

Year Two Summary Report on Care Coordination

Connecting Youth Placed Out of County to Trauma-Informed Care

PRODUCED FOR



*Connecting communities with compassionate systems.
Reclaiming Bay Area futures.*

WRITTEN BY

Be the CH  NGE
consulting

Made possible with generous support from
Substance Abuse and Mental Health Services
Administration (SAMHSA)

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Section One

Establishing Trauma Transformed

Executive Summary

Over the past 10 months, the Trauma Transformed care coordination and oversight teams delved into an exploration of the challenges experienced in providing uninterrupted services to foster youth who are placed across county lines. This issue is neither new nor easy to solve. Our aspirations to seek out new solutions to old challenges was partially inspired by the level of commitment from the Bay Area Childrens Systems of Care leadership to make this a regional imperative—not “my county’s kids” or “your county’s kids,” but our youth in care, our Bay Area children, youth and families.

We feel grateful to SAMHSA, who funded this lofty ideal and provided us with the space and resources to tackle this problem from the ground up. Throughout this process, our seven county partners (Alameda, Contra Costa, Marin, Santa Clara, Santa Cruz, San Francisco, and San Mateo) sought to better define and clarify the problem, and articulate the cracks in our systems that allow this problem to persist. We have been humbled by the humans who work hard and tirelessly to provide strong services within this system. Simultaneously we acknowledge the deep flaws in our systems that allow us to keep the problem vague and mystified. An unnamed problem allows those of us in the system to deflect blame, live in denial, or give up hope all of which perpetuate trauma.

We envision a trauma-transforming process, where organizations can practice naming challenges, addressing gaps, and shifting the impact on young people most vulnerable to these problems. We believe such a shift will support our young people, but also those working within these systems experiencing vicarious trauma each day.

Towards this end, we are touched by the enthusiasm of our seven county partners to band together to “see” this issue as a challenge that can be solved. We are hopeful that through ongoing collaboration and development of tools, our efforts for Continuous Quality Improvement around coordinating care for youth who cross our county lines will be realized.

We know there are many youth and families who need us to find better solutions, quickly.

Signed,

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Project Background

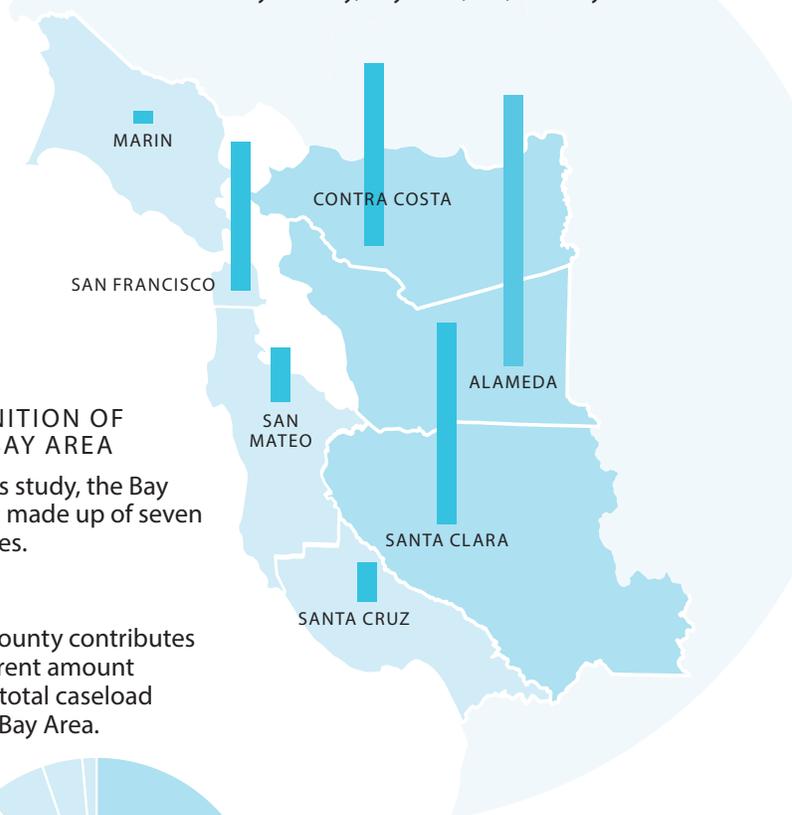
This year, one in five California foster youth will be taken from their county of origin and placed in another county. At present, this represents a total of 12,626—or 20 percent of all California children and youth in a foster care placement—who live in a different county than the one that they previously called home.¹

The reasons why foster children are forced to cross county lines so often boils down to conflicting goals within the system, simple geography, and the push and pull of housing costs.

One way to understand the out-of-county issue is to look at the different types of placements to which children are sent. In April, the Center for Social Services Research (CSSR) at the University of California, Berkeley, drawing data from California's 58 counties, reported that there were 62,915 children in foster care, a number that has been steadily rising since a low point of around 55,000 in 2011. The main placement types for children are with kin, in privately run foster family agencies (FFA), in county-run foster homes and, finally, in group homes, which generally get the older and harder-to-place youth.

Data pulled from CSSR's California Child Welfare Indicators Project shows that in 2015, 21 percent of kin (such as extended family members), 24 percent of FFA, 5 percent of county foster care and a whopping 36 percent of group home placements were out of county.

CHART 1
COUNTY TO COUNTY POPULATION FLOW ANALYSIS
Total Caseload by County, Bay Area, CA, January 2016



DEFINITION OF THE BAY AREA

For this study, the Bay Area is made up of seven counties.

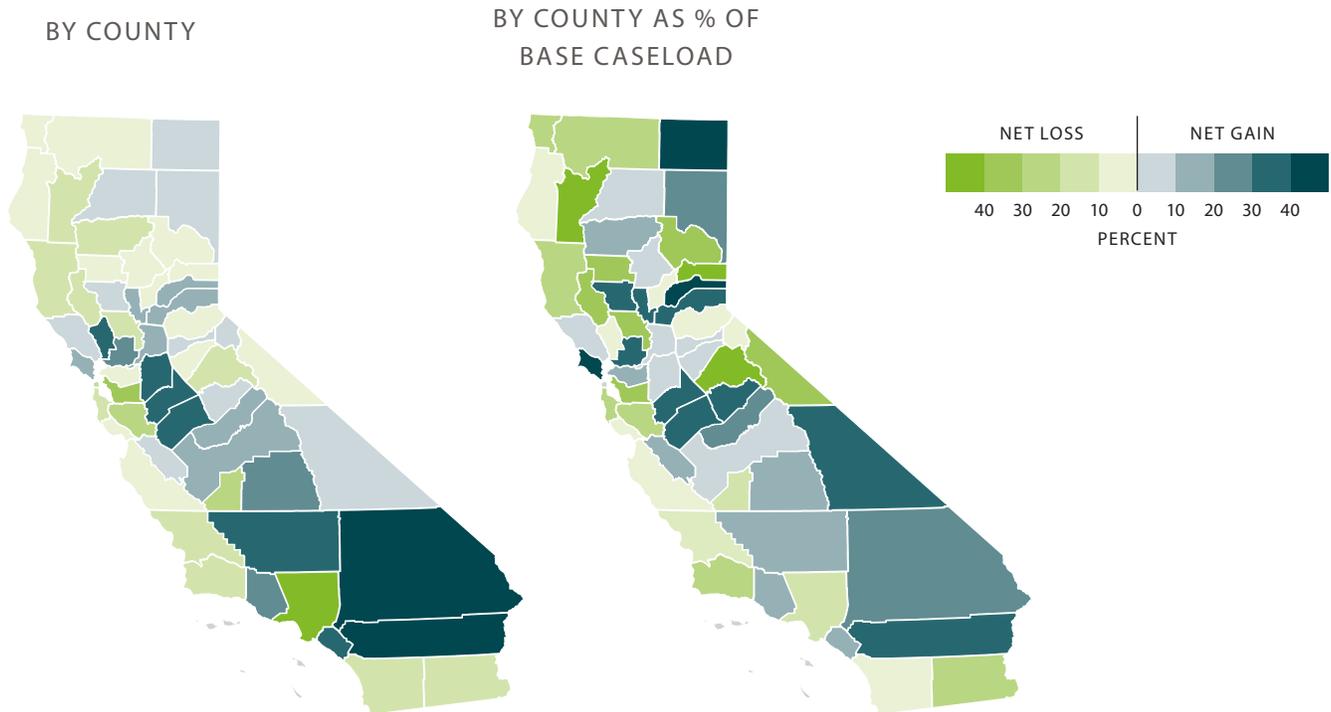
Each county contributes a different amount to the total caseload of the Bay Area.



Alameda, Santa Clara, and Contra Costa make up 72% of the child welfare cases in the Bay Area.

1 <https://chronicleofsocialchange.org/featured/out-of-county-ca-going-the-distance/12240>

CHART 2
NET CASELOAD CHANGE
January 2016



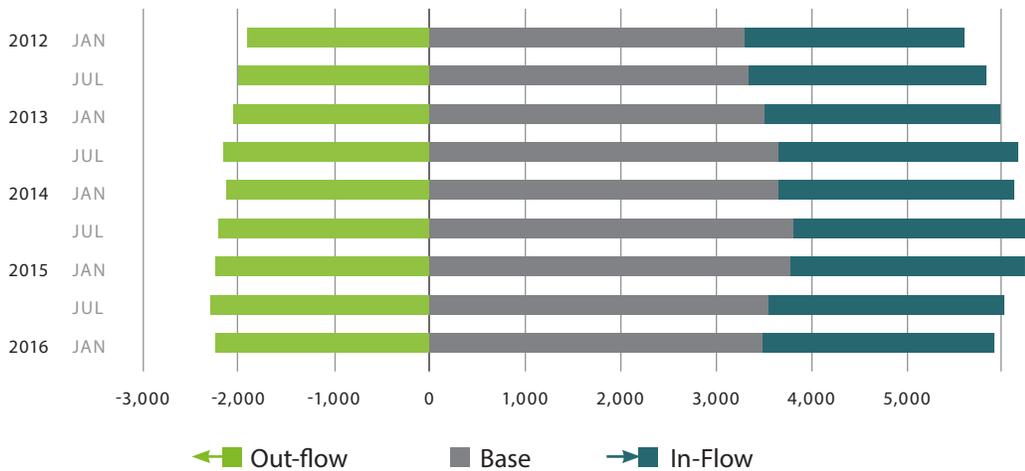
Early data from a Trauma Transformed-commissioned study allows us to connect this challenge to concrete numbers. Chart 1 affirms commonly understood information—more Bay area counties place youth outside the county, while accepting fewer placements into their counties.

Talking about the flow of populations from one area to another can be confusing. Defining terms can help make these changes in dynamics clearer. County caseload has five phases:

- 
START CASELOAD
 Those child welfare cases that originate in a given county.
- 
COUNTY INFLOW
 Of those cases that are physically placed in a given county that originated outside of that county.
- 
END CASELOAD
 All of those cases, both those that originate in a county and those that came from outside the county, that currently reside within a given county.
- 
COUNTY OUTFLOW
 Of those cases that originate in a given county the number that end up placed outside of their home county.
- 
BASE CASELOAD
 Of those cases that originate in a given county that stay in that county.

Chart 3 shows some early analysis of how caseloads are impacted from county to county. As we build the tools to track this information, more cross county collaboration and problem solving will be possible.

CHART 3
BAY AREA TOTAL CASELOAD, 2012-2016



WHY IS CROSSING COUNTY LINES AN ISSUE?

As children cross county lines they become more vulnerable to missing school, interrupting services like therapy or access to medications, and increase the likelihood of mental health and wellness issues. The challenges presented often seem daunting and insurmountable especially to a young person who may be in the midst of losing the only home they have known, friends, and community.

This issue is not new news. However, Trauma Transformed sees itself as optimally positioned to tackle the issue, leveraging the power of a seven-county team to collectively examine the sources of the challenge, and seek out at least a few solutions to mitigate the impact of out of county placements for this already vulnerable population of young people.

We understand this population already experiences the burden of a high allostatic load of early and ongoing adversity—child abuse, neglect, and other reasons for entering the child welfare system. Add to this the trauma of being moved around, within, and between systems and we have a toxic brew of an allostatic load that compounds layers of adversity and trauma. But the problems are not limited to just the youth. Our workforce—from those that authorize and bill services to members of provider nonprofit organizations to state/county child welfare, education and public health are also impacted by the vicarious trauma and helplessness of feeling ineffective at supporting and advocating for these young people. It is deeply disempowering to work day after day in a system that seems broken, and unable to meet the needs of the population it is designed to serve. As the work on this project evolves, we see the benefits for both the young people and the members of the workforce.

Initiative Goals and Timeline

In July of 2012, the Children Youth System of Care Directors across the seven Bay Area Counties came together to develop and share plans to take trauma-informed practices to a new level of regional coordination. The group began a planning process to launch the Bay Area Trauma Informed System of Care Initiative designed to:

- Build a Trauma Transformed Model to articulate a shared understanding of trauma and response strategies.
- Embed stakeholders (including organizational leaders, youth, and parent peers) to be champions of change within and across the systems serving children and youth.
- Support and maintain change efforts by deploying experts and consumer voices within our region.
- Address common and pervasive patterns of disproportionality with respect to historical trauma and fragmented service delivery systems.

The group anticipates gradual shifts in how we provide cross-county care, as systems change is unwieldy and slow moving.

In October 2014, this group of Directors was awarded a Substance Abuse and Mental Health Service Administration (SAMHSA) grant for their proposal to respond to trauma on a systems level. The vision of this project is to create a trauma-informed regional infrastructure to implement, sustain, and improve services for children and youth affected by trauma, and the workers who provide these services.

In July 2015, a lead nonprofit agency, East Bay Agency for Children, opened the doors to the T² Trauma Transformed Bay Area Regional Center in Oakland, California and began to operationalize the vision and aspirations set forth by the Bay Area leadership team.





Goals

Transform the regional, overlapping systems into a coordinated, trauma-informed, youth-guided and family driven, evidence-based system of care.

1.

Develop a Physical and Virtual Regional Center.

Develop a regional center in located in Oakland and a virtual hub to support and sustain a system of care that is trauma-informed, youth-guided, family-driven, and culturally competent.

2.

Provide Trauma-informed Training.

Develop and coordinate trauma informed training resources for dissemination to county staff, providers, and consumers.

3.

Oversee the Coordination of Care.

Establish a regional model to provide coordinated services for youth and children placed out of county, and children, youth, and families served by multiple systems within counties.

4.

Explore Sustainability Practices through Policy.

Develop and sustain promising practices from the project and incorporate them throughout the region.

One “coping mechanism” often used to persevere within trauma-induced systems is to disconnect from the traumatic human experiences within the foster care system. This applies to youth, their families, and the workers who provide services. Adopted from the work of San Francisco Department of Public Health, the Trauma

Transformed center uses the principles of trauma-informed systems to re-humanize ourselves and our systems and bring to life the simultaneously complex and simple self-preservation dynamics that kick into effect during crisis. These principles help our workforce and center teams to operate from a different stance than many systems.

Principles

Understanding Trauma & Stress

Without understanding trauma, we are more likely to adopt behaviors and beliefs that are negative and unhealthy. However, when we understand trauma and stress we can act compassionately and take well-informed steps toward wellness.

1. Trauma. We understand that trauma is common, but experienced uniquely due to its many variations in form and impact.
2. Stress. We understand that optimal levels of positive stress can be healthy, but that chronic or extreme stress has damaging effects.
3. Reactions. We understand that many trauma reactions are adaptive, but that some resulting behaviors and beliefs may impede recovery and wellness.
4. Recovery. We understand that trauma can be overcome effectively through accessible treatments, skills, relationships, and personal practices.

Compassion & Dependability

Trauma is overwhelming and can leave us feeling isolated or betrayed, which may make it difficult to trust others and receive support. However, when we experience compassionate and dependable relationships, we reestablish trusting connections with others that foster mutual wellness.

1. Compassion. We strive to act compassionately across our interactions with others through the genuine expression of concern and support.
2. Relationships. We value and seek to develop secure and dependable relationships characterized by mutual respect and attunement.
3. Communication. We promote dependability and create trust by communicating in ways that are clear, inclusive, and useful to others.

Safety & Stability

Trauma unpredictably violates our physical, social, and emotional safety resulting in a sense of threat and need to manage risks. Increasing stability in our daily lives and having these core safety needs met can minimize our stress reactions and allow us to focus our resources on wellness.

1. Stability. We minimize unnecessary changes and, when changes are necessary, provide sufficient notice and preparation.
2. Physical. We create environments that are physically safe, accessible, clean, and comfortable.
3. Social-Emotional. We maintain healthy interpersonal boundaries and manage conflict appropriately in our relationships with others.

Collaboration & Empowerment

Trauma involves a loss of power and control that makes us feel helpless. However, when we are prepared for and given real opportunities to make choices for ourselves and our care, we feel empowered and can promote our own wellness.

1. Empowerment. We recognize the value of personal agency and understand how it supports recovery and overall wellness.
2. Preparation. We proactively provide information and support the development of skills that are necessary for the effective empowerment of others.
3. Opportunities. We regularly offer others opportunities to make decisions and choices that have a meaningful impact on their lives.

Cultural Humility & Responsiveness

We come from diverse social and cultural groups that may experience and react to trauma differently. When we are open to understanding these differences and respond to them sensitively we make each other feel understood and wellness is enhanced.

1. Differences. We demonstrate knowledge of how specific social and cultural groups may experience, react to, and recover from trauma differently.
2. Humility. We are proactive in respectfully seeking information and learning about differences between social and cultural groups.
3. Responsiveness. We have and can easily access support and resources for sensitively meeting the unique social and cultural needs of others.

Resilience & Recovery

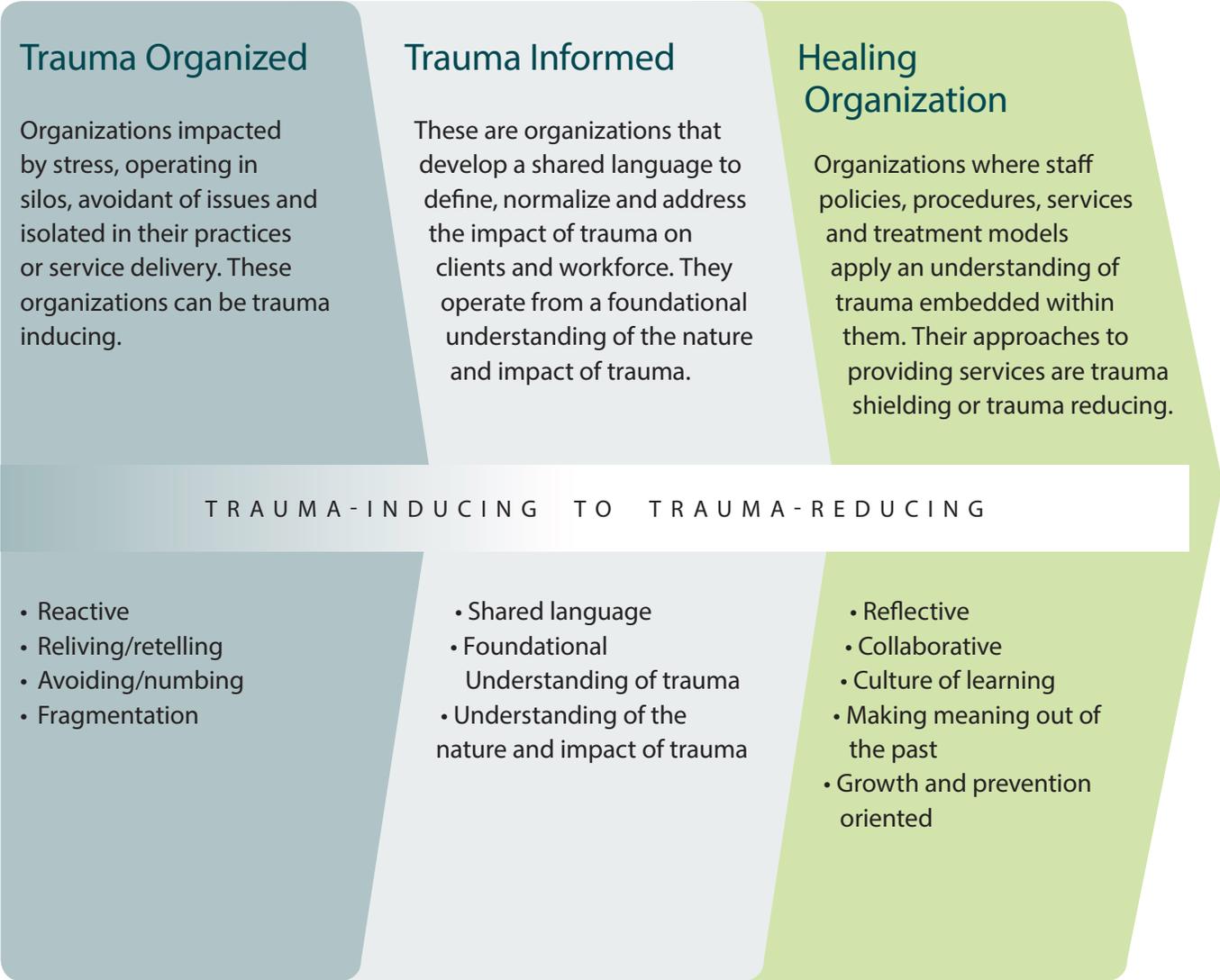
Trauma can have a long-lasting and broad impact on our lives that may create a feeling of hopelessness. Yet, when we focus on our strengths and clear steps we can take toward wellness we are more likely to be resilient and recover.

1. Path. We recognize the value of instilling hope by seeking to develop a clear path towards wellness that addresses stress and trauma.
2. Strengths. We proactively identify and apply strengths to promote wellness and growth, rather than focusing singularly on symptom reduction.
3. Practices. We are aware of and have access to effective treatments, skills, and personal practices that support recovery and resiliency.

These principles were adopted by the San Francisco Department of Public Health, and are in the process of being adopted regionally through board resolutions and through the dissemination of the Trauma Informed Systems 101 (TIS 101) to demonstrate commitment to creating stories of healing across our public health systems.

Our Approach to Systems Change

We believe that this transformation—from systems that induce trauma to systems that can sustain healing practices and wellness occurs along a continuum from Trauma Organized (systems impacted by organizational stress and trauma that they present similar symptoms as individuals with post-traumatic stress disorder) to Healing Organizations and Systems of Care.





Section Two

Report on Coordination of Care

One of the goals of the Trauma Transformed team is to establish a regional model to provide coordinated services for youth and children placed out of county, and children, youth, and families served by multiple systems within counties. As we delved deeply into the Coordination of Care several learnings emerged, resulting in three key recommendations for next steps. We will focus the remainder of this report on the findings and planned next steps towards the goal of increased care coordination.

We tackled this goal through the following steps:



1 Define the Problem

It is hard to motivate systems change when the young people who end up falling through the cracks of our care are largely invisible. However, findings from various research sources help us clarify who we are talking about, and the number of young people affected.



Across the seven partner counties, **20% of foster youth** are placed out of county each year. In the Bay Area, 40–60% of foster youth are placed out of county. Overall, California's out of county placement rates are much higher than other states.²

IT'S NOT ALL BAD!

Cross-County Placements Work When Services Continue Uninterrupted

Through interviews with Young Minds Advocacy we learned that about 40% of the time, young people placed across county lines fare as well as an in-county youth. Cross-county placements work best when:



A service provider has access to transportation and drivers to transport youth to appointments, such as therapy, medical appointments, school registration and intake, etc.



Youth have family members in the county of placement who support their transition and advocate aggressively for them.



Service providers maintain vigilant tracking of youth, and commit to problem solving as needed.



The dental, therapy and medical services are comprehensive and allow for WRAP around care.

2 Source: Child Welfare Indicators Project.

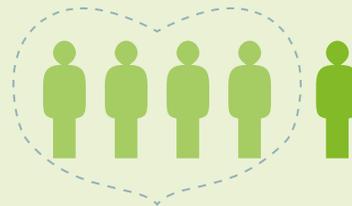
2 Understand the Experiences of Youth

Typically, a foster youth can move homes and transfer schools up to 8 times in their adolescence. This results in a loss of friends, continuously shifting relationships with teachers, and shaky access to guidance counselors, therapists, and social workers. For young people experiencing disruptions in their family life, these external sources of community, care and stability become increasingly critical.

WHEN YOUTH ARE PLACED OUT OF THEIR OWN COUNTY....



1 in 3 are more likely to be in a group home.

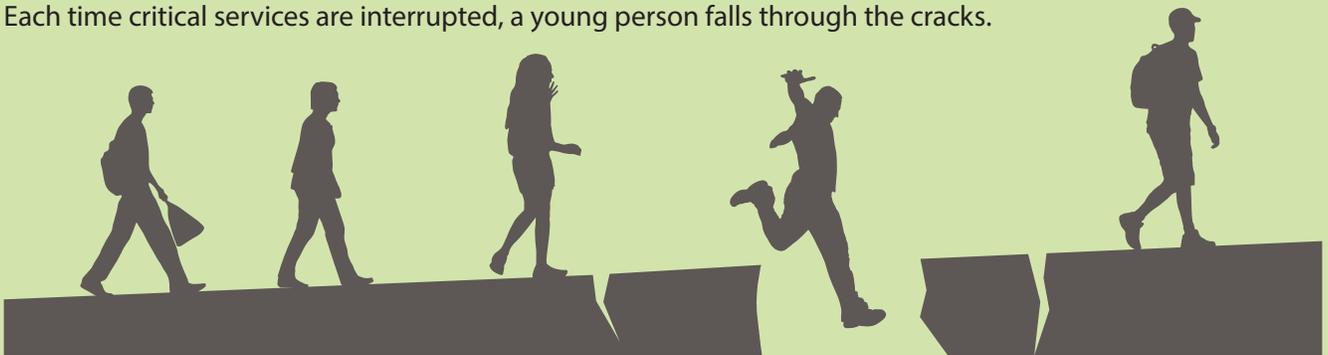


1 in 5 are less likely to receive any care there.



50% of foster youth have four or more Adverse Childhood Experiences (ACES).³ Foster youth in general are 3 to 6 times more likely to experience mental health challenges than children in the general population.⁴ This increases as youth cross county lines.

Each time critical services are interrupted, a young person falls through the cracks.



3 Source: Bramlett, M. D., & Radcliff, L. F. Adverse family experiences among children in nonparental care, 2011-2012. (2014). National Health Statistics Reports, no. 74, 1-8. <http://www.cdc.gov/nchs/data/nhsr/nhsr074.pdf>

4 Source: Mental Health Services for Children Placed in Foster Care: An Overview of Current Challenges by Peter J. Pecora, Peter S. Jensen, Lisa Hunter Romanelli, Lovie J. Jackson, PhD, MSW, Abel Ortiz. Published in PMC, US National Library of Medicine National Institutes of Health, March 21, 2011.

3 Hold a Series of Listening Circles with Key Informant Interviews

Tracking down the stories of the challenges is difficult, which in turn makes systems change daunting. We held a series of interviews and focus groups to better understand the experiences of those who interact with the system. The following experience map demonstrates how our systems are not designed to meet the complex needs and circumstances of these young people.

These experiences highlight the many heartbreaking dynamics that our young people face each day. The stress of insecure placements combined with the loss of love and support definitely contributes to physical and emotional challenges. While we cannot change some of the social/family dynamics our young people

face, a better understanding of their stories might help us build a system of support around them that is dynamic enough to build a safety net under them to allow for uninterrupted education, housing and mental health supports.

EXPERIENCES WITH THE SYSTEM



I'm a foster parent with a 9-year-old foster-daughter.



Her school credits didn't transfer for five months.



We drove back and forth to her original school 1.5 hours each day.



The time, money on travel and strain makes adjusting to a new family even harder.



I am a county social worker.



Service codes from each county vary and are confusing.



I spend hours on the phone with faceless cross-county providers trying to figure it all out.



I feel stressed, depressed and hopeless at the many walls I hit each day.



I'm a foster youth placed in a group home.



My Medi-Cal records didn't go through.



My anger management meds were disrupted.

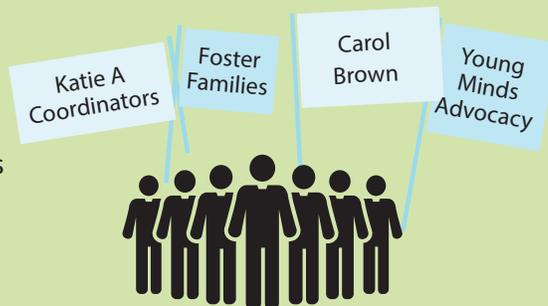


I got into fight after fight at the group home and was ultimately kicked out.

4 Synthesize Expert Opinion

Why can't our systems be more responsive to these dynamic needs?

To build a system flexible enough to catch the young people at risk for falling through the cracks when there are so many simultaneous challenges coming at them would be a challenging task for anyone. To unpack the barriers and hurdles youth experience in our current system, we held multiple service provider and stakeholder interviews. Each interview gave us insight into one aspect of the challenges faced.



As we sorted through the overlapping themes from the interviews, the following four issues emerged as key barriers to providing uninterrupted services.

Category	Challenge Description
CODING & INTERPRETATION	<p>Standardized state policies are interpreted and coded differently from county to county. Medi-cal eligibility can transfer inconsistently or incompletely despite foster care aid codes qualifying youth for immediate services.</p> <p>There is no standard training across counties to support a uniform or trauma-informed process.</p>
TRACKING	<p>When young people are transferred out of county, tracking their access to timely and appropriate care becomes challenging for the county of origin. If services are denied due to a misinterpretation of code, the county of origin will not know, and therefore cannot advocate for the youth. Even when services transfer, in highly impacted counties, the infrastructure to support the flow of foster youth is oftentimes not developed as quickly as the rate of youth placements.</p> <p>As services become interrupted, the likelihood of young people running away, dropping out of school, or spiraling without meds or support goes up. They can fall off the grid and become invisible.</p> <p>To shift practices within a system there needs to be evidence of a problem, but these young people are not in any system, resulting in a hazy understanding of the issue and denial of the problem.</p>
PROVIDERS	<p>There are not enough resources in high placement counties. Even when services transfer appropriately, there may not be enough shelters, therapists, school counselors, etc. to adequately build a relationship and support a young person's transfer to a new place.</p> <p>Diverse providers with language ability and cultural competencies are even scarcer in counties highly impacted, such as San Joaquin.</p> <p>These limitations of resources become grave liabilities for youth.</p>
BILLING & INVOICING	<p>Long delays in reimbursements to billing create denials—some counties have less ability to sustain financial losses or carry forward liabilities and await reimbursements as other more resourced counties.</p>



5 Make Recommendations

We understand these issues are complex and multi-layered. Progressions in state policy will continue to evolve our thinking. For example, new legislation likely to be passed in 2016 in the form of AB 1299 (Ridley-Thomas) transfers responsibility for providing mental health treatment to the county of residence for most foster youth. This bill will provide:

- A shift in the focus of responsibility to provide or arrange for mental health services from the home to the host county. This will stop counties from declining to provide mental health services to foster youth simply because they entered foster care in another county.
- An assurance that the providing host county is reimbursed the full cost of serving out-of-county foster children—including the federal, state, and home county cost-shares of all treatment.

We are hopeful that by officially transferring responsibility for the foster youth to the host county this legislation will resolve the issue of who foots the bill, and who should be tracking the youth. However we understand that the process from passing a bill to enforcing its terms in practice will take time. In the meantime, our care coordination team reflected on these findings to identify actionable solutions, which we will continue to evolve as the field shifts.

While we don't expect our systems to shift dramatically overnight, our care coordination team believes we can impact significant change through three interventions.

1. STANDARDIZED TRAINING

We believe all participating county systems will benefit from identifying a standardized training protocol, jointly conducting training with child welfare and behavioral healthcare staff, and the integration of shared learning approaches including adopting one regional policy and guidelines for training and implementing changes to policies at the state level. These trainings may also reflect the TIS model—framing for service providers on how to move from Trauma Inducing to Trauma Reducing within our practices and with practical applications for how we coordinate and communicate with one another across county lines to connect youth to care.

As a result of our regional focus groups, our workforce was able to build relationships amongst the people engaging in a task. We heard from participants that they would be more likely now to pick up the phone and call the county of origin to confirm the services that should transfer for a youth. We also learned that Katie A Coordinators and Billing Authorization Specialists engaging in the regional collective found tremendous benefit through their own “coordination across county lines” demonstrating one of the core principles of a Trauma-Informed System: Collaboration and Empowerment. For providers who feel overwhelmed by hopelessness for so many youth, breaking isolation and coming together to take action inspires hope and resilience.





Make Recommendations, continued

2. ESTABLISHING A CONTINUOUS QUALITY IMPROVEMENT TEAM

Comprised of cross-county care providers, this group will reflect on and monitor the flow of youth placed across county lines. To ensure these meetings are data-driven, these gatherings we will secure a shared data agreement with participating counties to track foster care flow by county, placement type, proximity to care, and service authorization and access through Trauma Transformed GIS (Geographic Information Systems) partnership with Chapin Hall. We also recommend an additional data sharing agreement between Trauma Transformed and the UC Berkeley School of Social Welfare, as this department oversees the Child Welfare Indicators database—a critical source of statewide child welfare data.

Establishing effective regional tools to make visible the current and progressive status of young people as they cross county lines will allow our systems to measure the impact of our continuous quality improvement efforts.

Securing this data will be no easy task! Each county tends to have different legal concerns based on county council priorities and perspectives—however—Trauma Transformed as a regional clearinghouse can serve as a “risk incubator”-allowing for courageous risks to be taken collectively toward solving the big problems that plague us regionally. What we could not do alone, we may be able to accomplish through this regional approach.

Currently, Trauma Transformed is working with Chapin Hall, a policy research branch of the University of Chicago, to produce a geospatial analysis of young people’s welfare when placed across county lines. This map will include trauma screenings, evidence-based treatments for trauma, and emerging or promising practices to

treat trauma with specific focus on culturally and linguistically responsive care models available to foster youth. This map would serve as a proof of concept that a regional analysis of child welfare issues can have significant positive impact on improving outcomes for children and families. We believe this tool will help inspire data sharing agreements so that we can accurately match episodes of care to flow between counties, placement types, and demographics.

The work with Chapin Hall, the 7 counties and Trauma Transformed will ultimately result in four products:

1. A system comparison between the seven Bay Area counties.
2. A policy brief outlining the current system and suggesting actionable ways to make changes that standardize systems across the counties and reduce redundancy both between and within the counties.
3. A written analysis for the flow of Bay Area foster youth between California counties.
4. A spatial gap analysis for mental health providers and foster care populations to pilot in one county first, then include all seven.

Once these tools are produced, we anticipate building a toolkit to help practitioners use these tools to advocate, educate and motivate change within our counties. We will utilize our digital clearinghouse to disseminate information to the larger workforce on how to improve access, quality, and cultural and linguistic responsive care for youth in our region placed outside their Home Counties and progress toward this vision.





Make Recommendations, continued

3. FORMALIZING PARTNERSHIPS AND COLLABORATION THROUGH A 7-COUNTY MEMORANDUM OF UNDERSTANDING.

This process has begun to dissolve silos, put faces to names, and activate personal agency through relationships. As the work unfolded, it became clear that the work ahead of us toward this vision of providing uninterrupted services to youth crossing county lines would take more time and effort than we anticipated. In an effort to establish Trauma Transformed as a regional CQI center dedicated to this analysis and a “risk incubator” to pilot new practices, our seven partners are encouraged to establish an MOU (Memorandum of Understanding) to clarify points of agreement related to the regional CQI team and recommendations or policy changes as a result of this work. The MOU will allow our 7 counties to pilot a process of joint support and increased scrutiny to monitor the journey of young people placed from partner counties into our counties. An MOU of this scope may include agreements such as the following listed though by no means limited to these areas:

- The development of standardized training including common language, training guidelines, and frequency of training for eligibility workers and others who authorize/request care or interpret authorizations/requests for care. While

this may change given the passing of AB1299, the need for a universal protocol to implement these reforms remains.

- A regional best practice around tracking foster care youth as they access care or as they “fall off” from our continuum of care (requires data sharing).
- As part of this MOU, a commitment to establishing and maintaining necessary data sharing agreements so that efforts and activities remain data-driven.
- Consider blended funding or joint RFQ processes to support care provision in counties most impacted with Bay Area foster youth.
- Consider the cultural and linguistic needs of foster care youth placed in counties with lack of resources to effectively deliver care to address trauma. Work with Trauma Transformed Practice Team to disseminate promising practices or linguistically adapted practice models to counties demonstrating gaps in care.
- Continue stakeholder meetings, as a strategy to activate a sense of agency, promote collaboration, and build the relationships amongst people that can sometimes tackle a coding issue far more effectively than policies.



Reflect on Our Journey

In the next phase of our project we anticipate building a toolkit to support advocates to use the GIS mapping tools, piloting a coordinated care workgroup to monitor youth placed across county lines, share data, and support the training coordination of SARS eligibility requirements across county lines.

As AB1299 takes effect we may respond by shifting our activities to support the implementation of that policy, but feel our experiences and learning in this project will support our implementation strategies. These projects in and of themselves are large undertakings. We anticipate some shifts in the experiences of our youth as a result, but know there is still a long way ahead.

Looking back on our work we feel a mixture of gratitude for the time to research this issue, with regret that more concrete forward-moving actions were not taken. We realize the problems our young people experience exist not because of lack of heart, care, or desire. The problems are created through many small cracks in a long and difficult pathway our young people are forced to journey through, due to no fault of their own. We are heartened by the willingness of the system partners involved to dedicate time and attention to first examine the issues, define the problems, and identify pilot strategies to shift things, one at a time.

We are holding ourselves to a lofty vision, to transform institutionalized trauma as we build healing organizations.