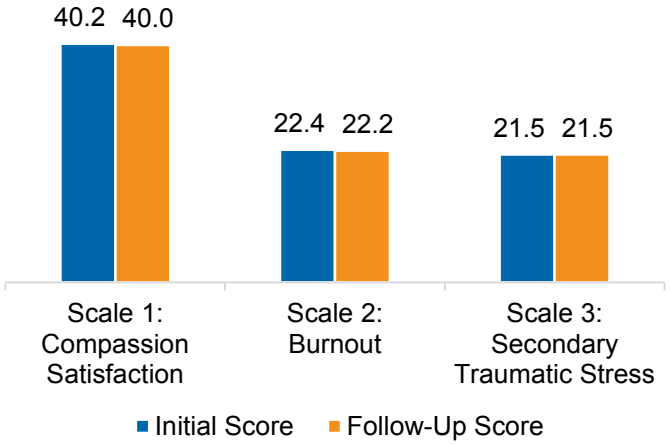
Opportunities for future impact

Over the course of the year, Fostering Futures showed measurable impact on the CITs and beyond. However, there were some areas that did not show improvement, which provide opportunities for growth in the future.

There were no significant changes in levels of compassion satisfaction, burnout, or secondary trauma in Phase II. Initial and follow-up results for the ProQOL 5 showed little to no change on scales measuring compassion satisfaction, burnout, and secondary traumatic stress (Figures 9-10). This finding was consistent across county and state CITs as well as Cross-sections for county and state CITs (Appendix C, Figures C10-C12, C15-C17).

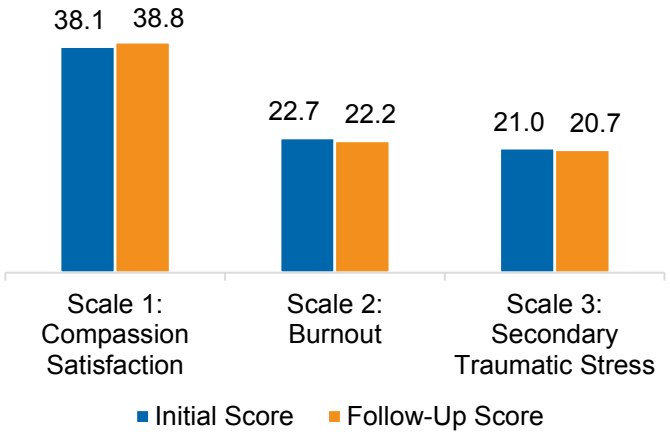
Despite the lack of any significant change during Phase II on the ProQOL 5, respondents overall showed "average" levels of compassion satisfaction with their jobs and "low" levels of burnout and secondary traumatic stress, which is positive (Appendix C, Figures C10-C12, C15-C17).

9. Comparison of county CIT participant results from the initial and follow-up ProQOL 5 (N=57-60)



Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50; according to established cut-off scores, a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score. Differences were tested using a paired samples t-test; none of the differences between the initial score and follow-up score were statistically significant.

10. Comparison of state CIT participant results from the initial and follow-up ProQOL 5 (N=21-22)



Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50; according to established cut-off scores, a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score. Differences were tested using a paired samples t-test; none of the differences between the initial score and follow-up score were statistically significant.

Few changes in organizational policies and procedures occurred over the course of Phase II. While CITs cited numerous accomplishments and various changes to agency practices, few CIT leaders reported formal changes to agency policy during the year (Core Team Reports, PMT). Less than one-quarter of all county and state teams reported any updates to policies and procedures related to screening and assessment, the role of consumers in various facets of the organization, workforce development, or creating a safe and secure environment (Figure 11).

However, there were some notable exceptions in the creation of trauma-informed policies. Five additional CITs reported that their agency had a way to assess the comfort and safety of their environment by the end of the year, and 10 additional agencies had put a system in place to track and analyze performance on one or more trauma-informed care domains (Figure 11).

In addition, a number of CITs had already established trauma-informed policies before joining Fostering Futures, such as 3 of 7 state agencies that came into the initiative with guidelines to ensure adequate staffing to promote safety of staff and consumers, and 5 of 7 state agencies with an established policy to ensure collaboration, continuity, and coordination of care (71%).

11. Comparison of PMT results related to formal policy changes at CIT agencies

	CIT leaders that responded "YES" to each statement					
	Initial PMT		Mid-Point PMT		Final PMT	
	Number	%	Number	%	Number	%
Domain 1: Policies and procedures have been updated to address trauma related to screening and assessment (N=21)	0	0%	2	10%	2	10%
Domain 2: Policies have been formally changed to include involvement of consumers (paid or volunteer) in influential roles, activities, and evaluation of the organization (N=21)	1	4.8%	2	9.5%	1	4.8%
Domain 3: Since beginning this Learning Community, formal changes have been made to our policies and procedures regarding workforce development and trauma-informed care (N=21)	0	0%	1	5%	3	14%
Domain 5: Policies and procedures have been revised to address safe and secure environment (N=20-21)	4	19%	3	14%	4	20%
Domain 5: We have a system in place to assess the comfort and safety of our environment (N=20-21)	5	24%	10	48%	10	50%
Domain 7: Our organization has a system in place to track and analyze performance on one or more trauma-informed care domains in a way that effectively addresses challenges and reinforces progress (N=20-21)	1	5%	7	33%	11	55%

Note. Given inconsistencies in CIT leader responses and limitations of the PMT tool when used for evaluation purposes, the number of CIT leaders that responded "Yes" to each statement was calculated by combining those that responded, "Yes, we started this prior to the learning community," and "Yes, we started/expanded this since we joined this learning community," to each statement.

Implementation results

The following section describes the primary activities of the Core Implementation Teams (CITs), as well as the challenges CITs experienced implementing this work.

Summary of CIT activities and accomplishments

High levels of participant engagement

- There was regular and steady attendance by participants, at all levels, including executive leaders and parent/consumer representatives
- CITs engaged in a range of outreach activities, most notably collaborating with courts/judicial teams and implementing TIC education and trainings with staff
- CITs were optimistic that they would continue to meet to advance the work even after the formal learning community ended

CITs met regularly and maintained steady attendance throughout the first year. Executive leadership was more frequently involved in CIT meetings than parent or consumer representatives, especially among state CITs. Parent or consumer representatives were more likely to meet with their coaches each quarter than to attend CIT meetings (Figure 12).

Both county and state CITs engaged in a number of outreach activities during Phase II. These activities included **collaborating or meeting with courts/judicial teams** and **presenting their CIT work to staff**. Outreach activities for state teams more often included **the implementation of TIC education or trainings for their staff.** Other CIT work included enhancing their workplace environment and creating a shared mission. These implementation accomplishments are provided in greater detail in the section that follows.

12. Core Implementation Team activities at a glance

	County CITs (N=14)	State CITs (N=7)	All CITs (N=21)
Average number of meetings per quarter	4.02	4.40	4.16
Average number of attendees at each CIT meeting	8.90	8.10	8.56
Percentage of team meetings where executive leadership was present	85%	75%	80%
Percentage of team meetings where a parent/consumer representative was present	55%	11%	41%
Average number of CIT outreach activities per quarter	2.26	2.04	2.17
Total number of CIT outreach activities in Phase II	97	53	150

Core Implementation Teams maintained a steady meeting frequency and attendance level during Phase II. A quarter by quarter analysis of CIT reports shows that, on average, both county and state CITs met between 3 and 5 times per quarter – or more than once a month (Appendix C, Figure C41). In terms of attendance, both county and state CITs reported similar numbers of attendees at their meetings, with an overall average of between 8 and 9 people in attendance. Meeting attendance ranged from 2 to 21 people. On average, 8.9 people attended county CIT meetings and 8.1 people attended state CIT meetings. Attendance was consistent throughout the year (Appendix C, Figure C42).

Executive leaders attended the majority of state and county CIT meetings. Quarterly Team Reports asked CIT leaders to report if executive leadership was present at each CIT meeting. Overall, 80 percent of CIT meetings included executive leadership, with county teams reporting higher frequency of executive leadership attendance (85% of meetings) than state CITs (75% of meetings) (Figure 12).

There was authentic participation by parents/consumers. Although there was a relatively limited number of parents or consumers who participated in Fostering Futures, the experience for those who were involved was very positive. Focus group participants in particular noted how they felt included in the work, that their voices were heard, and that their ideas were validated.

> *"We feel valued because everyone on that side of the table doesn't have our experience. Our trauma experience is not judged. We feel safe." [Focus group]*
>
> *"I gave a suggestion about training new social workers [what I thought would work well in the community]. I mentioned having people come in and talk about trauma informed care instead of using PowerPoints, manuals. The response was well received – they said it was a good idea. It made me feel included, like I belonged." [Focus group]*

CITs engaged in a consistent level of outreach activities throughout the year. In total, CITs reported a total of 150 outreach activities during Phase II (Figure 12). Both county and state CITs averaged around two outreach activities per quarter, with the exception of a slow start for state CITs in Quarter 1 (Appendix C, Figure C43). The range of total outreach activities varied somewhat by CIT, with state teams engaging in anywhere from 0 to 8 outreach activities per quarter.

CITs were also asked to provide detail about their outreach activities in the Quarterly Team Reports, and some significant differences emerged between county and state teams. While both county and state teams mentioned **collaborating or meeting with courts/judicial teams** and **presenting their CIT work to staff**, these activities were more common among county teams.

For state teams, the most common outreach activity noted was **implementing TIC education or training**, such as inviting outside speakers, holding workshops, or conducting awareness activities to gauge staff understanding of TIC topics and spur discussion.

CIT-lead training and education

State and county CITs organized a range of training opportunities, including training for themselves, for broader agency staff, and – in fewer cases – for staff of neighboring agencies. In particular:

- Nearly all teams involved in some form of staff training indicated that they or their staff attended webinars on topics relevant to the initiative
- A common theme across trainings, particularly for staff, was self-care – including education about compassion fatigue or secondary traumatic stress
- Many teams noted that the trainings or educational activities they implemented were well-attended and/or well-received
- Several teams prioritized the implementation of Trauma-Informed Care "basics" in order to ensure that all staff had a foundation of knowledge regarding TIC

Teams reported working on getting staff trained, enhancing their workplace environments, and creating a shared mission. Quarterly Reports also asked CITs to identify any action items that emerged from Core Team meetings. The most commonly cited action item among both county and state teams was to conduct staff education or training (13 county teams, 7 state teams), such as training colleagues about secondary trauma or conducting seminars on compassion fatigue. Making changes to their facility was another recurring action item included in Core Team reports (9 county teams), including actions such as enhancing the physical environment of lobbies and forming a committee to conduct a scan on workspace environment. In addition, both county and state teams often included the creation of a shared mission, vision, or set of values among their action items (9 county teams, 4 state teams).

Other common themes among action items included sharing information or updates (about the initiative and its work) with staff (8 county teams, 7 state teams), and surveying or getting feedback from staff (7 county teams, 3 state teams).

Implementation opportunities

As might be expected in the first year of an initiative of this scope and complexity, teams encountered some challenges during their participation. Identifying these barriers was of particular interest in this evaluation because they offered important lessons and opportunities for enhancing the work in Phase III.

- **Significant time commitment**. For both the county and state teams, the most frequently cited challenge on the Quarterly Reports was the significant amount of time participants spent engaged in this initiative (9 county teams, 4 state teams). Focus group participants also noted this as a challenge, with most remarking that they had not expected to invest that much time. This was a challenge for many as participants are attempting to fit this work into their already heavy workloads.

- **Less engagement/interest among staff outside of the CIT**. Although the message of the initiative generally resonated with Core Implementation Team members, uptake among agency colleagues has been somewhat more mixed. Focus group participants spoke about bringing back the concepts and framework to their broader organization through trainings and one-on-one conversations and reported a mixed response. As noted, some participants cited fairly pervasive changes throughout their organizational structure (e.g., use of common language among staff around the core concepts; a more collaborative, engaged, and empathic workforce). However, other participants reported that while the initiative has generally had an impact on the attitudes and behaviors of most, if not all Core Team members, this has *not* been the case for their agency as a whole, citing resistance to change and lack of buy-in/interest among some of their colleagues. Some agency staff are reportedly more reluctant to embrace the framework for a variety of reasons including politics/partisanship, a lack of time or capacity, feeling like they are already trauma-informed, or feeling burnt out by the work and past initiatives.

  > *"We had some social workers that seem to be applying it more than people who aren't on the team. Their interactions with people they work with have been more positive – they've had people comment, 'I've worked with your agency before and it wasn't like this.' So I'm seeing that shift. It's more the people on our team – maybe we're not getting that out to the agency as much." [Focus group]*
  >
  > *"They [other staff] just keep saying, 'we do this all the time'. I take a step back and say, 'you guys are the ones who need it most'. But they are so convinced that they already have it and they already do it. That's where some of my frustration is…" [Focus group]*

> *"There are people struggling who have been trying to work on this for a long time and then the First Lady comes along and says there's this initiative… we got a ton of feedback from brown bags and a lot of politics being thrown into this, coming from the First Lady/our administration. There's a lot of mistrust in that. We're trying to speak to that and acknowledge that. Our employees are feeling like there has been trauma given from above. It's difficult to speak to that." [Focus group]*
>
> *"I don't think we're there yet, but, within our small Core Team, I think the relationships and trust are being built…. Sometimes the stress people are under and requirements are getting in the way of that. We don't have capacity in our county, it gets to be a stress, and we're supposed to take care of ourselves." [Focus group]*
>
> *"Consistent with implementation science and organizational change theory, [agency] employees have a range of approaches/reactions to the initiative. In general, there is a group of enthusiastic supporters (i.e., early adopters); a large group of staff with an undecided/wait and see approach; and a group of skeptics, cynics, and resisters." [Quarterly Reports]*

- **Less engagement of and consistent participation by parents/consumers in CIT meetings, especially among the state teams.** Each CIT was asked to recruit a team member that represented a parent of a youth involved with their agency or a direct consumer voice. During the focus group and in the Quarterly Reports, state team participants noted that it was challenging to engage consumers to be a part of the CIT and this work. Some did not see the benefit or relevance of including consumers when it came to the work of their state agency. Overall, 41 percent of state and county CIT meetings included parent or consumer representation. County CITs were more likely to involve parent or consumer team members in their meetings (55% of all county CIT meetings) when compared with state CITs (11% of all state CIT meetings) (Figure 12).

Looking more closely at the inclusion of parent or consumer voice by team, at least 86 percent of county CITs (12 of 14 teams) included a parent or consumer representative in **at least one** of their CIT meetings, compared to 43 percent of state teams (3 of 7 teams). These percentages drop when we look at how many CITs included a parent or consumer **in at least half** of their CIT meetings. Still, more county teams involved parent or consumer in at least half of their CIT meetings (57%) than state teams (14%) (Figure 13).

13. Parent/consumer involvement in CITs: quarterly reports

	County CITs (N=14)	State CITs (N=7)	All CITs (N=21)
Percentage of CITs that reported a parent/consumer attended **at least one** meeting	86%	43%	71%
Percentage of CITs that reported a parent/consumer attended **at least half** of CIT meetings	57%	14%	43%

- **Not enough coaching, specific guidance, or tools**. Among respondents who completed the Participant Feedback Survey, and those who participated in the focus group, the most common suggestion to enhance Fostering Futures going forward – from both county and state teams – was to provide additional guidance and coaching around this work. Many expressed frustration about the process of reporting out what their team was doing without getting any specific guidance, strategies, or tools in return. In particular, a number of participants said they would appreciate something like a toolkit or manual that included strategies to guide them in this process. Several also said that it would be helpful to have specific tools, such as trauma screening tools; some noted that these were referenced in a broad, general sense, but they wanted someone to identify specific tools to save them the time and resources needed to look for and review instruments (Quarterly Reports, Participant Feedback Survey, focus groups).

  > *"Clearer support and guidance with the coaching calls. The calls, though helpful, often were simple report outs as opposed to a coaching moment." [Participant Feedback Survey]*
  >
  > *"More substantial coaching. Coaching calls were more about sharing what we've done than getting ideas, suggestions, or trouble shooting." [Participant Feedback Survey]*
  >
  > *"Greater guidance from the coaching calls. Feel like we have had very little guidance and have had to find our way ourselves as a non-direct service organization." [Participant Feedback Survey]*
  >
  > *"More examples of tools and processes that have worked." [Participant Feedback Survey]*
  >
  > *"Concrete steps as to how we continue moving forward efforts in our agency." [Participant Feedback Survey]*
  >
  > *"A toolkit to help with direction, goal development, examples/ideas would help in the early stages; we did struggle." [Participant Feedback Survey]*
  >
  > *"Sample language, sample screenings, what services you can send families to - and more on resiliency. Yes, this mom went through this stuff but look how well she's doing! Really pointing out resiliency. And tools!" [Focus group]*
  >
  > *"At the end of the first Summit meeting, I couldn't believe they didn't leave us with more specifics examples around how to make our organization to be more trauma informed. Everyone on our team was expecting that… I was like, you need to give people specific stuff, something. If it was an intentional hiding-the-ball thing, I don't like that. Great set up, but then how do you do this?" [Focus group]*

- **Lack of clarity related to the goals, process, and expectations**. Especially in the early phase of the initiative, some participants noted feeling "overwhelmed" and "unsure" about what they were doing. They felt there was a lack of clarity at the beginning about the goals of the initiative and what the work would entail – and the amount of work involved (focus groups). On the one hand, some participants described struggling with how to define the work and identifying what steps they should take; as a result, some felt like they wasted several months at the outset of the initiative. On the other hand,

other participants reported feeling rushed to complete so many tasks in the early months of the initiative that they did not have enough time to adequately explore certain topics or issues. Both state and county team participants agreed that the initiative involved a lot more work than they expected. Expectations around how much any team or organization would achieve varied quite a bit.

> *"Clearly identify the goals of project. It took too long to get focus." [Participant Feedback Survey]*
>
> *"Yeah, just reassure it's a slow process but you have to keep going. I think we felt like we have to make progress by our first call and that's unrealistic." [Focus group]*
>
> *"For us there was confusion and lack of clarity. We were overwhelmed and confused. We have taken this as an agency wide initiative. I can say across the board, and I've shared this with Fostering Futures – I think there was a lot of confusion. I felt rushed. We were starting to get involved in good conversations and it was on to the next task. It was so task-oriented, it lost the ability to be rich. We had good stuff to walk away with and it was like oh, we're done. I get that we have to have timelines, but some of it felt unrealistic in terms of what we had to do in that time period." [Focus group]*
>
> *"The kickoff itself was overwhelming. I wish we could have had a copy of what people came up with; we spent 4 meetings on a vision statement. That activity was great, but we did it with separate people and we didn't get copies of it. When we started on implementation, we thought big – law enforcement, medical, and finally it was like, we gotta bring it down and back to what we can do, what we can control." [Focus group]*

- **Limited opportunities to share and collaborate across teams**. Several participants indicated that it would be beneficial to hear more about what other teams are doing with respect to implementing trauma-informed care in their agencies. Respondents wanted more opportunity to connect with and learn from one another (Quarterly Reports, Participant Feedback Survey, focus groups). Some expressed that it was only at the end of the first year that they began to learn about the strategies and approaches being utilized by other teams, and that this type of sharing would have been helpful earlier in the process.

> *"Feedback was shared in the focus group, but it would be helpful to be more connected to the other agencies' efforts throughout the year and have insight into what they're doing." [Participant Feedback Survey]*
>
> *"Continue to offer opportunities for learning from each other." [Participant Feedback Survey]*
>
> *"More collaboration between agencies to share best practices not only once a year like the summit meeting." [Participant Feedback Survey]*

- **Lack of relevance of some content/materials to the CITs**. Some participants on both the county and state teams felt that the material and tools used during the initiative were not always relevant to the work they were doing. This was especially true among state teams; several participants in the focus groups, in the Quarterly Reports, and on the Participant Feedback Survey reported that the content and survey instruments were not particularly relevant to non-direct service agencies like themselves. Among county teams, some participants commented that the suggested tools and strategies were cited as being useful in clinical settings, which child welfare agencies are not.

  > *"Provide more guidance or alternatives to non-service organizations." [Participant Feedback Survey]*
  >
  > *"Be sure groups that don't do direct service work… understand how to do this." [Participant Feedback Survey]*
  >
  > *"…And work with counties. It seems like everything has been – 'well, this is for behavioral health clinics'. Well, that's not us. What about the rest of us?" [Focus group]*

Conclusions and recommendations

During their first year as participants of the Phase II learning community, the Fostering Futures Core Implementation Teams (CITs) engaged in a wide range of learning and outreach activities. Overall, several key themes emerged:

- **There was a high level of engagement by participants**. CIT meetings were well-attended and included representation from executive leadership and parents/consumers, who in particular shared that they felt heard and validated during the process. Teams conducted a range of outreach activities (e.g., collaborating with courts/judicial teams, implementing TIC trainings), and participants were committed to meeting and advancing the work even after the formal learning community ended.

- **The dynamics of agency workforces were transformed**. Participants successfully brought trainings to their agencies around TIC, ACEs, and related topics, which increased agency staff's knowledge about these issues, as well as their feelings of engagement in their own work and ability to advocate for change around TIC. Many participants described more supportive and collaborative workplaces as a result, and making conscious efforts to integrate trauma-informed principles into their interactions with colleagues.

- **There are early indications of impact at both the policy and consumer levels**. Although few CIT leaders reported formal changes to actual agency *policy* by the end of Phase II, several agencies had implemented changes in agency-wide *practices,* such as integrating trauma-informed principles into their hiring/recruitment processes and implementing plans to track and analyze their performance on TIC domains. There were also anecdotal reports that consumers were beginning to notice the effects of this work; participants reported that some families felt their relationship with social services was more positive than before, and acknowledged improvements to the physical spaces of agencies as well.

Overall, findings suggest that teams made marked improvements in the three domains of focus for this initiative: (1) building a trauma-informed workforce; (2) creating a safe and secure environment; and (3) conducting performance improvement and evaluation.

Not unexpectedly, teams did encounter several implementation challenges during this first year. These learnings offer Fostering Futures specific opportunities for enhancing this initiative in the future, as participating teams continue their work beyond Phase II, and as Phase III gets set to launch in early 2018. Based upon these findings and the accomplishments achieved to date, the recommendations include:

- **Consider ways of enhancing the coaching/technical assistance provided and offer concrete tools and supports when possible**. Especially in the early stages of a learning community, it may be helpful to provide CIT members with more guidance around how to carry out the work, such as sharing specific examples, strategies, and tools used by other teams. Offer concrete supports such as toolkits, resources, and information about evidence-based practices, and funding when possible.

- **Provide clarity around the goals, process, and expectations in the early stages**. Being upfront with participants about the expectations for the type and amount of work involved and the anticipated outcomes, in the first year and beyond, might alleviate some of the stress and uncertainty some participants experienced.

- **Offer support to CITs around including meaningful parent or consumer representation on their teams.** Parent or consumer members were less likely to attend CIT meetings and met infrequently with their designated coaches. However, parent and consumer focus group participants spoke highly of their CIT involvement and felt that their perspectives were valued by other members. Consider gathering successful strategies utilized by CITs with active parent or consumer members, and provide additional support to teams – especially those at the state level – in defining, identifying, recruiting, and retaining parent or consumer members.

- **Identify opportunities for sharing and cross-agency collaboration**. Focus group members spoke highly of opportunities to learn about the work of other CITs during the Summits, and expressed interest in an initiative-wide gathering that would include both county and state CITs. Consider finding ways – both in-person and virtually – for CITs to interact, share resources centrally, and learn about each other's work.

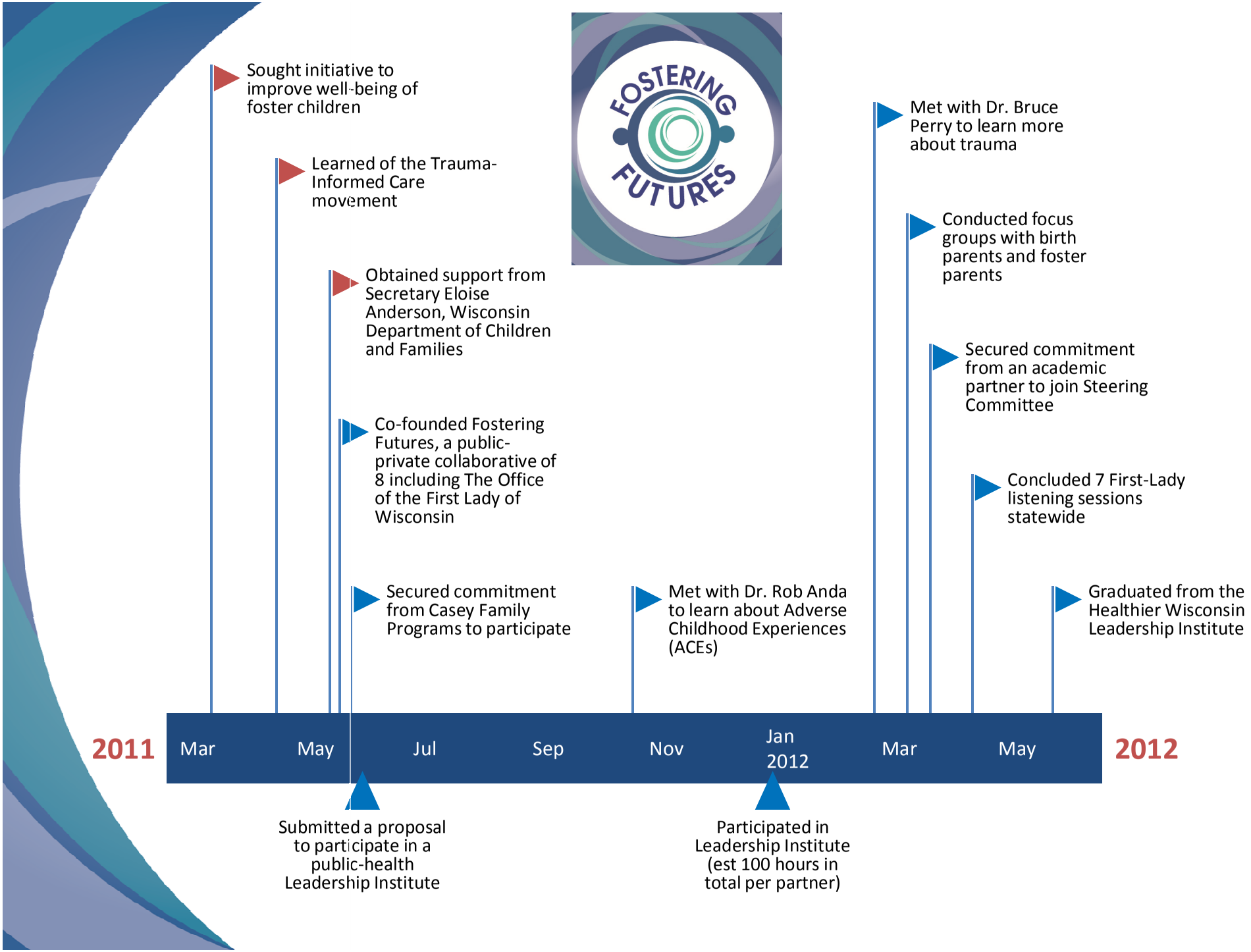
- **Tailor the content and strategies to fit the work of the county and, especially, state agencies.** Ensure that the materials/tools, language, and examples used with CITs are relevant to the type of work they do, the populations they serve, and the settings in which they operate. Many of the tools and assessments were originally designed for direct service behavioral health clinics and had limited applicability for government agencies.

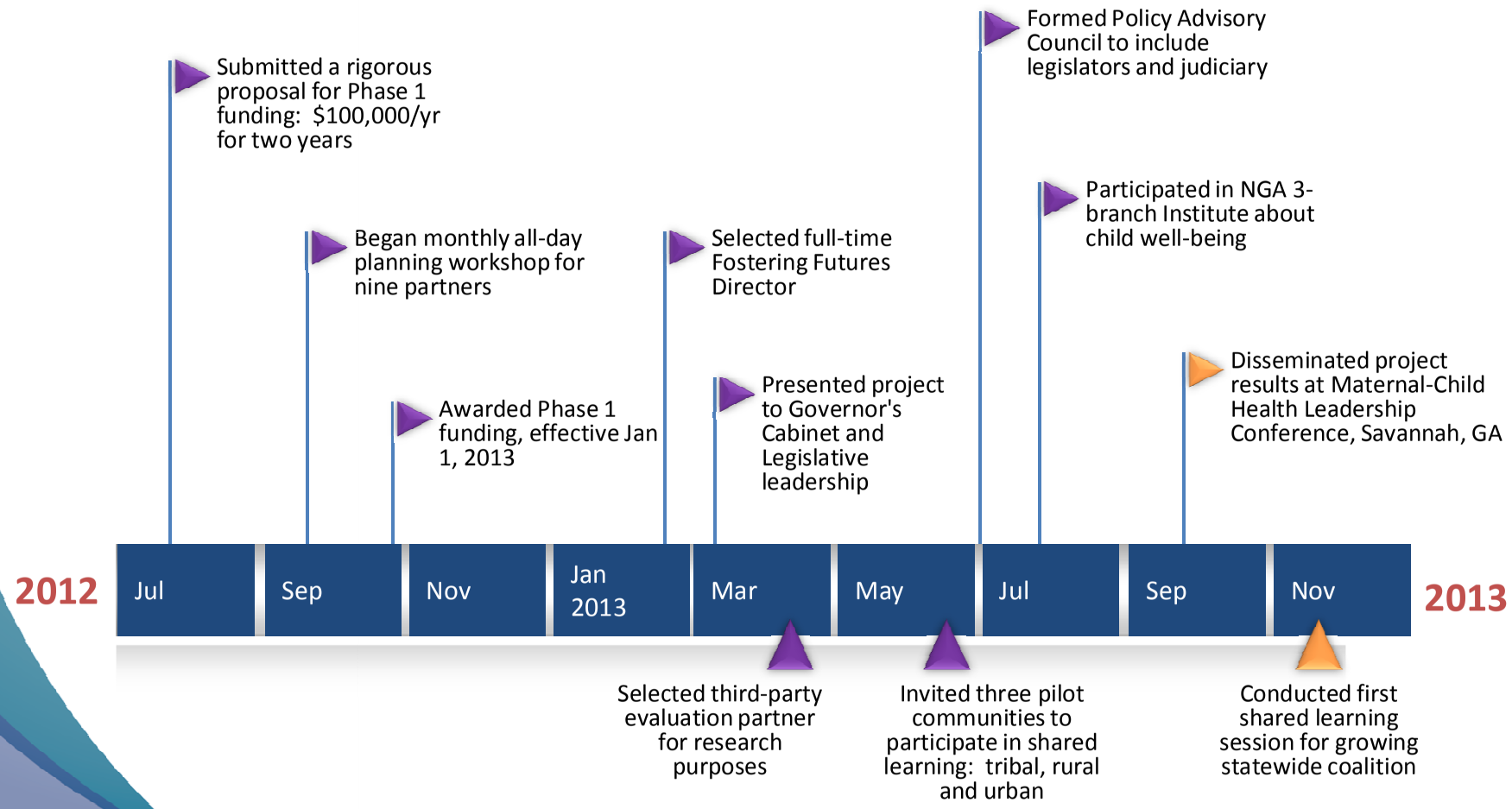
- **Assess the quantity and utility of surveys and other tools administered to CITs.** CIT members completed a series of assessments at multiple times throughout the year as part of the learning community, resulting in survey fatigue by many participants. In addition, several assessments were not created for evaluative purposes, limiting their value as learning and measurement tools for the initiative. Consider reexamining the survey tools and methods used in Phase II given the goals of the initiative, evaluation questions, and CIT member feedback.

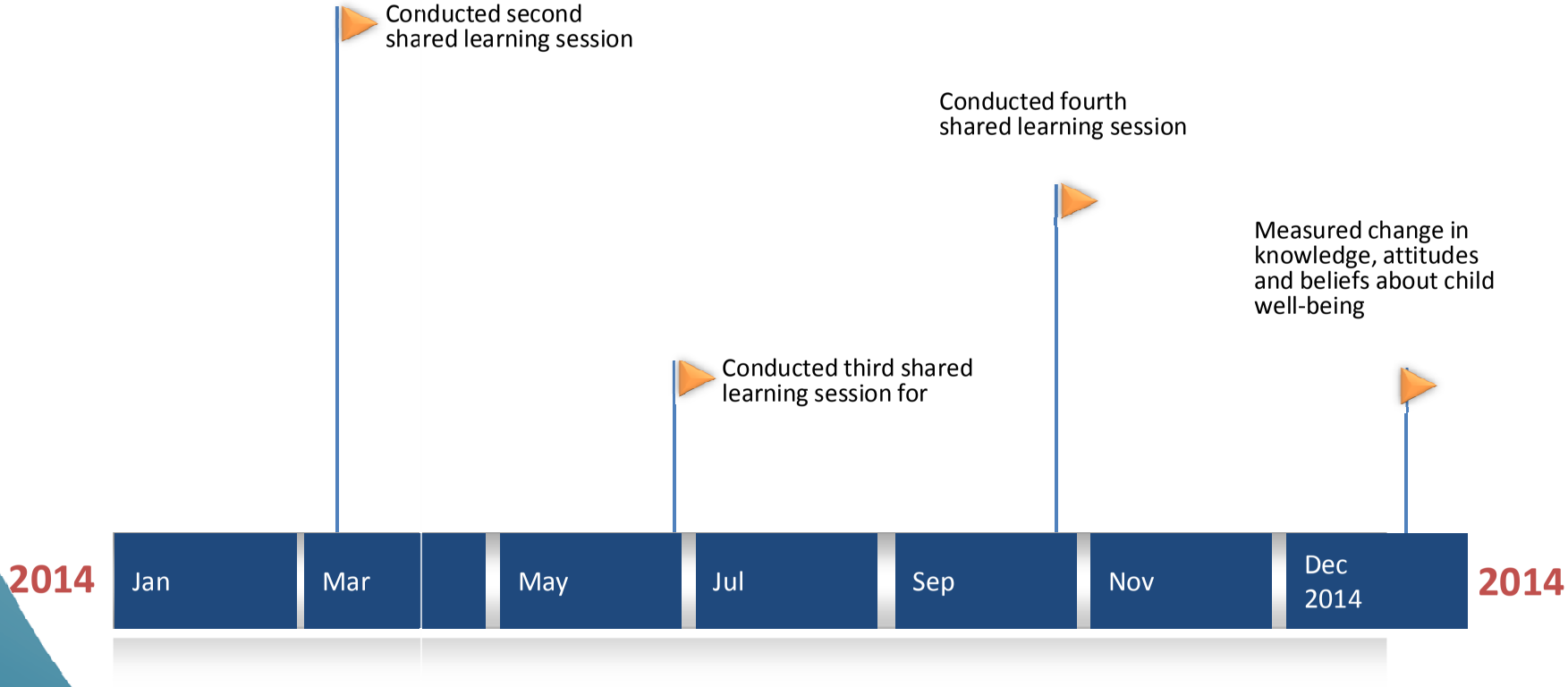
- **Include assessments of longer-term changes in future evaluations.** Given that the evaluation was limited to examining outcomes that occurred in the first year of a multi-year initiative, it was perhaps too early to capture longer-term outcomes such as policy and procedural changes at the county and state levels, changes in staff turnover and retention, and changes at the child/family level. Consider incorporating measures that assess these longer-term outcomes in future evaluation efforts.

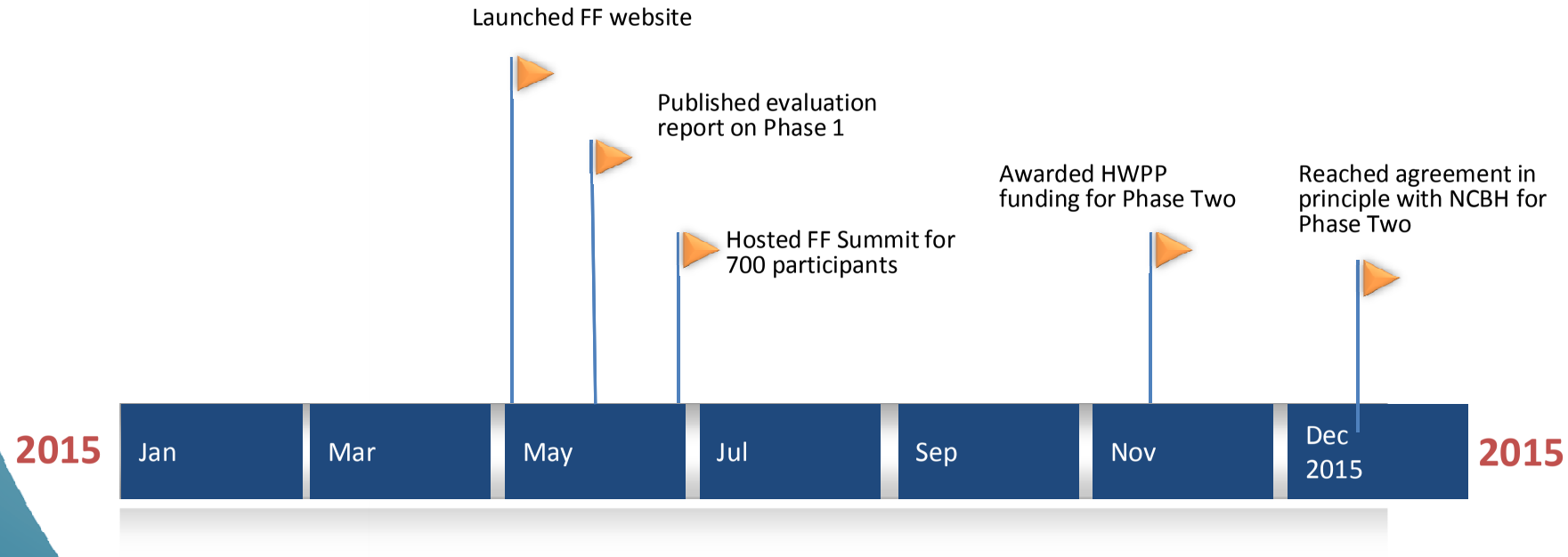
Appendix

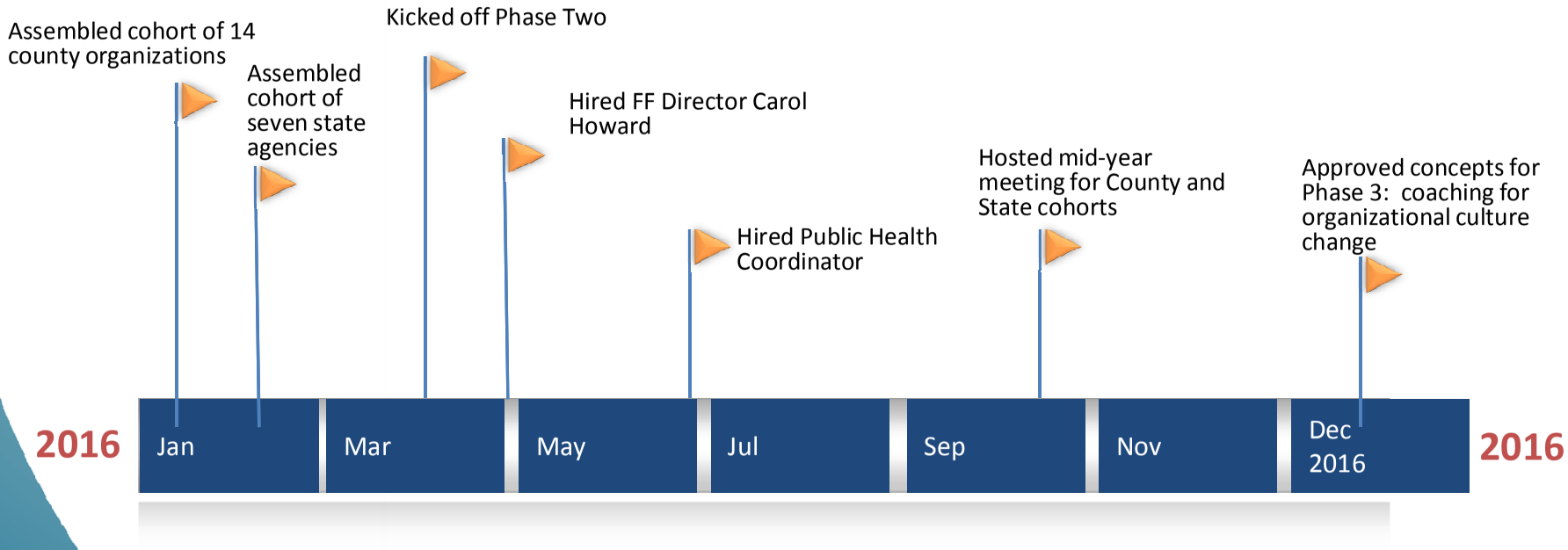
A. River of Time timeline

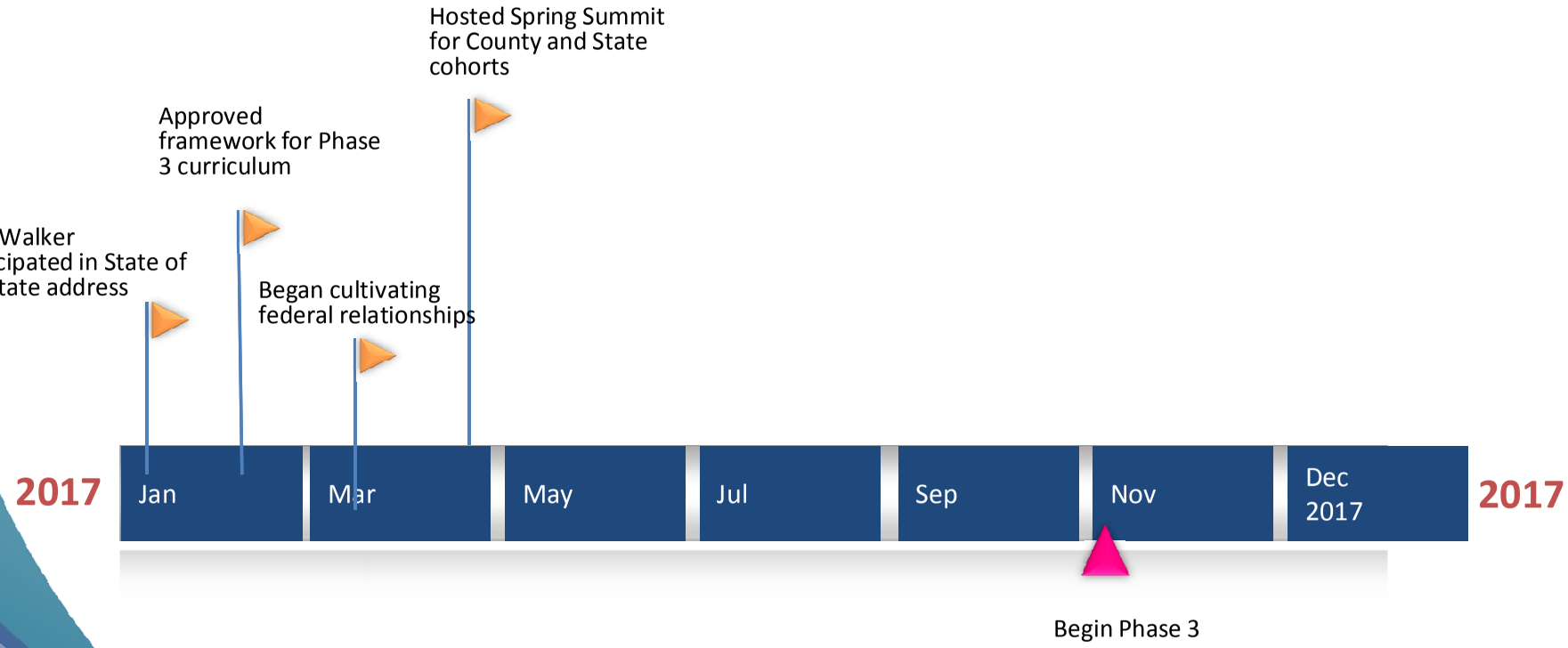



Submitted a rigorous proposal for Phase 1 funding: $100,000/yr for two years
Began monthly all-day planning workshop for nine partners
Awarded Phase 1 funding, effective Jan 1, 2013
Selected full-time Fostering Futures Director
Presented project to Governor's Cabinet and Legislative leadership
Formed Policy Advisory Council to include legislators and judiciary
Participated in NGA 3-branch Institute about child well-being
Disseminated project results at Maternal-Child Health Leadership Conference, Savannah, GA
2012
Jul
Sep
Nov
Jan 2013
Mar
May
Jul
Sep
Nov
2013
Selected third-party evaluation partner for research purposes
Invited three pilot communities to participate in shared learning: tribal, rural and urban
Conducted first shared learning session for growing statewide coalition


Conducted second shared learning session
Conducted fourth shared learning session
Measured change in knowledge, attitudes and beliefs about child well-being
Conducted third shared learning session for
2014
Jan
Mar
May
Jul
Sep
Nov
Dec 2014
2014


Launched FF website
Published evaluation report on Phase 1
Hosted FF Summit for 700 participants
Awarded HWPP funding for Phase Two
Reached agreement in principle with NCBH for Phase Two
2015
Jan
Mar
May
Jul
Sep
Nov
Dec 2015
2015


Assembled cohort of 14 county organizations
Assembled cohort of seven state agencies
Kicked off Phase Two
Hired FF Director Carol Howard
Hired Public Health Coordinator
Hosted mid-year meeting for County and State cohorts
Approved concepts for Phase 3: coaching for organizational culture change
2016
Jan
Mar
May
Jul
Sep
Nov
Dec 2016
2016


Hosted Spring Summit for County and State cohorts
Approved framework for Phase 3 curriculum
Mrs. Walker participated in State of the State address
Began cultivating federal relationships
2017
Jan
Mar
May
Jul
Sep
Nov
Dec 2017
2017
Begin Phase 3

B. Evaluation methods

The initial design of the evaluation considered the volume and scope of tools selected for its programmatic value by the National Council for Behavioral Health and the Fostering Futures Steering Committee. The Organizational Self-Assessment (OSA), Performance Measurement Tool (PMT), and the Professional Quality of Life Scale (version 5; ProQOL 5) were used primarily as reflective tools for Core Implementation Teams to assess their organization's level of trauma-informed care and provide concrete data points for working with NCBH coaches. Given the quantity and nature of data collected by these tools, the evaluation team utilized the results of these surveys to learn about the implementation and impact of Phase II.

In addition, Wilder Research worked with the Fostering Futures Evaluation Committee to design new tools to measure specific evaluative questions. The Focus Groups, Quarterly Core Team Reports, and Participant Feedback Survey provided additional qualitative information and a retrospective view on individual and organizational impacts of Fostering Futures on its participants.

The following provides detailed information about each tool used in the report, the administration of the tool, and the response rates for each tool.

In total, all 14 county teams and 3 state teams identified a Cross-section of colleagues within their agency to participate in the OSA and ProQOL surveys.

Quarterly Core Team Reports

Core Team reports were a new tool created for Fostering Futures to capture the activities and work of Core Teams throughout Phase II. The reports asked CIT leaders to provide information about the frequency of CIT meetings, attendance at meetings, key accomplishments, challenges, and outreach activities.

CIT leaders were asked to submit Quarterly Core Team Reports to the Director of Fostering Futures four times throughout Phase II:

- July 8, 2016 – to cover Core Team work completed in April – June 2016
- October 7, 2016 - to cover Core Team work completed in July – September 2016
- January 6, 2017 – to cover Core Team work completed in October – December 2016
- April 7, 2017 - to cover Core Team work completed in January – March 2017

Out of a maximum number of 84 reports, team leaders submitted a total of 70 quarterly reports. All teams submitted at least one Core Team report. State agencies were more likely than county agencies to complete a report each quarter, with states submitting 27 reports total (out of a maximum of 28 reports, a 96% response rate) and counties submitting 43 reports total (out of a maximum of 56 reports, a 77% response rate).

Organizational Self-Assessment (OSA)

The Organizational Self-Assessment (OSA) is a tool created and selected by the National Council for Behavioral Health to measure the degree to which an organization's policies, procedures, practices, and social and physical environment reflect the core principles and values of a trauma-informed care organization. A matched comparison of baseline and follow-up OSA data intended to show any improvements in the scores of Core Team members and Cross-section participants for each of the seven domains assessed through the OSA:

- Domain 1: Early Screening and Comprehensive Assessment of Trauma
- Domain 2: Consumer Driven Care and Services
- Domain 3: Trauma-Informed, Educated, and Responsive Workforce
- Domain 4: Provision of Trauma-Informed, Evidence-Based, and Emerging Best Practices
- Domain 5: Create Safe and Secure Environments
- Domain 6: Engage in Community Outreach and Partnership Building
- Domain 7: Ongoing Performance Improvement and Evaluation

Overall scores were calculated by averaging the scores given by each respondent for all questions in that domain. Only those who responded to at least half of the questions in a domain were included in the average score. Please note that respondents who participated in the initial OSA are not necessarily the same team members that participated in the follow-up OSA. To be included in the matched analysis, respondents had to participate in both the initial and follow-up OSA, which included 62 county CIT members, 24 state CIT members, and 51 county Cross-section participants. (Please note that there is some variation in sample size when looking across each domain because not all respondents answered all OSA questions.)

CIT members and county[1] Cross-section members were administered the OSA twice during Phase II – once towards the beginning of the Core Team's involvement with Fostering Futures, and again at the end of the year. The timeline and response rates for the OSA for each sample are provided in Figure B1.

B1. OSA administration and response rates

Sample	Initial survey timing and response rate	Follow-up survey timing and response rate
County CIT members	April 2016, N=108 (Response rate: 92%)	March 2017, N=92 (Response rate: 63%)
State CIT members	April 2016, N=50 (Response rate: 83%)	March 2017, N=35 (Response rate: 52%)
County Cross-Section participants	August 2016, N=96 (Response rate: 29%)	March 2017, N=81 (Response rate: 25%)

The Professional Quality of Life Scale, version 5 (ProQOL 5)

The ProQOL 5 is a tool selected by the National Council on Behavioral Health to assess the negative and positive effects of helping others who experience suffering and trauma. It uses a series of questions to measure an individual's compassion satisfaction, burnout, and compassion fatigue.

Wilder Research administered the ProQOL 5 electronically to CIT members and all Cross-section members twice during Phase II – once towards the beginning of the Core Team's involvement with Fostering Futures, and again at the end of the year. The timeline and response rates for each ProQOL 5 sample are provided in Figure B2.

[1] The OSA was administered to county Cross-sections but not to state Cross-sections. The three state core implementation teams that identified Cross-sections chose not to administer the OSA to their Cross-section participants due to concerns about the applicability and appropriateness of the OSA questions to the realities and day-to-day work of state-level workers.

B2. ProQOL 5 administration and response rates

Sample	Initial ProQOL 5 timing and response rate	Follow-up ProQOL 5 timing and response rate
County CIT members	April 2016, N=119 (Response rate: 88%)	March 2017, N=148 (Response rate: 64%)
State CIT members	April 2016, N=59 (Response rate: 78%)	March 2017, N=70 (Response rate: 50%)
County Cross-section	August 2016, N=148 (Response rate: 44%)	March 2017, N=125 (Response rate: 39%)
State Cross-section	August 2016, N=102 (Response rate: 45%)	March 2017, N=97 (Response rate: 40%)

Note. Differences in the sample sizes between initial surveys and follow-up surveys are due to changes in the composition of each CIT or Cross-section throughout the year or incorrect email addresses provided by the teams. Please see the Appendix C, Figure C10, for the number of respondents included in the matched analysis.

Overall ProQOL 5 scores were calculated by averaging the scores given by each respondent for all questions in each scale. Only those who responded to at least half of the questions in a given scale were included in the average score. Please note that respondents who participated in the initial ProQOL 5 are not necessarily the same team members that participated in the follow-up ProQOL 5. To be included in the matched analysis, respondents had to participate in both the initial and follow-up ProQOL 5, which included 60 county CIT members, 22 state CIT members, 84 county Cross-section participants, and 22 state Cross-section participants. (Please note that there is some variation in sample size when looking across each scale because not all respondents answered all survey questions).

Performance Measurement Tool (PMT)

The Performance Measurement Tool (PMT) was a tool selected by the National Council for Behavioral Health to measures Core Team progress in creating systems change within their organization. Wilder Research administered the PMT electronically to the **leaders** of state and county CITs at three different time points throughout Phase II. The timeline and response rates for each PMT are provided in Figure B3.

B3. PMT administration and response rates

Sample	Initial PMT	Mid-point PMT	Follow-up PMT
County CIT leaders	April 2016, N=14 (Response rate: 100%)	August 2016, N=14 (Response rate: 100%)	February 2017, N=14 (Response rate: 100%)
State CIT leaders	April 2016, N=7 (Response rate: 100%)	August 2017, N=7 (Response rate: 100%)	February 2017, N=7 (Response rate: 100%)

A matched comparison of initial, mid-point, and follow-up PMT data intended to show any changes in the practices of CIT agencies around seven domains:

- Domain 1: Early Screening and Comprehensive Assessment of Trauma
- Domain 2: Consumer Driven Care and Services
- Domain 3: Trauma-Informed, Educated, and Responsive Workforce
- Domain 4: Provision of Trauma-Informed, Evidence-Based, and Emerging Best Practices
- Domain 5: Create Safe and Secure Environments
- Domain 6: Engage in Community Outreach and Partnership Building
- Domain 7: Ongoing Performance Improvement and Evaluation of Trauma-informed Care

Given the smaller number of total participants (21 team leaders) and the limitations of the PMT when used for evaluative purposes, a matched analysis was not conducted for the PMT. Rather, its results were used to triangulate or support findings discovered through other evaluation measures.

Focus groups

To supplement the survey data, Wilder Research designed and administered focus groups to CIT participants to learn about their experience with different facets of the initiative, the impact of the work, and suggestions for enhancing the initiative. The focus group protocols were created by Wilder Research in collaboration with the Fostering Futures Evaluation Committee.

Three focus groups were hosted at the April 2017 Summits, at the conclusion of the first year:

- One focus group with county CIT professionals, at which 12 agency employees representing 12 county CITs attended
- One focus group with parent or consumer representatives from county CITs, at which 5 parent or consumer representatives attended from 4 different county CITs
- One with state CIT professionals, at which 6 state employees representing 6 state CITs attended

Participant Feedback Survey (PFS)

Wilder Research designed the Participant Feedback Survey (PFS) in collaboration with the Fostering Futures Evaluation Committee to gather information about individual CIT members' perceived changes in their own attitudes, knowledge, practices, and beliefs related to trauma-informed principles, as well as changes in their partnerships with others.

Specifically, the PFS asked CIT members to assess themselves in the following areas:

- Understanding of ACEs
- Awareness of the prevalence of trauma
- Role in both exacerbating and reducing the effects of trauma for clients
- Use of trauma-informed principles in their work with others

As a retrospective self-assessment, the PFS asks respondents to rate themselves on each item both *before* they began their involvement with Fostering Futures and *after* participating for a year. Both responses for each item are compared using a statistical test (a paired samples t-test) to identify any change that occurred over the course of their involvement. The PFS also asked a number of open ended questions about the impact of the initiative and included demographic questions.

The PFS was administered in-person at the April 2017 Summits for both county and state CIT members (on April 25 and 26, respectively). Wilder Research also emailed electronic links of the survey to CIT members that were not in attendance at the April Summit. In total, the PFS response rate was 52 percent (81 out of 155) for county CITs and 68 percent (45 out of 66) for state CITs.

C. Data tables

C1. Participating county and state agencies

County agencies	State agencies
Adams County Health and Human Services Department	Department of Children and Families (DCF)
Barron County Department of Health and Human Services	Department of Corrections (DOC)
Chippewa County Human Services	Department of Health Services – Public Health (DHS-PH)
Dane County Department of Human Services	Department of Health Services – Long Term Supports (DHS-LTS)
Door County Department of Human Services	Department of Veterans Affairs (DVA)
Fond du Lac County Department of Social Services	Department of Workforce Development (DWD)
Jackson County Department of Health and Human Services	Wisconsin Economic Development Corporation (WEDC)
Department of Children and Families,	
Division of Milwaukee Child Protective Services*	
Kewaunee County Department of Human Services	
Oneida County Department of Social Services	
Price County Health and Human Services	
Sawyer County Health and Human Services	
Sheboygan County Health and Human Services Department	

* DCF-Milwaukee is a state-administered division, rather than a county-administered agency.

C2. County Cross-section participants report minimal changes in the trauma-informed nature of their agencies: OSA

Domain	Initial average score	Follow-up average score	Difference between initial and follow-up average score
Domain 1: Early Screening and Comprehensive Assessment of Trauma (N=44-49)	2.36	2.35	-0.01
Domain 2: Consumer Driven Care and Services (N=44-46)	1.93	1.86	-0.07
Domain 3: Trauma-Informed, Educated, and Responsive Workforce (N=38-44)	1.96	2.34	0.38
Domain 4: Provision of Trauma-Informed, Evidence-Based, and Emerging Best Practices (N=40-42)	2.19	2.34	0.15
Domain 5: Create Safe and Secure Environments (N=33-43)	2.08	2.29	0.21
Domain 6: Engage in Community Outreach and Partnership Building (N=37-42)	1.87	2.15	0.28
Domain 7: Ongoing Performance Improvement and Evaluation (N=34-37)	1.66	1.77	0.11

Note. The rating scale for each question ranged from 0 to 4, where 0=we do not meet this standard at all, 1=we minimally meet this standard, 2=we partially meet this standard, 3=we mostly meet this standard, and 4=we are exemplary in meeting this standard (we have much to offer other grantees). Differences in overall domain scores between the initial OSA assessment and the follow-up OSA assessment were analyzed using a paired samples test, and are significant ***p<.001.

C3. OSA respondents included in the matched analysis

	Number	%
County CITs	62	42%
County Cross-section	51	15%
State CITs	24	63%

Note. Percentages were calculated by using the total number of County CIT participants, County Cross-section participants, and State CIT participants in March 2017. All CITs (County and State) had at least one respondent included in the matched analysis. All but one County CIT had at least participant included in the Cross-section matched analysis. The OSA was not administered to State Cross-sections.

C4. Matched OSA Responses – Length of involvement with Fostering Futures

The Fostering Futures/National Council for Behavioral Health learning community officially kicked off in April 2016. Since then, how many months have you been participating?	County (N=59)		State (N=23)	
	Number	%	Number	%
Between 9-10 months	2	3%	1	4%
11 months	57	97%	22	96%

Note. This data was taken from the follow-up OSA that was administered in March 2017. Three county respondents and one state respondent did not answer this question on the follow-up OSA.

C5. OSA COUNTY Responses - What is your role on the Core Implementation Team (CIT)?

What is your role on the Core Implementation Team (CIT)?	Initial OSA (N=62)		Follow-up OSA (N=59)	
	Number	%	Number	%
Leader	10	16%	10	17%
Data	4	7%	3	5%
Other Core Team member	46	74%	44	75%
Parent/Consumer	2	3%	2	3%
Not on a Core Team	0	0%	0	0%

Note. Three county respondents did not answer this question on the follow-up OSA.

C6. OSA STATE Responses - What is your role on the Core Implementation Team (CIT)?

What is your role on the Core Implementation Team (CIT)?	Initial OSA (N=23)		Follow-up OSA (N=23)	
	Number	%	Number	%
Leader	4	17%	4	17%
Data	1	4%	2	9%
Other Core Team member	18	78%	16	70%
Parent/Consumer	0	0%	0	0%
Not on a Core Team	0	0%	1	4%

Note. One state respondent did not answer this question on the initial and follow-up OSA. Percentages may not add up to 100 due to rounding.

C7. OSA COUNTY Results - What is your role within your own community organization or agency?

What is your role within your own community organization or agency?	Initial OSA (N=62)		Follow-up OSA (N=59)	
	Number	%	Number	%
CEO	5	8%	6	10%
Other leader	7	11%	8	14%
Supervision	14	23%	13	22%
Worker	31	50%	27	46%
Other	4	8%	5	9%

Note. Three county respondents did not answer this question on the follow-up OSA. Percentages may not add up to 100 due to rounding.

C8. OSA STATE Results - What is your role within your own community organization or agency?

What is your role within your own community organization or agency?	Initial OSA (N=23)		Follow-up OSA (N=23)	
	Number	%	Number	%
Leader	2	9%	7	30%
Manager	12	52%	4	17%
Administrator	5	22%	3	13%
Program / Project staff	2	9%	9	39%
Other	2	9%	0	0%

C9. OSA COUNTY CROSS-SECTION Results - What is your role within your own community organization or agency?

What is your role within your own community organization or agency?	Initial OSA (N=46)		Follow-up OSA (N=47)	
	Number	%	Number	%
CEO	0	0%	0	0%
Other leader	2	4%	2	4%
Supervision	8	17%	7	15%
Worker	33	72%	35	75%
Other	3	7%	3	6%

Note. Five County Cross-section respondents did not answer this question on the initial OSA, and four did not answer this question on the follow-up OSA.

Matched ProQOL analysis

C10. ProQOL respondents included in the matched analysis

	Number	%
County CITs	60	41%
County Cross-section	84	26%
State CITs	22	31%
State Cross-section	22	23%

Note. Percentages were calculated by using the total number of eligible County CIT participants, County Cross-section participants, and State CIT participants, and State Cross-section participants in March 2017. All CITs (County and State) had at least one respondent included in the matched ProQOL analysis. All but one County CIT had at least participant included in the County Cross-section matched analysis. Three State CITs were included in the State Cross-section analysis.

County ProQOL tables

Compassion satisfaction is about the pleasure you derive from being able to do your work well. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job. Lower scores indicate that you may either find problems with your job, or there may be some other reason – for example, you might derive your satisfaction from activities other than your job.[2]

C11. County compassion satisfaction scale results – matched analysis (N=59)

	Average score (ranges from 10-50)	Compassion satisfaction level (Low, Average, or High)
County initial compassion satisfaction average score	40.20	Average
County follow-up compassion satisfaction average score	39.97	Average

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

Burnout is one of the elements of Compassion Fatigue (CF) associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. Higher scores on this scale mean that you are at higher risk for burnout. Lower scores reflect positive feelings about your ability to be effective in your work.[2]

[2] Descriptions of each scale were taken from the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL), copywritten by B. Hudnall Stamm, 2009-2012. Additional description and information on the scales can be found at http://www.proqol.org/ProQol_Test.html.

C12. County burnout scale results – matched analysis (N=58)

	Average score (ranges from 10-50)	Burnout level (Low, Average, or High)
County initial burnout average score	22.36	Low
County follow-up burnout average score	22.19	Low

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

Secondary traumatic stress is about your work related, secondary exposure to extremely or traumatically stressful events. High scores on this scale indicate an above-average level of secondary traumatic stress, while lower scores indicate a below-average level of secondary traumatic stress.[3]

C13. County secondary traumatic stress scale results – matched analysis (N=56)

	Average score (ranges from 10-50)	Compassion satisfaction level (Low, Average, or High)
County initial secondary traumatic stress average score	21.54	Low
County follow-up secondary traumatic Stress average score	21.53	Low

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

C14. ProQOL COUNTY Results - What is your role on the Core Implementation Team (CIT)?

What is your role on the Core Implementation Team (CIT)?	Initial ProQOL (N=60)		Follow-up ProQOL (N=60)	
	Number	%	Number	%
Leader	12	20%	12	20%
Data	5	8%	5	8%
Other Core Team member	41	68%	41	68%
Parent/Consumer	2	3%	2	3%
Not on a Core Team	0	0%	0	0%

Note. Percentages may not add up to 100 due to rounding.

C15. ProQOL COUNTY Results - What is your role within your own community organization or agency?

What is your role within your own community organization or agency?	Initial ProQOL (N=60)		Follow-up ProQOL (N=60)	
	Number	%	Number	%
CEO	5	8%	6	10%
Other leader	7	12%	7	12%
Supervision	16	27%	14	23%
Worker	22	37%	25	42%
Other	10	17%	8	13%

Note. Percentages may not add up to 100 due to rounding.

State ProQOL tables

Compassion satisfaction is about the pleasure you derive from being able to do your work well. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job. Lower scores indicate that you may either find problems with your job, or there may be some other reason – for example, you might derive your satisfaction from activities other than your job.[3]

[3] Descriptions of each scale were taken from the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL), copywritten by B. Hudnall Stamm, 2009-2012. Additional description and information on the scales can be found at http://www.proqol.org/ProQol_Test.html.

C16. State compassion satisfaction scale results – matched analysis (N=22)

	Average score (ranges from 10-50)	Compassion satisfaction level (Low, Average, or High)
State initial compassion satisfaction average score	38.05	Average
State follow-up compassion satisfaction average score	38.82	Average

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

Burnout is one of the elements of Compassion Fatigue (CF) associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. Higher scores on this scale mean that you are at higher risk for burnout. Lower scores reflect positive feelings about your ability to be effective in your work.[4]

C17. State burnout scale results – match analysis (N=21)

	Average score (ranges from 10-50)	Burnout level (Low, Average, or High)
State initial burnout average score	22.67	Low
State follow-up burnout average score	22.19	Low

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

Secondary traumatic stress is about your work related, secondary exposure to extremely or traumatically stressful events. High scores on this scale indicate an above-average level of secondary traumatic stress, while lower scores indicate a below-average level of secondary traumatic stress.[4]

[4] Descriptions of each scale were taken from the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL), copywritten by B. Hudnall Stamm, 2009-2012. Additional description and information on the scales can be found at http://www.proqol.org/ProQol_Test.html.

C18. State secondary traumatic stress scale results – matched analysis (N=22)

	Average score (ranges from 10-50)	Secondary traumatic stress level (Low, Average, or High)
State initial secondary traumatic stress average score	20.95	Low
State follow-up secondary traumatic stress average score	20.68	Low

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

C19. ProQOL STATE Results - What is your role on the Core Implementation Team (CIT)?

	Initial ProQOL (N=22)		Follow-up ProQOL (N=22)	
What is your role on the Core Implementation Team (CIT)?	Number	%	Number	%
Leader	7	32%	5	23%
Data	2	9%	2	9%
Other Core Team member	13	59%	15	68%
Parent/Consumer	0	0%	0	0%
Not on a Core Team	0	0%	0	0%

Note. Percentages may not add up to 100 due to rounding.

C20. ProQOL STATE Results - What is your role within your own community organization or agency?

	Initial ProQOL (N=22)		Follow-up ProQOL (N=22)	
What is your role within your own community organization or agency?	Number	%	Number	%
Leader	3	14%	6	27%
Manager	7	32%	5	23%
Administrator	6	27%	3	14%
Program / Project staff	4	18%	8	36%
Other	2	9%	0	0%

Note. Percentages may not add up to 100 due to rounding.

County Cross-section ProQOL tables

Compassion satisfaction is about the pleasure you derive from being able to do your work well. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job. Lower scores indicate that you may either find problems with your job, or there may be some other reason – for example, you might derive your satisfaction from activities other than your job.[5]

C21. County cross-section compassion satisfaction scale results – matched analysis (N=84)

	Average score (ranges from 10-50)	Compassion satisfaction level (Low, Average, or High)
County cross section initial compassion satisfaction average score	38.54	Average
County cross section follow-up compassion satisfaction average score	38.29	Average

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

Burnout is one of the elements of Compassion Fatigue (CF) associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. Higher scores on this scale mean that you are at higher risk for burnout. Lower scores reflect positive feelings about your ability to be effective in your work.[5]

[5] Descriptions of each scale were taken from the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL), copywritten by B. Hudnall Stamm, 2009-2012. Additional description and information on the scales can be found at http://www.proqol.org/ProQol_Test.html.

C22. County cross-section burnout scale results – matched analysis (N=84)

	Average score (ranges from 10-50)	Burnout level (Low, Average, or High)
County cross section initial burnout average score	23.31	Average
County cross section follow-up burnout average score	23.30	Average

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

Secondary traumatic stress is about your work related, secondary exposure to extremely or traumatically stressful events. High scores on this scale indicate an above-average level of secondary traumatic stress, while lower scores indicate a below-average level of secondary traumatic stress.[6]

C23. County cross-section secondary traumatic stress scale results – matched analysis (N=84)

	Average score (ranges from 10-50)	Secondary traumatic stress level (Low, Average, or High)
County cross section initial secondary traumatic stress average score	20.75	Low
County cross section follow-up secondary traumatic stress average score	20.77	Low

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

[6] Descriptions of each scale were taken from the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL), copywritten by B. Hudnall Stamm, 2009-2012. Additional description and information on the scales can be found at http://www.proqol.org/ProQol_Test.html.

C24. ProQOL COUNTY CROSS-SECTION Results - What is your role within your own community organization or agency?

What is your role within your own community organization or agency?	Initial ProQOL (N=84)		Follow-up ProQOL (N=84)	
	Number	%	Number	%
CEO	1	1%	2	2%
Other leader	6	7%	6	7%
Supervision	16	19%	17	20%
Worker	51	61%	53	63%
Other	10	12%	6	7%

Note. Percentages may not add up to 100 due to rounding.

State Cross-section ProQOL tables

Compassion satisfaction is about the pleasure you derive from being able to do your work well. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job. Lower scores indicate that you may either find problems with your job, or there may be some other reason – for example, you might derive your satisfaction from activities other than your job.[7]

C25. State cross-section compassion satisfaction scale results – matched analysis (N=22)

	Average score (ranges from 10-50)	Compassion satisfaction level (Low, Average, or High)
State cross section initial compassion satisfaction average score	38.05	Average
State cross section follow-up compassion satisfaction average score	38.14	Average

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

[7] Descriptions of each scale were taken from the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL), copywritten by B. Hudnall Stamm, 2009-2012. Additional description and information on the scales can be found at http://www.proqol.org/ProQol_Test.html.

Burnout is one of the elements of Compassion Fatigue (CF) associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. Higher scores on this scale mean that you are at higher risk for burnout. Lower scores reflect positive feelings about your ability to be effective in your work.

C26. State cross section burnout scale results – matched analysis (N=22)

	Average score (ranges from 10-50)	Burnout level (Low, Average, or High)
State cross section initial burnout average score	23.00	Average
State cross section follow-up burnout average score	22.64	Low

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

Secondary traumatic stress is about your work related, secondary exposure to extremely or traumatically stressful events. High scores on this scale indicate an above-average level of secondary traumatic stress, while lower scores indicate a below-average level of secondary traumatic stress.

C27. State cross section secondary traumatic stress scale results – matched analysis (N=22)

	Average score (ranges from 10-50)	Secondary traumatic stress level (Low, Average, or High)
State cross section initial secondary traumatic stress average score	21.95	Low
State cross section follow-up secondary traumatic stress average score	21.23	Low

Note. The average scores for each of the three scales were calculated using the results of all respondents that answered all survey questions pertaining to each scale. The rating scale for each subscale ranges from 10 to 50, where a score of 22 or less indicates a **low** score, a score between 23 and 41 indicates an **average** score, and a score of 42 of more indicates a **high** score.

C28. ProQOL state cross section results – What is your role within your own community organization or agency?

What is your role within your own community organization or agency?	Initial ProQOL (N=22)		Follow-up ProQOL (N=22)	
	Number	%	Number	%
Leader	0	0%	0	0%
Manager	7	32%	9	41%
Administrator	3	14%	2	9%
Program/Project staff	10	46%	9	41%
Other support staff	1	5%	1	5%
Other	1	5%	1	5%

Note. Percentages may not add up to 100 due to rounding.

Performance Measurement Tool (PMT) tables

C29. Minimal formal policy changes at CIT agencies in Phase II: PMT

	CIT leaders that responded "YES" to each statement*					
	Initial PMT		Mid-point PMT		Final PMT	
	Number	%	Number	%	Number	%
We have developed the basic knowledge and awareness of TIC within our workforce (N=21)	12	57%	17	81%	19	90%
We provide training on Compassion Fatigue to address secondary trauma in the workplace (N=19-21)	7	33%	9	43%	12	63%

* Due to limitations of the PMT tool, the categories "Yes, we started this prior to the learning community" and "Yes, we started/expanded this since we joined the learning community," were combined.

C30. CIT meeting frequency

	Initial PMT (N=21)		Mid-Point PMT (N=21)		Final PMT (N=21)	
	Number	%	Number	%	Number	%
Our Core Implementation Team continues to meet regularly (at least 1x monthly)	20	95%	21	100%	19	91%

Note. Due to limitations of the PMT tool, the categories "Yes, we started this prior to the learning community" and "Yes, we started/expanded this since we joined the learning community," were combined.

C31. CIT inclusion of external staff in TIC-related workgroups

	Initial PMT (N=21)		Mid-Point PMT (N=21)		Final PMT (N=21)	
	Number	%	Number	%	Number	%
Our CIT has broadened the number of staff involved in TIC related workgroups beyond the CIT	10	48%	14	67%	17	81%

Note. Due to limitations of the PMT tool, the categories "Yes, we started this prior to the learning community" and "Yes, we started/expanded this since we joined the learning community," were combined.

Participant Feedback Survey data tables

C32. Changes in knowledge, attitudes, and behaviors related to trauma-informed care: County and state teams (means)

			County CITs		State CITs	
	N	Before FF	After FF	N	Before FF	After FF
I understand the profound effects of adverse childhood experiences (ACEs) and other trauma on individuals.	79	3.1	3.8	45	3.0	3.9
I recognize the high prevalence of traumatic experiences in people who receive mental health, physical health, and substance abuse services.	79	3.2	3.9	45	3.2	3.9
I understand how human service staff might unintentionally cause additional trauma to those we serve.	79	3.0	3.8	44	3.1	3.8
I contribute to efforts that make my organization a safe, trusting, and healing environment.	78	3.0	3.6	45	3.1	3.7
I integrate trauma-informed principles into my interactions with others at work.	79	2.9	3.6	44	2.7	3.5
I understand that a person's symptoms of a mental health, substance abuse, or medical problem may be their way of coping with trauma.	79	3.2	3.8	45	3.1	3.8
I frequently consider the findings from ACEs research in my interactions with others.	77	2.5	3.3	45	2.1	3.1
I consider the role that trauma may be playing in the difficulties an individual may be experiencing.	77	3.1	3.8	45	2.8	3.6

Note. Respondents were asked to indicate the extent to which they agreed with each statement **before** participating in Fostering Futures and then **after** participating in Fostering Futures. The scale was: 4=strongly agree, 3=somewhat agree, 2=somewhat disagree, and 1=strongly disagree.

Differences from before the initiative to after the initiative were tested using a paired samples test. Differences between means from "Before FF" to "After FF", for all items, are statistically significant at p<.001.

C32. Changes in knowledge, attitudes, and behaviors related to trauma-informed care: County and state teams (means) (continued)

	County CITs			State CITs		
	N	Before FF	After FF	N	Before FF	After FF
In my work, I use a toolbox of skills to actively engage and build positive relationships with staff, clients, and/or families.	78	3.1	3.6	45	3.0	3.4
I feel inspired to engage in the promotion of trauma-informed care (TIC).	78	2.8	3.8	45	2.7	3.6
My organization has made changes to support trauma-informed care principles.	78	2.4	3.6	45	2.2	3.3
I have a clear understanding of the degree to which my organization is trauma-informed.	77	2.1	3.4	45	1.9	3.2
I can identify areas in which my organization can become more trauma-informed.	77	2.6	3.7	44	2.4	3.6
I partner with the families of clients to improve services. {County teams only}	70	2.6	3.2	--	--	--
I incorporate trauma-informed principles into my collaboration with other agencies and/or organizations.	75	2.5	3.3	45	2.2	3.0
I include the views and priorities of the people affected by our work in the improvement of our services.	76	2.7	3.4	45	2.6	3.2
When making changes to organizational practices and policies, I consider the well-being of and the potential impact on staff members.	76	2.8	3.6	44	3.0	3.5

Note. Respondents were asked to indicate the extent to which they agreed with each statement **before** participating in Fostering Futures and then **after** participating in Fostering Futures. The scale was: 4=strongly agree, 3=somewhat agree, 2=somewhat disagree, and 1=strongly disagree.

Differences from before the initiative to after the initiative were tested using a paired samples test. Differences between means from "Before FF" to "After FF", for all items, are statistically significant at $p<.001$.

C33. Changes in knowledge, attitudes, and behaviors related to trauma-informed care: County teams (percentages) (N=70-79)

		Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
I understand the profound effects of adverse childhood experiences (ACEs) and other trauma on individuals.	Before FF	35%	48%	8%	9%
	After FF	82%	18%	0%	0%
I recognize the high prevalence of traumatic experiences in people who receive mental health, physical health, and substance abuse services.	Before FF	38%	52%	6%	4%
	After FF	89%	11%	0%	0%
I understand how human service staff might unintentionally cause additional trauma to those we serve.	Before FF	32%	42%	25%	1%
	After FF	86%	11%	3%	0%
I contribute to efforts that make my organization a safe, trusting, and healing environment.	Before FF	23%	50%	22%	1%
	After FF	65%	32%	3%	0%
I integrate trauma-informed principles into my interactions with others at work.	Before FF	17%	56%	24%	4%
	After FF	57%	42%	1%	0%
I understand that a person's symptoms of a mental health, substance abuse, or medical problem may be their way of coping with trauma.	Before FF	37%	48%	13%	3%
	After FF	82%	18%	0%	0%
I frequently consider the findings from ACEs research in my interactions with others.	Before FF	16%	36%	34%	14%
	After FF	42%	52%	5%	1%
I consider the role that trauma may be playing in the difficulties an individual may be experiencing.	Before FF	29%	52%	16%	4%
	After FF	82%	18%	0%	0%
In my work, I use a toolbox of skills to actively engage and build positive relationships with staff, clients, and/or families.	Before FF	28%	53%	15%	4%
	After FF	55%	45%	0%	0%
I feel inspired to engage in the promotion of trauma-informed care (TIC).	Before FF	23%	39%	32%	6%
	After FF	80%	19%	1%	0%
My organization has made changes to support trauma-informed care principles.	Before FF	6%	40%	40%	14%
	After FF	65%	31%	3%	1%
I have a clear understanding of the degree to which my organization is trauma-informed.	Before FF	5%	29%	39%	27%
	After FF	42%	53%	4%	1%

Note. Respondents were asked to indicate the extent to which they agreed with each statement **before** participating in Fostering Futures and then **after** participating in Fostering Futures. The scale was: 4=strongly agree, 3=somewhat agree, 2=somewhat disagree, and 1=strongly disagree.

C33. Changes in knowledge, attitudes, and behaviors related to trauma-informed care: County teams (percentages) (N=70-79) (continued)

		Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
I can identify areas in which my organization can become more trauma-informed.	Before FF	14%	42%	34%	10%
	After FF	70%	30%	0%	0%
I partner with the families of clients to improve services.[*county teams only*]	Before FF	20%	39%	21%	20%
	After FF	39%	46%	13%	3%
I incorporate trauma-informed principles into my collaboration with other agencies and/or organizations.	Before FF	13%	40%	32%	15%
	After FF	40%	55%	4%	1%
I include the views and priorities of the people affected by our work in the improvement of our services.	Before FF	13%	51%	25%	11%
	After FF	43%	51%	5%	0%
When making changes to organizational practices and policies, I consider the well-being of and the potential impact on staff members.	Before FF	22%	47%	20%	11%
	After FF	62%	37%	1%	0%

Note. Respondents were asked to indicate the extent to which they agreed with each statement **before** participating in Fostering Futures and then **after** participating in Fostering Futures. The scale was: 4=strongly agree, 3=somewhat agree, 2=somewhat disagree, and 1=strongly disagree.

C34. Changes in knowledge, attitudes, and behaviors related to trauma-informed care: State teams (percentages) (N=44-45)

		Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
I understand the profound effects of adverse childhood experiences (ACEs) and other trauma on individuals.	Before FF	44%	24%	18%	13%
	After FF	87%	13%	0%	0%
I recognize the high prevalence of traumatic experiences in people who receive mental health, physical health, and substance abuse services.	Before FF	47%	31%	13%	9%
	After FF	93%	4%	2%	0%
I understand how human service staff might unintentionally cause additional trauma to those we serve.	Before FF	27%	55%	18%	0%
	After FF	87%	11%	2%	0%
I contribute to efforts that make my organization a safe, trusting, and healing environment.	Before FF	24%	64%	11%	0%
	After FF	76%	22%	2%	0%

Note. Respondents were asked to indicate the extent to which they agreed with each statement **before** participating in Fostering Futures and then **after** participating in Fostering Futures. The scale was: 4=strongly agree, 3=somewhat agree, 2=somewhat disagree, and 1=strongly disagree.

C34. Changes in knowledge, attitudes, and behaviors related to trauma-informed care: State teams (percentages) (N=44-45) (continued)

		Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
I integrate trauma-informed principles into my interactions with others at work.	Before FF	21%	39%	27%	14%
	After FF	61%	34%	0%	5%
I understand that a person's symptoms of a mental health, substance abuse, or medical problem may be their way of coping with trauma.	Before FF	36%	44%	16%	4%
	After FF	84%	16%	0%	0%
I frequently consider the findings from ACEs research in my interactions with others.	Before FF	4%	27%	40%	29%
	After FF	33%	51%	11%	4%
I consider the role that trauma may be playing in the difficulties an individual may be experiencing.	Before FF	24%	40%	24%	11%
	After FF	64%	33%	2%	0%
In my work, I use a toolbox of skills to actively engage and build positive relationships with staff, clients, and/or families.	Before FF	24%	53%	18%	4%
	After FF	49%	47%	4%	0%
I feel inspired to engage in the promotion of trauma-informed care (TIC).	Before FF	24%	36%	22%	18%
	After FF	71%	20%	7%	2%
My organization has made changes to support trauma-informed care principles.	Before FF	16%	16%	47%	22%
	After FF	47%	36%	16%	2%
I have a clear understanding of the degree to which my organization is trauma-informed.	Before FF	4%	16%	42%	38%
	After FF	31%	58%	9%	2%
I include the views and priorities of the people affected by our work in the improvement of our services.	Before FF	13%	49%	27%	11%
	After FF	38%	51%	9%	2%
When making changes to organizational practices and policies, I consider the well-being of and the potential impact on staff members.	Before FF	27%	46%	23%	5%
	After FF	61%	32%	5%	2%

Note. Respondents were asked to indicate the extent to which they agreed with each statement **before** participating in Fostering Futures and then **after** participating in Fostering Futures. The scale was: 4=strongly agree, 3=somewhat agree, 2=somewhat disagree, and 1=strongly disagree.

C35. Participant Feedback Survey respondents (N=126)

	Number	%
County	81	64%
State	45	36%

Note. At least one individual from each of the 21 CITs participated in the Participant Feedback Survey.

C36. As a Core Implementation Team member, have you personally proposed at least one action step or idea about how to apply trauma-informed care (TIC) principles to improve your organization's work? (N=124)

		County		State	
		Number	%	Number	%
As a Core Implementation Team (CIT) member, have you personally proposed at least one action step or idea about how to apply trauma-informed care (TIC) principles to improve your organization's work?	Yes	75	95%	44	98%
	No	2	3%	0	0%
	Don't know	2	3%	1	2%

C37. Do you have a clear understanding of your Core Implementation Team's strategy for change? (N=124)

		County		State	
		Number	%	Number	%
Do you have a clear understanding of your Core Implementation Team's strategy for change?	Yes	70	89%	105	85%
	No	5	6%	13	11%
	Don't know	4	5%	6	5%

C38. To what extent do you feel like your Core Implementation Team (CIT) has accomplished its goals over this past year? My CIT has accomplished: (N=124)

		County		State	
		Number	%	Number	%
To what extent do you feel like your Core Implementation Team (CIT) has accomplished its goals over this past year? My CIT has accomplished:	All of its goals	0	0%	2	4%
	Most of its goals	33	42%	23	51%
	Some of its goals	39	49%	13	29%
	Very few of its goals	7	9%	5	11%
	None of its goals	0	0%	2	4%

C39. The Fostering Futures/National Council for Behavioral Health learning community officially kicked off in April 2016. Since then, how many months have you been participating? (N=125)

		Number	Mean
The Fostering Futures/National Council for Behavioral Health learning community officially kicked off in April 2016. Since then, how many months have you been participating?	County	80	10.5
	State	45	10.3

C40. What is your role on the Core Implementation Team (CIT)? (N=123)

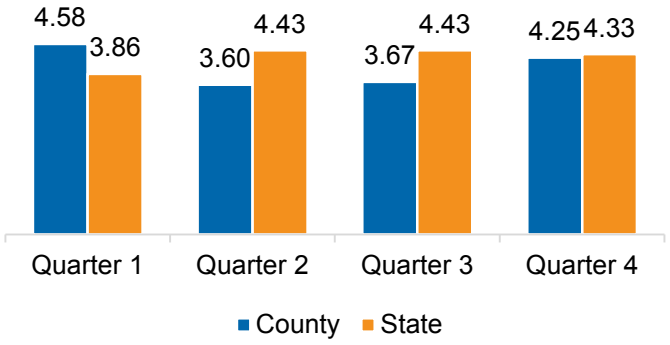
	County		State	
What is your role on the Core Implementation Team (CIT)?	Number	%	Number	%
Leader	13	16%	7	16%
Data	7	9%	1	2%
Other Core Team member	57	71%	34	79%
Parent/Consumer	3	4%	1	2%

C41. What is your role within your own community organization or agency? (N=117)

	County		State	
What is your role within your own community organization or agency?	Number	%	Number	%
Leader	0	0%	9	23%
Manager	0	0%	12	30%
Administrator	0	0%	1	3%
Program / Project staff	0	0%	13	33%
Office support staff	0	0%	2	5%
CEO	6	8%	0	0%
Other leader	10	13%	0	0%
Supervision	21	27%	0	0%
Worker	30	39%	0	0%
Other	10	13%	3	8%

Quarterly report tables

C42. Number of county and state CIT meetings during Phase II



C43. CITs meeting attendance throughout Phase II

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Overall Phase II
Average county CIT meeting attendance	8.7	7.5	9.7	9.6	8.9
Average state CIT meeting attendance	7.9	8.3	8.3	7.3	8.1

C44. CIT outreach activities by quarter during Phase II

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Overall Phase II
Average number of county CIT outreach activities	2.46	2.60	1.83	2.13	2.26
Average number of state CIT outreach activities	0.86	2.86	2.14	2.40	2.04

2017 Participant Feedback Survey - COUNTY
Fostering Futures

Fostering Futures is interested in learning how this initiative helped you to grow as a leader and service provider. This questionnaire will ask you to reflect on your experiences before participating in the initiative and how you have grown as a result of the initiative.

The questionnaire is voluntary, but we hope you will take time to complete it and provide important information about the impact of the initiative. Whether or not you decide to complete this survey will not affect your participation in the initiative, and there are no penalties or loss of any benefits for not participating, nor are there any significant risks to participating. You may skip any questions or stop the survey at any time if you decide not to participate. It should take approximately 15 minutes to complete.

There are no right or wrong answers, and your responses will remain confidential. Only Wilder Research will have access to identifiable responses, and all information will be de-identified in the resulting reports. Some information may be reported out at the team or agency level, or by your role on the team (aggregated across teams), but only if there are a sufficient number of responses such that the information is not identifiable. The information you provide will be used only for the purpose of this project, but we may have to share this information if it is required by law or if you make a threat to harm yourself or someone else.

If you have any questions or concerns about the project, please contact Monica Idzelis Rothe, Research Manager at Wilder Research at 651-280-2657 or monica.idzelis@wilder.org.

If you agree to participate in the questionnaire, please indicate your consent below:

☐ No, I do not agree to participate {**STOP HERE**}

☐ Yes, I agree to participate

Please indicate which Core Implementation Team (CIT) you were affiliated with: _____

The first set of questions asks you to think about your skills, knowledge and experiences BEFORE and AFTER participating in Fostering Futures.

	Think back to **BEFORE** participating in Fostering Futures. Please rate your level of agreement or disagreement with the following statements.					Now rate your agreement or disagreement with the following statements **AFTER** having participated in Fostering Futures.			
	BEFORE PARTICIPATING					**AFTER PARTICIPATING**			
	Strongly Agree	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**	→	**Strongly Agree**	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**
1a. I understand the profound effects of adverse childhood experiences (ACEs) and other trauma on individuals.	☐4	☐3	☐2	☐1	**1b.**	☐4	☐3	☐2	☐1
2a. I recognize the high prevalence of traumatic experiences in people who receive mental health, physical health, and substance abuse services.	☐4	☐3	☐2	☐1	**2b.**	☐4	☐3	☐2	☐1
3a. I understand how human service staff might unintentionally cause additional trauma to those we serve.	☐4	☐3	☐2	☐1	**3b.**	☐4	☐3	☐2	☐1
4a. I contribute to efforts that make my organization a safe, trusting and healing environment.	☐4	☐3	☐2	☐1	**4b.**	☐4	☐3	☐2	☐1
5a. I integrate trauma-informed principles into my interactions with others at work.	☐4	☐3	☐2	☐1	**5b.**	☐4	☐3	☐2	☐1
6a. I understand that a person's symptoms of a mental health, substance use, or medical problem may be their way of coping with trauma.	☐4	☐3	☐2	☐1	**6b.**	☐4	☐3	☐2	☐1
7a. I frequently consider the findings from ACEs research in my interactions with others.	☐4	☐3	☐2	☐1	**7b.**	☐4	☐3	☐2	☐1
8a. I consider the role that trauma may be playing in the difficulties an individual may be experiencing.	☐4	☐3	☐2	☐1	**8b.**	☐4	☐3	☐2	☐1
9a. In my work, I use a toolbox of skills to actively engage and build positive relationships with staff, clients, and/or families.	☐4	☐3	☐2	☐1	**9b.**	☐4	☐3	☐2	☐1
10a. I feel inspired to engage in the promotion of trauma-informed care (TIC).	☐4	☐3	☐2	☐1	**10b.**	☐4	☐3	☐2	☐1
11a. My organization has made changes to support trauma-informed care principles.	☐4	☐3	☐2	☐1	**11b.**	☐4	☐3	☐2	☐1

		Think back to **BEFORE** participating in Fostering Futures. Please rate your level of agreement or disagreement with the following statements.					Now rate your agreement or disagreement with the following statements **AFTER** having participated in Fostering Futures.			
		BEFORE PARTICIPATING					**AFTER PARTICIPATING**			
		Strongly Agree	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**	→	**Strongly Agree**	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**
12a.	I have a clear understanding of the degree to which my organization is trauma-informed.	☐4	☐3	☐2	☐1	**12b.**	☐4	☐3	☐2	☐1
13a.	I can identify areas in which my organization can become more trauma-informed.	☐4	☐3	☐2	☐1	**13b.**	☐4	☐3	☐2	☐1
14a.	I partner with the families of clients to improve services. [*county teams only*]	☐4	☐3	☐2	☐1	**14b.**	☐4	☐3	☐2	☐1
15a.	I incorporate trauma-informed principles into my collaboration with other agencies and/or organizations.	☐4	☐3	☐2	☐1	**15b.**	☐4	☐3	☐2	☐1
16a.	I include the views and priorities of the people affected by our work in the improvement of our services.	☐4	☐3	☐2	☐1	**16b.**	☐4	☐3	☐2	☐1
17a.	When making changes to organizational practices and policies, I consider the well-being of and the potential impact on staff members.	☐4	☐3	☐2	☐1	**17b.**	☐4	☐3	☐2	☐1

ADDITIONAL QUESTIONS

The following set of questions asks about your current activities related to this work, your background and role on the project, and your overall reflections about and suggestions related to the work.

18. As a Core Implementation Team member, have you personally proposed at least one action step or idea about how to apply trauma-informed care (TIC) principles to improve your organization's work?

☐1 Yes ☐2 No ☐3 Don't know

19. Do you have a clear understanding of your Core Implementation Team's strategy for change?

☐1 Yes ☐2 No ☐3 Don't know

20. To what extent do you feel like your Core Implementation Team (CIT) has accomplished its goals over this past year? My CIT has accomplished:

- ☐5 All of its goals
- ☐4 Most of its goals
- ☐3 Some of its goals
- ☐2 Very few of its goals
- ☐1 None of its goals

21. The Fostering Futures/National Council for Behavioral Health learning community officially kicked off in April 2016. Since then, how many months have you been participating?

_____ months

22. What changes would you suggest to enhance the work of the Fostering Futures initiative going forward, especially for the new group starting this year?

_____

_____

_____

23. What is your role on the Core Implementation Team?

- ☐1 Leader ➡
- ☐2 Data ➡
- ☐3 Other core team member ➡
- ☐4 Parent/consumer

↳ 23b. What has been the biggest impact of the Fostering Futures initiative on you? On other families with experience interacting with the child welfare system?

_____

_____

_____

_____

_____

24. What is your role within your own community organization or agency?

- ☐1 CEO
- ☐2 Other Leader
- ☐3 Supervisor
- ☐4 Worker
- ☐6 Other, please describe: _____

25. What has been the biggest impact of the Fostering Futures initiative on you personally and/or professionally? On your organization? On the families you serve?

_____

_____

_____

_____

Thank you for completing the questionnaire!

2017 Participant Feedback Survey - STATE
Fostering Futures

Fostering Futures is interested in learning how this initiative helped you to grow as a leader and service provider. This questionnaire will ask you to reflect on your experiences before participating in the initiative and how you have grown as a result of the initiative.

The questionnaire is voluntary, but we hope you will take time to complete it and provide important information about the impact of the initiative. Whether or not you decide to complete this survey will not affect your participation in the initiative, and there are no penalties or loss of any benefits for not participating, nor are there any significant risks to participating. You may skip any questions or stop the survey at any time if you decide not to participate. It should take approximately 15 minutes to complete.

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If you have any questions or concerns about the project, please contact Monica Idzelis Rothe, Research Manager at Wilder Research at 651-280-2657 or monica.idzelis@wilder.org.

If you agree to participate in the questionnaire, please indicate your consent below:

☐ No, I do not agree to participate {**STOP HERE**}

☐ Yes, I agree to participate

Please indicate which Core Implementation Team (CIT) you were affiliated with: _____

The first set of questions asks you to think about your skills, knowledge and experiences BEFORE and AFTER participating in Fostering Futures.

	Think back to **BEFORE** participating in Fostering Futures. Please rate your level of agreement or disagreement with the following statements.					Now rate your agreement or disagreement with the following statements **AFTER** having participated in Fostering Futures.			
	BEFORE PARTICIPATING					**AFTER PARTICIPATING**			
	Strongly Agree	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**	→	**Strongly Agree**	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**
1a. I understand the profound effects of adverse childhood experiences (ACEs) and other trauma on individuals.	☐4	☐3	☐2	☐1	**1b.**	☐4	☐3	☐2	☐1
2a. I recognize the high prevalence of traumatic experiences in people who receive mental health, physical health, and substance abuse services.	☐4	☐3	☐2	☐1	**2b.**	☐4	☐3	☐2	☐1
3a. I understand how human service staff might unintentionally cause additional trauma to those we serve.	☐4	☐3	☐2	☐1	**3b.**	☐4	☐3	☐2	☐1
4a. I contribute to efforts that make my organization a safe, trusting and healing environment.	☐4	☐3	☐2	☐1	**4b.**	☐4	☐3	☐2	☐1
5a. I integrate trauma-informed principles into my interactions with others at work.	☐4	☐3	☐2	☐1	**5b.**	☐4	☐3	☐2	☐1
6a. I understand that a person's symptoms of a mental health, substance use, or medical problem may be their way of coping with trauma.	☐4	☐3	☐2	☐1	**6b.**	☐4	☐3	☐2	☐1
7a. I frequently consider the findings from ACEs research in my interactions with others.	☐4	☐3	☐2	☐1	**7b.**	☐4	☐3	☐2	☐1
8a. I consider the role that trauma may be playing in the difficulties an individual may be experiencing.	☐4	☐3	☐2	☐1	**8b.**	☐4	☐3	☐2	☐1
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10a. I feel inspired to engage in the promotion of trauma-informed care (TIC).	☐4	☐3	☐2	☐1	**10b.**	☐4	☐3	☐2	☐1
11a. My organization has made changes to support trauma-informed care principles.	☐4	☐3	☐2	☐1	**11b.**	☐4	☐3	☐2	☐1

		Think back to **BEFORE** participating in Fostering Futures. Please rate your level of agreement or disagreement with the following statements.					Now rate your agreement or disagreement with the following statements **AFTER** having participated in Fostering Futures.			
		BEFORE PARTICIPATING					**AFTER PARTICIPATING**			
		Strongly Agree	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**	→	**Strongly Agree**	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**
12a.	I have a clear understanding of the degree to which my organization is trauma-informed.	☐4	☐3	☐2	☐1	**12b.**	☐4	☐3	☐2	☐1
13a.	I can identify areas in which my organization can become more trauma-informed.	☐4	☐3	☐2	☐1	**13b.**	☐4	☐3	☐2	☐1
14a.	I partner with the families of clients to improve services. [*county teams only*]	☐4	☐3	☐2	☐1	**14b.**	☐4	☐3	☐2	☐1
15a.	I incorporate trauma-informed principles into my collaboration with other agencies and/or organizations.	☐4	☐3	☐2	☐1	**15b.**	☐4	☐3	☐2	☐1
16a.	I include the views and priorities of the people affected by our work in the improvement of our services.	☐4	☐3	☐2	☐1	**16b.**	☐4	☐3	☐2	☐1
17a.	When making changes to organizational practices and policies, I consider the well-being of and the potential impact on staff members.	☐4	☐3	☐2	☐1	**17b.**	☐4	☐3	☐2	☐1

ADDITIONAL QUESTIONS

The following set of questions asks about your current activities related to this work, your background and role on the project, and your overall reflections about and suggestions related to the work.

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☐1 Yes ☐2 No ☐3 Don't know

19. Do you have a clear understanding of your Core Implementation Team's strategy for change?

☐1 Yes ☐2 No ☐3 Don't know

20. To what extent do you feel like your Core Implementation Team (CIT) has accomplished its goals over this past year? My CIT has accomplished:

- ☐5 All of its goals
- ☐4 Most of its goals
- ☐3 Some of its goals
- ☐2 Very few of its goals
- ☐1 None of its goals

21. The Fostering Futures/National Council for Behavioral Health learning community officially kicked off in April 2016. Since then, how many months have you been participating?

_____ months

22. What changes would you suggest to enhance the work of the Fostering Futures initiative going forward, especially for the new group starting this year?

_____

_____

23. What is your role on the Core Implementation Team?

- ☐1 Leader ➡
- ☐2 Data ➡
- ☐3 Other core team member ➡
- ☐4 Parent/consumer

↳ 23b. What has been the biggest impact of the Fostering Futures initiative on you? On other families with experience interacting with the child welfare system?

_____

_____

_____

_____

_____

24. What is your role within your own community organization or agency?

- ☐1 Leader
- ☐2 Manager
- ☐3 Administrator
- ☐4 Program/Project staff
- ☐5 Office support staff
- ☐6 Other, please describe: _____

25. What has been the biggest impact of the Fostering Futures initiative on you personally and/or professionally? On your organization?

_____

_____

_____

_____

Thank you for completing the questionnaire!

Fostering Futures Focus Groups

Purpose: The focus groups will ask participants to answer open-ended questions about their experience with different facets of the initiative, the impact of the work, and ask them to provide suggestions for enhancing the initiative. Representatives from Core Implementation Teams (CITs) will be invited to participate in one or more in-person focus groups later in the initiative (spring of each year). Three focus groups will be held: a) one with parent participants, b) one with representatives from the county teams, and c) one with representatives from the state teams. Focus groups will include participants representing a mix of roles at the county and state levels (a mix of CEO/Directors and child welfare workers).

Introduction:

Welcome! Thank you for joining us here today. My name is _____ and I work for Wilder Research. We are here to discuss your participation in the Fostering Futures Initiative. Before we start talking, I want to let you know a few things.

- First, your participation is voluntary. Whether you participate in this focus group or not will not affect your participation in the Fostering Futures initiative. You can choose to not answer any questions, or stop participating, at any time. There are no direct benefits or costs to you for participating.
- Second, we are using this information for evaluation purposes to help us understand how the initiative is working. We will be taking notes, but to ensure that we capture the entire conversation and don't miss anything, we would also like to record our discussion. Only the researchers at Wilder Research working on this project will listen to the recording and it will be destroyed after the results are summarized. Are you comfortable with us recording this discussion? [START RECORDING ONLY IF ALL PARTICIPANTS GIVE CONSENT]
- Third, we will not link your name to your responses in any reports summarizing the findings from today's group. As much as possible, everything you say today will be kept confidential. Please respect the privacy of others in the group by not sharing what others have said outside of this group. We cannot guarantee that others will not share what is said here with others, but we ask for your help in maintaining everyone's privacy.
- Fourth, we want to hear what everyone thinks. Try not to talk if someone else has the floor.
- Finally, my job as facilitator is to make sure we stay on topic and get through the questions. In order to do that, I might interrupt the discussion, especially if it seems like we are getting off topic. I apologize in advance if this happens, but I want to make sure we finish on time.
- By continuing with this focus group, you signify that you understand the information we have provided and that you want to participate in this evaluation activity.

- If you have any questions about the focus group or your participation, please contact Monica Idzelis Rothe, Research Manager at Wilder Research, at 651-280-2657 or monica.idzelis@wilder.org. For your reference, I have posted this contact information on the board/note pad here.

Are there any questions? Okay, let's get started. First, could everyone go around and say:

1) Your first name
2) Which Core Implementation Team (CIT) you belong to
3) Your role on the CIT (county/state groups only), and
4) How long you've been participating on the CIT?

Parent FG Questions:

1.) Before your involvement with Fostering Futures, had you heard of the terms Adverse Childhood Experiences (ACEs), resiliency, or trauma-informed care? How familiar were you with these concepts?

2.) Do these ideas resonate with you and your experiences in the child welfare system (i.e., do you see how these ideas or practices affect families in the system)? How so/why not?

3.) What were your expectations of being involved in the initiative before you joined? Have they been met? How so (or how have they not been met)?

4.) How has your involvement with Fostering Futures/the Core Implementation Team (CIT) changed your awareness or knowledge of Adverse Childhood Experiences, resiliency, or trauma-informed care?

5.) How did you get connected with your CIT? What was the recruitment/invitation process like?

6.) Were there any barriers to your participation in the CIT? If there were barriers, what would have helped you to overcome them?

7.) Do you feel like your voice and input have been valued by other CIT members? Can you give an example of how it was or wasn't?

8.) Did you have the opportunity to talk with your coach? Were these meetings helpful? In what ways? Was the amount of coaching about right, not enough or too much?

9.) As a parent with experience interacting with the child welfare system, are you starting to see any impacts of the CIT work? Like what?

10.) As you may know, there is another group of county and state teams that will be starting this year. What suggestions/advice do you have for them as they begin their work? What suggestions do you have for the Fostering Futures leadership?

11.) Finally, if you could wave a magic wand, what would a truly trauma-informed child welfare system look like? How would it work differently? What would be improved?

County/State FG Questions:

1.) Before your involvement with Fostering Futures, had you heard the terms Adverse Childhood Experiences (ACEs), resiliency, or trauma-informed care? How familiar were you with these concepts?

2.) Do these ideas resonate with you and your experiences? How so?

3.) How did you get connected with your CIT? What was the recruitment/invitation process like?

4.) How has your involvement with Fostering Futures/your CIT changed your awareness or knowledge of ACEs, resiliency or trauma-informed care?
    a. For those who work with families directly, has it changed the way that you interact with clients and their families? How so? Can give you give an example?
    b. Has it changed the way that you interact with staff/colleagues? Has it changed how organizational decisions are made? How so? Can you give an example?

5.) What were your expectations of being involved in the initiative before you joined? (Probe for expectations around their participation, learnings, and the application of those learnings – i.e., expected impacts at this point). Have they been met? How so (or how have they not been met)?

6.) What programmatic elements or support/TA/coaching has been the most helpful to your CIT in its work? What additional supports are needed?

7.) What are the biggest accomplishments of your CIT thus far? Are you starting to see any impacts of your CIT work within your organization? Impact on staff? On clients? On yourself? Please describe.

8.) As you may know, there is another cohort of county and state teams that will be starting this spring. What suggestions/advice do you have for them as they begin their work? What suggestions do you have for the Fostering Futures leadership/ steering committee?

9.) Do you think your CIT will continue to meet and collaborate after this spring (beyond the 1-year mark)? What would increase the likelihood of this happening? What barriers do you foresee?