

GENERAL INFORMATION

<p>Treatment Description</p>	<p>Acronym (abbreviation) for intervention: TA-FC</p> <p>Average length/number of sessions: 1 session/week for 6 months</p> <p>Aspects of culture or group experiences that are addressed (e.g., faith/spiritual component, transportation barriers): Families are referred to Trauma Adapted Family Connections (TA-FC) because they are struggling to meet the basic needs of their children. Through a collaborative process, trauma is identified as a contributor to these struggles, while significant attention is given to daily stressors and crises related to the environmental contexts in which these families reside that are laden with traumatic events and the lack of adequate resources or access to resources. Families are often at risk of neglect and their histories include complex developmental trauma. Subsequently the design of TA-FC emphasizes reaching out to the families, meeting with them in their homes and community with an emphasis on engagement and re-engagement throughout the course work together. Most often, families lack basic concrete needs (e.g., food, clothing, utilities), and TA-FC directly provides resources in addition to facilitating linkages to other community resources to engender empowerment and self sufficiency. A trauma-focused comprehensive family assessment yields service plans tailored to the family's defined needs with consideration of every household member. Intervention strategies include individual, family and group modalities that enhance family cohesion and strengthen relationships, with particular focus on the families' capacities to provide safety for every member.</p> <p>Trauma type (primary): developmental, chronic and complex</p> <p>Trauma type (secondary): intergenerational</p> <p>Additional descriptors (not included above): TA-FC is a manualized trauma-focused practice rooted in the principles of Family Connections (FC), specifically designed to reduce risk factors for child maltreatment, increase protective factors, improve child safety, and reduce internalizing and externalizing child behavior. Themes of collaboration, reflection, and transparency are infused throughout three phases of treatment to assist families with their shared meaning making of their trauma experiences. TA-FC strategies include engagement, trauma informed family assessment, safety building and enhancement, meeting basic needs, service plan, psycho-education, cognitive behavioral strategies, strengthening family and community relationships, emotion identification and affect regulation, and family shared meaning of trauma through narrative family work.</p>
<p>Target Population</p>	<p>Age range: Family with at least one child between 0 and 18 years of age who resides in the household.</p> <p>Gender: <input type="checkbox"/> Males <input type="checkbox"/> Females <input checked="" type="checkbox"/> Both</p> <p>Ethnic/Racial Group (include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans): All ethnic and racial groups are appropriate.</p>

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<p>Target Population continued</p>	<p>Other cultural characteristics (e.g., SES, religion): There are no specific income restrictions for participation; however, TA-FC targets families who are struggling to meet the basic needs of their children and have been impacted by trauma.</p> <p>Language(s): English, but can be translated to other languages, current pilot work being done in Spanish</p> <p>Region (e.g., rural, urban): urban, suburban, rural, and tribal communities</p> <p>Other characteristics (not included above): TA-FC targets families who have been impacted by trauma and are at risk of child neglect/maltreatment</p>
<p>Essential Components</p>	<p>Theoretical basis: Trauma Theory, Eco-Structural Model, Bowen Family Therapy, Narrative Practice, Cognitive Behavioral strategies, and Attachment Theory</p> <p>Key components: TA-FC is a six month outcome driven prevention intervention. All families receive a comprehensive family assessment, emergency assistance, a service plan, advocacy, and coordinated referrals to community agencies. There are three treatment phases, with each phase lasting approximately two months. The majority of services are delivered weekly in the home or community setting of the family. Themes of collaboration, reflection and transparency permeate the work conducted in the TA-FC program. Partnering with families sends a message that they are the “experts” about their lives, while collaboration strengthens the helping alliance.</p> <p>Phase One: The first phase of the intervention begins with trauma informed family engagement, a comprehensive family assessment using standardized measures and individualized service planning. Further, within this phase it is critical for the clinician to collaborate with the family to build and enhance physical and psychological safety as they help families connect to resources within their community that will allow them to meet their basic needs.</p> <p>Phase Two: Services from phase one sets a solid foundation for the second phase which addresses family psychoeducation related to developmental, chronic, and complex trauma as well as emotion identification and affect regulation of caregivers and children. The second phase is also focused on improving elements of family processes and functions including family communication, interpersonal relationships, and cohesion.</p> <p>Phase Three: In the final phase of TA-FC, the family develops a shared meaning of the trauma(s), while addressing stressors related to endings and preparing for case closure. TA-FC uses an interlocking narrative family practice perspective that provides a framework and therapeutic stance to understand, examine, and apply strategies that are appropriate for families exposed to trauma (either historical or current), live in poverty, and have poor connections to both informal and formal social/community networks. Using narrative techniques throughout treatment is a way to work with the family as a whole and create a shared meaning related to their traumatic experiences.</p>

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<p>Essential Components continued</p>	<p>The three phases of TA-FC are not only complimentary, but they also build upon one another; however, because our strategies accommodate the iterative nature of clinical work, practitioners are encouraged to revisit specific components of each phase, when applicable, as their work with each family progresses. Clinician professional development related to secondary traumatic stress is also addressed in the TA-FC model. Monitoring providers' reactions and resilience safeguards their well-being and decreases contamination of practice. Essential strategies include a daily regimen of self-care practices, self-reflection, and professional consultation that bolster clinicians' tools to cope with traumatic material and stress.</p>
<p>Clinical & Anecdotal Evidence</p>	<p>Are you aware of any suggestion/evidence that this treatment may be harmful? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Uncertain</p> <p>Extent to which cultural issues have been described in writings about this intervention (scale of 1-5 where 1=not at all to 5=all the time). 5</p> <p>This intervention is being used on the basis of anecdotes and personal communications only (no writings) that suggest its value with this group. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please include citation:</p> <p>Strieder, F.H., Clarkson Freeman, PA. and Talbot, N. (2012). Family Connections: Maryland Department of Human Resources Social Services Administration Final Report. Baltimore, MD: Family Connections.</p> <p>Strieder, F.H., Clarkson Freeman, PA. and Talbot, N. (2011). Family Connections: Maryland Department of Human Resources Social Services Administration Final Report. Baltimore, MD: Family Connections.</p> <p>Connors, K.; Collins, K.S., Belcher, H.; Kiser, L. (2011) National Child Traumatic Stress Initiative Community Treatment and Service Centers FY10 Annual Progress Review. Baltimore, MD: NCTSN.</p> <p>Collins, K.S. (2011). Trauma Adapted Family Connections. Colorado State University. Fort Collins, Colorado. September 26, 2011.</p> <p>Connors, K.; Collins, K.S., Belcher, H.; Kiser, L. (2010) National Child Traumatic Stress Initiative Community Treatment and Service Centers FY10 Annual Progress Review. Baltimore, MD: NCTSN.</p> <p>DePanfilis D, Strieder, F.H. and Murray, K. (2010). Family Connections: Maryland Department of Human Resources Social Services Administration Final Report. Baltimore, MD: Family Connections.</p>

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Clinical & Anecdotal Evidence continued

Has this intervention been presented at scientific meetings? Yes No

If YES, please include citation(s) from last five presentations:

Collins, K. S., Strieder, F., Clarkson Freeman, P.A. & Tabor, M. (2012). Results of a Pilot Study of Trauma Adapted Family Connections: Reducing Development and Complex Trauma Symptomatology to Prevent Child Abuse and Neglect. November 3, 2012. International Society for Traumatic Stress 28th Annual Meeting, Los Angeles, CA.

Ross, L., Strieder, F., & Vrabel, C. Organizational Impact and Intervention of STS. The National Center for Child Traumatic Stress Speaker Series. [Webinar] March 30, 2012.

Collins, K. S., Strieder, F., Tabor, M., & Clarkson Freeman, P.A. (2012). Trauma Adapted Family Connections: Reducing Development and Complex Trauma Symptomatology to Prevent Child Abuse and Neglect. Family Informed Trauma Treatments: Supporting Family Recovery. Raising the Standard of Care Improving Access Services: Past Accomplishments and Future Goals. NCTSN All-Network Conference. March 8, 2012. Baltimore, MD.

Connors, K., Gardner, S., Kiser, L., & Strieder, F. (2012). Family Informed Trauma Treatments: Supporting Family Recovery. Raising the Standard of Care Improving Access Services: Past Accomplishments and Future Goals. Pre-Conference Day, NCTSN All-Network Conference. March 5, 2012. Baltimore, MD.

DePanfilis, D., Collins, K.S., Bellin, M, Rice, K, Williams, C. (2011). Back to the Future: Designing & Implementing Social Work Intervention Research. Workshop: Society for Social Work & Research 15th Annual Conference – Emerging Horizons for Social Work Research. January, 2011, Tampa, FL.

Are there any general writings which describe the components of the intervention or how to administer it? Yes No

If YES, please include citation:

Collins, K.S., Strieder, F.H., DePanfilis, D., Tabor, M., Clarkson Freeman, P.A., Linde, L., & Greenberg, P. (2011). Trauma Adapted Family Connections (TA-FC): Reducing developmental and complex trauma symptomatology to prevent Child abuse and neglect. *Child Welfare*, 90(6), 29-47.

Figley, C., Kiser, L., Saltzman, W., Streider, F. (NCTSN). (2011). September 16: Innovations in Family-Centered Approaches to Trauma and Loss. in *Family Systems Speaker Series*. Retrieved from <http://learn.nctsn.org/>

Has the intervention been replicated anywhere? Yes No

Other countries? *(please list)* No

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Research Evidence	Sample Size (N) and Breakdown <i>(by gender, ethnicity, other cultural factors)</i>	Citation
Pilot Trials/Feasibility Trials <i>(w/o control groups)</i>	<p>Total N for caregivers and children with baseline and closing data=35 Caregivers; 57 children.</p> <p>Caregivers are African American, predominantly single (i.e. never married), unemployed, with an average education of 11.66 years. Average traumatic events reported, 13.37 (SD=5.18).</p> <p>Children are predominantly African American; average age 8.4 years; primarily complex trauma exposure.</p>	<p>Collins, K., Strieder, F.H., Clarkson Freeman, PA., Tabor, J., Linde, L., & Greenberg, P. (2012, in preparation). Reducing developmental and complex trauma symptomatology to prevent child abuse and neglect: Results from a pilot study of trauma adapted family connections. Manuscript in preparation.</p>
Randomized Controlled Trials	In Process	
Outcomes	<p>What assessments or measures are used as part of the intervention or for research purposes, if any?</p> <p>Life Stressors Check List; Post-traumatic Checklist – Civilian, Centrality of Event Scale, Center for Epidemiologic Studies—Depressed Mood Scale (20-item version), Brief Symptom Inventory, CAGE-AID, Parenting Stress Index Short Form, Parenting Sense of Competence Scale, The Family Adaption and Cohesion Evaluation Scales (FACES IV), Perceived Neighborhood Scale, Family Resource Scale, RAND 36-Item Health Survey, Everyday Stressors Index, Parent Outcome Interview, UCLA PTSD Scale, Traumatic Events Screening Inventory for Children Form (TESI-C-Brief), Trauma Symptom Checklist, Children’s Attributions and Perceptions Scale, Children’s Report of Social Support, Child Behavior Checklist,</p>	

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<p>Outcomes continued</p>	<p>If research studies have been conducted, what were the outcomes?</p> <p>The outcome evaluation for TA-FC includes the use of any of the above listed measures for baseline and follow-up assessments across multiple domains of identified risk and protective factors. Currently analyses (Collins et al., unpublished manuscript) show significant changes over time for a variety of domains. TA-FC families show reductions in risk factors, including caregiver trauma symptomatology, caregiver depressive symptoms, caregiver psychological functioning, parenting stress, and child self-report trauma symptomatology. Significant changes have also been found for protective factors, including parenting sense of competence (efficacy and satisfaction), sense of community (as indicated by the Perceived Neighborhood Scale), and perceived access to family resources. Significant improvements for caregiver well-being have also been identified, specifically for psychological/emotional well-being.</p>
<p>Implementation Requirements & Readiness</p>	<p>Supervision requirements (e.g., review of taped sessions)? Clinical supervision and training are acquired through: weekly individual supervision, monthly case reviews, group supervision, weekly practice seminars, and monthly administrative meetings.</p>
<p>Training Materials & Requirements</p>	<p>List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.</p> <p>Collins, K, Hayward, A, Strieder, FH, Davis, S, and Harkness, M. (2009) Trauma Adapted Family Connections: Advanced Intervention Strategies In DePanfilis, D. (Ed). Family Connections Intervention Manual, Sixth Edition. (101-145) Baltimore, MD: University of Maryland, School of Social Work.</p> <p>How/where is training obtained? Contact Kathryn S. Collins, MSW, PhD</p> <p>What is the cost of training? Contact Kathryn S. Collins, MSW, PhD</p> <p>Are intervention materials (handouts) available in other languages? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, what languages? Spanish</p>
<p>Pros & Cons/ Qualitative Impressions</p>	<p>What are the pros of this intervention over others for this specific group (e.g., addresses stigma re. treatment, addresses transportation barriers)?</p> <p>This is a family focused intervention that considers the needs of all family members. Families who present with increased levels of traumatic grief, fear, anxiety, and depression, as well as post-traumatic stress disorder related to traumatic or violent events receive individualized, culturally sensitive trauma specific interventions. TA-FC is an intensive home-based intervention, requiring weekly meetings with family members over six months. Trauma informed engagement strategies to facilitate comprehensive trauma-focused assessments are conducted to guide the development of individualized intervention plans and to measure outcomes.</p>

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<p>Pros & Cons/ Qualitative Impressions continued</p>	<p>What are the cons of this intervention over others for this specific group <i>(e.g., length of treatment, difficult to get reimbursement)?</i></p> <p>Working with families who are struggling to meet their basic needs and have experienced attachment is a labor-intensive venture. Consequently, caseloads are relatively small. Stress management to counter secondary traumatic stress and vicarious trauma is an important component of worker supervision</p>
<p>Contact Information</p>	<p>Name: Kathryn S. Collins, MSW, PhD</p> <p>Address: University of Maryland School of Social Work 525 West Redwood Street Baltimore, Maryland 21201</p> <p>Phone number: (410) 706.0814</p> <p>Email: kcollins@ssw.umaryland.edu</p> <p>Website: http://www.ssw.umaryland.edu/</p>