DEPARTMENT OF CHILD SAFETY

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Report on Adoption Outcomes for Children and Youth with Complex Trauma

December 31, 2021

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INTRODUCTION

Pursuant to Laws 2021, First Regular Session, Chapter 56, Section 1, the Department of Child Safety (DCS) jointly with the Arizona Health Care Cost Containment System (AHCCCS) is required to submit a report to Chairperson of the House of Representatives Health and Human Services Committee and the Chairperson of the Senate Health and Human Services, by December 31, 2021, related to children who are adopted for the Arizona child welfare system.

Requirements of this current report include:

- System improvements for children who are adopted out of foster care with complex trauma that results in dangerous behaviors.
- An evaluation, including outcome data, of programs and services that are offered by other states to address complex trauma.
- Mechanisms within the department for suspending parental rights when the adoptive child is a danger to the family as corroborated by law enforcement while maintaining the goal of permanency as required by federal law or other alternatives to terminating parental rights.

Children and youth who enter out-of-home care through the Arizona child welfare system do so through no fault of their own and almost always as a result of abuse or neglect. It is not surprising they often experience trauma prior to entering care. Childhood is made up of both good and bad experiences that shape and impact development throughout adolescence and into adulthood. When connected to caregivers, children develop a strong bond, and families provide the love and connection needed to become healthy, well-adjusted adults with a strong sense of self. Without that connection and/or if a child experiences adverse childhood experiences (ACEs), they may experience challenges that impact them throughout their lives. ACEs are potentially traumatic incidents that occur before a child is eighteen. ACEs refer to specific types of trauma children may experience, including physical, sexual, and emotional abuse, neglect, losing a parent such as through divorce, being exposed to domestic violence, having a parent with a mental illness, having a member of the household who abuses drugs or alcohol, and/or having a parent who has been incarcerated. Children living through these experiences may suffer from adverse effects for the rest of their lives. The impact of these traumatic events can create challenges throughout the person's life. A healthy adult is critical to support children's resilience helping them avoid or at least better manage potential chronic health conditions like depression, asthma, or diabetes that are associated with ACEs.

If a child experiences toxic stress long-term, they may adopt unhealthy coping mechanisms like substance abuse. When a child experiences chronic stress, it can lead them to have a lower tolerance for stressful situations in adulthood. Children can also experience Post Traumatic Stress Disorder (PTSD) and other mental health issues. The chronic stress of child maltreatment has been associated with prolonged, elevated levels of stress hormones resulting in dysregulation of the neurobiological systems involved in brain maturation, cognitive development, and emotion/behavior regulation (Cohen, Perel, DeBellis, Friedman, & Putnam, 2002).1

Youth who enter foster care often either have little or no stable relationship history with a healthy adult. Therefore, it is even more critical that they develop a long lasting and nurturing relationship with a stable caregiver. While more than sixty-five percent of all children who enter DCS custody exit to permanency with a relative (including reunification with parents, adoption or guardianship by a relative), the rest of the youth are adopted by non-relatives, age out of care, or other reasons.

Adoption creates a unique set of circumstances for some children, particularly older children, as their connection to their birth family may be momentarily or indefinitely broken. Adjusting to foster care then adjusting to a new and permanent home is stressful and may present families with challenges as they attempt to help their adopted children manage and cope with their personal trauma.

Arizona has long been successful in achieving permanency for youth unable to reunify with their parents or relatives. Additionally, Arizona's Title XIX behavioral health system is a robust array of services including wraparound, crisis, one-on-one, coaching, Child and Family Team, a wide variety of outpatient, inpatient and residential treatment. The Department refers all children who enter care for behavioral health assessment through an Integrated Rapid Response referral to determine their immediate needs and to begin identifying a child or youth's history of trauma. When children exit care, coordination of services is addressed prior to achieving permanency and the transition to another Title XIX health plan to continue behavioral health services is part of the process for those youth who remain eligible after they exit. Children and youth who are adopted and for whom adoption subsidy is approved, are eligible for these services through up until the age of 18.

This report will outline improvements to the system for youth who are adopted and have experienced chronic trauma. Additionally, it will review other states' systems for assisting these children. Finally, this report will evaluate the ethical and legal efficacy of terminating the parental rights of adoptive parents.

[1] Cohen, J. A., Perel, J. M., DeBellis, M. D., Friedman, M. J., Putnam, F. (2002). Treating traumatized children: Clinical implications of the psychobiology of Posttraumatic Stress Disorder. Trauma, Violence and Abuse, 3, 91–108.

SYSTEM IMPROVEMENTS FOR ADOPTED CHILDREN WITH COMPLEX TRAUMA

Adoption Subsidy supports adoptive families by removing financial barriers to adoption and providing ongoing assistance for children with special needs after adoption finalization. The number of children eligible and receiving adoption subsidy continues to increase. The number of children served in the adoption subsidy program grew from 34,589 on March 31, 2020 to 35,047 on March 1, 2021, with new special needs adoptions being subsidized in state fiscal year 2020 (SFY 2020). The Department reimbursed $4,411,473 of nonrecurring adoption expenses[2] in federal fiscal year 2020 (FFY 2020). Of the 3,524 children who were adopted during SFY 2020, approximately 85 percent were covered under a Title IV-E adoption assistance agreement, and the remaining 15 percent were covered under a state agreement. An executed adoption assistance agreement is required for reimbursing adoptive parents for their one-time non-recurring legal fees for adoption, and is required for the child's coverage through AHCCCS, therefor nearly all adoptions of children with special needs from foster care have an executed adoption assistance agreement.

The Adoption Subsidy program continues to offer post-adoption support to adoptive families of special needs children. Adoption subsidy staff provide support and resources to families and collaborate with community agencies to assist in meeting the needs of adoptive children. For example:

- The Adoption Subsidy handbook provides information about the program and addresses frequently asked questions from adoptive parents. In addition, a booklet containing information about adoption subsidy services, specifically respite services, is available to assist families.

- In SFY 2020, the Department introduced a new specialized rate for children who have significant developmental delays or behavioral health needs. To qualify for this special rate, the child must be currently in Medicaid paid therapeutic foster care or a child developmental home licensed by the Division of Developmental Disabilities/Office of Licensing, Certification and Regulation.

- Adoption subsidy staff continue to assist post adoptive families to coordinate services to meet the behavioral health needs of adoptive children by collaborating with the Title XIX behavioral health system. However, it is critical that families seeking to adopt children who are in DCS custody engage with this system before the adoption is finalized to receive support and services for the child or youth leading up to adoption. This engagement can impact post

[2] nonrecurring adoption expenses include the reasonable and necessary adoption fees, court costs, attorney fees and other expenses which are directly related to the legal adoption of a child with special needs,

adoption knowledge, experience and outcomes. It also assist in transitioning from the DCS CHP health plan to a Medicaid health plan after the adoption is finalized.

During SFY 2020, the Department continued the duties of the Behavioral Health Clinical Coordinator (BHCC) positions, ensuring that the needs of families could be met statewide. These positions assist prospective adoptive families to navigate the behavioral health system, including attendance at Child and Family Team (CFT) meetings to assist adoptive parents to understand and advocate for their children's needs. In April 2021, DCS and the Comprehensive Medical and Dental Program (CMDP) integrated behavioral health services with physical health services by contracting with Mercy Care to provide an integrated service model for youth in care. As a result, CMDP became the Comprehensive Health Plan (CHP) and the integrated services became Mercy Care DCS CHP and the BHCC positions were changed to System of Care Coordinators (SOCC) although the integrated services through this model are specific to youth still in DCS custody.

Additionally, the Department is establishing a contract for the Positive Parenting Program (Triple P) to provide post permanency support and training to adoptive families who are experiencing additional stressors in the home.

- The purpose of this solicitation is to contract with provider(s) for Post Permanency services for adoptive and guardianship families which have knowledge and experience of the entire Positive Parenting Program system, also known as Triple P. The goal is to mitigate situations that are escalating and prevent the reentry of post permanency children into out of home care.

- Each month there are children who are not residing in their adoptive home either due to the parents' request for DCS intervention, removal from home due to abuse or neglect, or because they are currently receiving services in a behavioral health residential setting.

- Post Permanency Services are referral driven services that are comprehensive, coordinated, community based, accessible and culturally responsive.

- Triple P is a parenting and family support system designed to prevent as well as treat issues within family function dynamics in children and teenagers. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential.

The goals of Triple P are:

- Promote the independence and health of families through enhancing the families knowledge, skills, confidence and self-sufficiency;

- Promote the development of non-violent, protective and nurturing environments for children;

- Promote the development, growth, health, and social competence of young children;

- Reduce the incidence of child maltreatment and behavioral/emotional problems in childhood and adolescence;

Triple P offers five (5) levels of intervention, ranging from "universal prevention" to "targeted intervention". DCS seeks to implement only Level Four (4) and Level Five (5) Triple P components because they are both Evidence Based programs.

The Department has compiled a list of support groups for adoptive families across the state. This list is provided to the licensing agencies, adoption subsidy Specialists, and the DCS field staff to be provided to families as needed. Examples of agencies that support adoptive families include the Lodestar Family Connections Center in Phoenix, the KARE Family Center in Tucson, Arizona Children's Association (AzCA) in Yuma, and the Family Involvement Center (FIC) in Phoenix and Prescott Valley. The Department continues to identify new community resources for children eligible for adoption subsidy.

In recent years, the Adoption Subsidy program has made strides in supporting adoptive families in the following ways. They have standardized the adoption subsidy application process to ensure that approval rates are consistently issued statewide and clearly based on the needs of the children. Through this standardization, the needs of the children and youth are thoroughly vetted through assessment, and documentation. The Department's Adoption Subsidy program has also established two Behavioral Health positions for the state. These positions were established to assist families receiving adoption subsidy in navigating Arizona's behavioral health system in hopes of keeping children from re-entering out of home care.

If trauma is known prior to the adoption, the adoption specialist will document information surrounding the trauma in the adoption subsidy application, the social study, and in the family history form. The Department ensures that a meeting to share non-identifying information is held with the prospective adoptive family prior to the first visit with the child. The Department provides the prospective adoptive family all information redacted including health and genetic history on the child and non-identifying information on the birth parents and members of the birth family in a written format. When the family has no prior relationship with the child or youth, information presented should include the child's history, their physical, emotional, social and educational needs, and the birth parents' wishes regarding sharing of identifying information.

The meeting with the family should include the child's therapist, attorney or Guardian ad litem, the certification work, the current caregiver, and when applicable the CASA, tribal representative and prior DCS Specialists or Supervisors. DCS representatives will bring copies of medical records, psychological evaluations, educational plans, therapy or CFT notes, information about birth parents and/or images/video of the child. Information is also shared through ongoing conversations at Child and Family Team meetings. They will also use this knowledge to ensure that appropriate services are in place prior to the finalization of adoption, to support the child and adoptive family post permanency.

The current post permanency supports for Adoptive families and adoptees through DCS are the Adoption Subsidy Program, and the Behavioral Health specialist through Adoption Subsidy. There are also community supports and resources through AzCA and the Arizona Association for Foster and Adoptive Parents (AAFAP). Additionally, an Adoption Preparation Program, which includes information on how trauma may manifest after an adoption is finalized, and how to successfully parent the traumatized child, may be beneficial for the pre-adoptive parents of children. Information regarding the parenting of a traumatized child is provided in the Foster Parent training, and would be beneficial for unlicensed as well as pre-adoptive parents who are adoption certified only.

EVALUATION OF OTHER STATES DATA AND PROGRAMS ADDRESSING ADOPTED YOUTH WITH COMPLEX TRAUMA

The Department consulted with a key stakeholder, Casey Family Programs (CFP), for assistance identifying post adoption services in other states that help address complex trauma. CFP is a renowned leader in child safety and child welfare whose mission is to provide and improve, and ultimately prevent the need for, foster care. The information provided by CFP is neither exhaustive nor does it necessarily reflect the views of CFP. The Department is grateful to CFP for their expertise and assistance in this effort.

Introduction

There is a growing body of research and resources available that address post-adoption services. This resource list provides an overview of interventions and treatments that address complex trauma, focusing on the unique needs of children and families post-adoption. The interventions listed in the tables below (evidence-based and additional interventions) were gathered from several published articles (see bibliography).

Evidence-based therapeutic interventions for complex trauma

The interventions listed in the table below have been rated well-supported, supported or promising by the California Evidence-Based Clearinghouse for Child Welfare (CEBC) for supporting children with complex trauma histories, and many have already been used or could be used with adopted children. This list is by no means exhaustive and provides only a brief description of the intervention. In some cases, provides intervention-specific academic resources and examples of organizations using the intervention. It should be noted that the cost of these interventions can vary greatly, many of which can be quite expensive to implement as well as sustain over time. While cost is not a determining factor in determining which program is most appropriate for any given population, it is a consideration that must be accounted for when making a final decision.

Intervention	CEBC Rating	Description	Example of Organization Utilizing Intervention
Attachment and Bio-Behavioral Catch-Up (ABC)	Well-Supported	Evidence-based parenting intervention for caregivers, infants, and toddlers who have experienced trauma. The program helps caregivers nurture and respond sensitively to their infants and has been found to help children develop better impulse control. Children also were found to show less anger during challenging tasks and switch between complex tasks more easily.[1]	The New York City Administration of Children's Services uses ABC as part of a two-pronged approach to provide support for post-adoptive families. This approach works alongside a Partnering for Success Program that involves partnership between child welfare and mental health providers.[2] South Carolina Infant Mental Health Association
Child-Parent Psychotherapy (CPP)	Supported	Aimed at children ages 0–6 years who have experienced trauma. Emphasizes parental sensitivity and responsiveness as well as secure attachment.[3]	currently available in Arizona's Title XIX behavioral health system
Child-Parent Relationship Therapy (CPRT)	Promising	Structured, time-limited intervention that trains caregivers to be therapeutic change agents for their children (typically children ages three to ten years old.) It promotes feelings of safety, acceptance, love and connection through play interactions. Impacts include a noted decrease in parental stress and disruptive behavior in their children, as well as increased parental empathy.[4]	currently available in Arizona's Title XIX behavioral health system
Dialectical Behavior Therapy (DBT)	Promising	Modification of cognitive behavioral therapy that may be used with adolescents. Treatment occurs through a combination of group, family, and individual sessions focused on increasing skills in interpersonal relations, distress tolerance, emotional regulation, and mindfulness. According to the CEBC, this intervention is particularly aimed at chronically suicidal youth with behaviors indicative of borderline personality disorder.3	currently available in Arizona's Title XIX behavioral health system
Eye Movement Desensitization and Reprocessing (EMDR, Child & Adolescent)	Well-Supported	Designed for children 2-17 years old. Involves eight phases of psychotherapy that integrate psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies.[5]	currently available in Arizona's Title XIX behavioral health system
The Incredible Years (IY)	Well-Supported	Targeted at parents, teachers, and children (ages 2-8 years old) and focuses on promoting parent competencies and strengthening the family as a whole, resulting in a reduction in children's behavioral challenges.[4]	currently available in Arizona's Title XIX behavioral health system

Intervention	CEBC Rating	Description	Example of Organization Utilizing Intervention
Multidimensional Family Therapy (MDFT)	Well-Supported	Originally developed as a strategy for adolescents with substance abuse and associated mental health and behavioral health challenges. MDFT aims to assess and intervene at the individual level and family level, as well as at the systems level, including child welfare, education, and juvenile justice, to engage all the systems involved in a child's life.[5]	currently available in Arizona's Title XIX behavioral health system
Parent-Child Interaction Therapy (PCIT)	Well-Supported	Originally developed to address disruptive behavior in children between the ages of 2 and 7 years old, PCIT has also been found to be an effective intervention for numerous behavioral and emotional health issues. PCIT focuses on reducing externalizing and internalizing behaviors in children by improving positive parenting skills and techniques, and reducing parenting stress.[4]	Arkansas (Little Rock): Child Study Center Outpatient Therapy Clinic Arkansas (Springdale): Schmideing Developmental Center California DHHS Humboldt County, currently available in Arizona's Title XIX behavioral health system
Theraplay	Promising	Combines traditional play and family therapy with psychoeducational parenting strategies to build attachment, self-esteem, and more positive interactions among parents and their children.[4]	currently available in Arizona's Title XIX behavioral health system
Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (Target-A)	Promising	For youth over 10 years old who have experienced trauma. TARGE-A uses a strengths-based psycho-educational approach to teach youth about the effects of trauma on human cognition; emotional, behavioral, and relational processes; and how stress impedes thinking systems.[6]	Additional resource: QIC-AG: Illinois Implementation Manual. Trauma Affect Regulation: Guide for Education and Therapy.
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Well-Supported	Focuses on psychoeducation about trauma in general, increasing positive parenting skills, and increasing relaxation and coping strategies, and it has been found to be effective with adopted children with known trauma histories, especially those with PTSD symptoms.[4]	Idaho Youth Ranch Lutheran Family Services of Nebraska currently available in Arizona's Title XIX behavioral health system
Triple P: Positive Parenting Program System (Triple P)	Promising	Social-learning-based intervention that focuses on increasing parental knowledge of child development, positive behavior management and parenting skills, and reducing coercive or punitive parental behaviors.[3]	currently available in Arizona's Title XIX behavioral health system

Intervention	CEBC Rating	Description	Example of Organization Utilizing Intervention
Trust-Based Relational Intervention (TBRI)	Promising	Relationship-based model that has three guiding principles: 1) empowerment (focused on the child's physiological and environment needs), 2) connection (focused on the child's self-awareness, attachment, and 3) correction (focused on the child's behavioral needs). TBRI includes both the child and their caregivers in order to decrease trauma-related symptoms and behavioral challenges.[4]	Arizona Family Counseling currently available in Arizona's Title XIX behavioral health system

The following tables lists additional therapeutic interventions for complex trauma that have been identified, however, have not yet been rated by CEBC but are in the process of developing an evidence base.

Intervention	CEBC Rating	Description	Example of Organization Utilizing Intervention
Adoption and Guardianship Enhanced Support (AGES)	Not yet rated	Developed by the Wisconsin Department of Children and Families to help respond to families who say they feel ill-equipped, unprepared, or unsupported in meeting the needs of their children after adoption. AGES was developed for the Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG).	
Attachment-based Family Therapy (ABFT)	Not yet rated	Focuses on teaching authoritative parenting skills that promote affect regulation within adolescents, in addition to rebuilding secure attachments in adolescence. ABFT was originally developed for depressed and/or suicidal adolescents and was then specifically adapted for children who were adopted and aims to strengthen the parent-child relationship.[4]	
Attachment, Regulation, and Competency (ARC)	Not yet rated	A framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC identifies three core domains that are frequently impacted among traumatized youth and which are relevant to future resiliency. Designed to be applied flexibly across child and family-serving systems.[7]	

Intervention	CEBC Rating	Description	Example of Organization Utilizing Intervention
Dyadic Developmental Psychotherapy (DDP)	Not yet rated	Specific treatment used with families with adopted or fostered children who have experienced neglect, abuse, and/or have suffered from developmental trauma. The interventions focus on helping rebuild positive relationships between the child and caregivers, in addition to increasing the child's sense of safety and feelings of connectedness through developing healthy patterns of relating and communicating.[4]	
Healing Centered Engagement	Not yet rated	A holistic approach to healing trauma where treatments involve incorporating culture, civic action, spirituality, and healing.[8]	Casey Family Programs' Children and Family Services
Integrated Treatment of Complex Trauma for Adolescents (ITCT-A)	Not yet rated	Multi-modal trauma therapy for adolescents that integrates treatment principles from attachment theory, the Self-Trauma Model, emotional regulation skills development, and components of cognitive behavioral therapy.[9]	
Neuro-Physiological Psychotherapy (NPP)	Not yet rated	Wrap-around approach involving multi-disciplinary, neuro-sequential, attachment-focused interventions for children and families who present with multiple, clinically significant emotional and behavioral health challenges. Children and younger people demonstrated significant changes in executive functioning, attachment strategies, and emotional and behavioral presentations as reported by their parents and teachers after engaging in NPP. Early adopted children with attachment difficulties appear to develop more secure representations of their adoptive caregivers over time.[4]	Additional resource: McCullough, E., Gordon-Jones, S., Last, A., Vaughan, J., & Burnell, A. (2016). An evaluation of Neuro-Physiological Psychotherapy: An integrative therapeutic approach to working with adopted children who have experienced early life trauma. *Clinical Child Psychology & Psychiatry, 21*(4), 582-601. doi: 10.1177/1359104516635221.
Neurosequential Model of Therapeutics (NMT)	Not yet rated	A way to organize a child's history and current functioning that is developmentally informed and biologically respectful, not a specific therapeutic technique or intervention. NMT integrates neurodevelopment, developmental psychology, trauma-informed services, and other disciplines to develop a comprehensive understanding of the child, family, and their environment in order to select the treatment(s) that will best fit the child's needs.[10]	Arizona's Children Association Casey Family Programs' Children and Family Services Additional resource: QIC-AC:Tennessee Implementation Manual. Neurosequential Model of Therapeutics currently available in Arizona's Title XIX behavioral health system

Intervention	CEBC Rating	Description	Example of Organization Utilizing Intervention
Trauma Systems Therapy (TST)		Care model for traumatized children that addresses individual child needs and the environment in which they live. It focuses on breaking down service system barriers and understanding the child's needs within the complexities of their world.	Boston Children's Hospital KVC Hospitals NYU Langone Medical Center
Tuning In To Teens (TINT)	Not Yet Rated	Emotional coaching program for parents of 10 to 18 years old that helps equip them with empathetic response strategies to help teens handle their emotions.	Additional resource: QIC-AG: New Jersey Implementation Manual. Tuning in to Teens.

1 Hartinger-Saunders, R.M., Jones, A., Rittner, B. (2019). *Journal of Child & Adolescent Trauma, 12*, 119-130. doi:10.1007/s40653-016-0104-1.
2 The Children's Law Center. New York Law School: Diane Abbey Law Institute for Children and Families Impact Center for Public Interest Law (2015, October 1). *Beyond permanency. One year later: Looking back, looking forward. Challenges for former foster youth and legal reform.* Beyond Permanency. Retrieved from https://www.clcny.org/files/120560604.pdf
3 Adapted from Teska, J. (2019). Quick lesson about: Post-adoption services. Cinahl Information Systems.
4 Reyka, J. (2019). Treatment considerations for adoption-related complex trauma. *National Louis University.* https://digitalcommons.nl.edu/diss/377/
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6 Quality Improvement Center on Adoption and Guardianship. (2020). *Illinois Implementation Manual. Trauma Affect Regulation: Guide for Education and Therapy.* Retrieved from https://www.qic-ag.org/wp-content/uploads/2020/06/QICAGSiteImplementationManualIllinoisFull.pdf
7 National Child Traumatic Stress Network website, accessed November 10, 2021.
8 Adapted from Youth Thrive. *Crosswalk: Youth Thrive & Healing Centered Engagement*. (2021)
9 Briere, J., Lanktree, C.B. (2016). *Integrative Treatment of Complex Trauma for Complex Trauma for Adolescents (ITCT-A) Treatment Guide, 2*nd *Edition.* University of Southern California. Retrieved from http://keck.usc.edu/adolescent-trauma-training-center/wp-content/uploads/sites/169/2016/06/ITCT-A-TreatmentGuide-2ndEdition-rev20131106.pdf
10 Adapted from The Neurosequential Network, accessed November 11, 2021.
11 Ai A.L., Foster, L.J.J., Pecora P.J., Delaney, N., & Rodriguez, W. (2013). Reshaping child welfare's response to trauma: assessment, evidence-based intervention, and new research perspectives. Research on Social Work Practice. 23(6), 651-668.

Steps to Becoming More Trauma Informed

Potential strategies for becoming trauma-informed:

- **Clear governance and leadership**: Identify a well-defined leadership team to advance the work. This should include key decision-makers at the agency, local, and state levels to ensure that assessment and treatment of child trauma is integrated across systems and programs and can adequately supported through financing, staffing, and other resources. Involve teams from within the agency and external agencies to promote buy-in, address challenges, and keep momentum moving forward.

  Examples from other states include the first lady of Wisconsin working in partnership with the Wisconsin Department of Children and Families, physical and behavioral health providers, faith-based community leaders; and private entities to better recognize, understand, and address the effects of trauma on the lives of children and families through their Fostering Futures initiative.

  The Custer County (Oklahoma) Trauma Team is tasked with leading the collaborative trauma efforts of the Oklahoma Department of Human Services, community behavioral health professionals, law enforcement, criminal justice, and mental health agencies.

- **Active outreach to community stakeholders**: Seek community input from providers serving adoptive families and find champions integral to system change in order to mobilize resources and to raise awareness of the prevalence and impact of child trauma. Create a shared understanding of trauma-informed principles with all partners and make available resources on trauma for any system collaborators. Support additional training for courts, physicians, mental health and substance abuse treatment providers, and others to introduce trauma-informed interventions appropriate for these settings. In Arizona, DCS partners with the Arizona Association for Foster and Adoptive Parents (AZAFAP) to continually identify the issues most critical for adoptive parents. AZAFAP established the Caregiver Advisory Panel (CAP) of foster, kinship and adoptive parents for the purpose of providing input and guidance with respect to services provided for children from foster care by systems in the state of Arizona including, but not exclusive to, DCS, AHCCCS and their Managed Care Organizations (MCOs) and providers, Mercy Care DCS Comprehensive Health Plan (CHP), Department of Economic Security / Division of Developmental Disabilities (DES/DDD), and other entities needing feedback.

  Examples from other states include Waupaca County, Wisconsin, who conducted 100 interviews with 100 key community stakeholders in 100 days to determine community support, needs, and interests in trauma-informed care initiatives. In Custer County, the

agency planned a communitywide summit on trauma, ACEs, and an overview of its trauma-informed initiative.

- **Comprehensive policy change:** Establish policies and cross-agency protocols that institutionalize a trauma-informed approach across all agency services and administration. These policies should support respectful, trusting interactions at all levels including policies related to safety assessments and violence in the workplace.

  Examples from other states include Connecticut DCF's CONCEPT modified 34 agency policies and practice guides to require that caseworkers consider children's exposure to trauma and how it may affect their current functioning.

- **Evidence-informed interventions:** Use evidence-informed and culturally responsive trauma screening, assessment, and treatment that examine the influence of intergenerational and historical trauma. Utilize a consistent trauma screening for all children with whom the Department engages. This may include the Trauma Symptom Checklist for Children.

  Examples from other states include Connecticut's CONCEPT, all children aged 6 and older who are placed into DCF care are screened for trauma, with services adjusted to meet the unique needs of immigrant or transgendered youth. Support implementation of evidence-informed interventions to address trauma.

- **Ongoing staff development:** Incorporate trauma-informed principles and activities into staff hiring, training, supervision, and performance evaluation. Agencies may provide specialized training and support to help competent social workers become skilled, resilient, and healthy supervisors, including training on reflective supervision and mindfulness techniques. Take steps to help caseworkers understand how their cultural backgrounds may influence how they perceive and support families.

  DCS developed a Supervision Coach program that supports practice fidelity in safety assessment and clinical case management. DCS established twenty (20) Supervision Coach positions statewide. Supervision Coaches regularly provide coaching to supervisors on safety assessment, clinical case management, clinical supervision, and administrative supervision. These activities can help supervisors support their staff identifying and assess the family's history and possible trauma.

  Examples from other states include, New Jersey, who offers an ongoing professional development series, Taming Trauma, designed to help staff more fully understand trauma,

explore secondary or vicarious trauma, and find tools to help mediate the impact of trauma. New York City's Resilience Alliance training curricula series is designed to mitigate the impact of secondary traumatic stress among child protective staff, supervisors, and leadership in New York City. Olmsted County's (Minnesota) Trauma Steering Committee assessed training needs and instituted cross-system capacity-building activities on trauma and its impact for the local Children's Justice Initiative, a collaboration between the Minnesota Judicial Branch and the Minnesota Department of Human Services.

- **Accessible critical incident and peer support:** Have experienced child safety retirees provide confidential peer support, given their understanding of the trauma and stress both on and off the job. Use trained facilitators, retirees, and peers to offer a 24/7 helpline or provide check-ins, coaching, and formal peer mentoring, as well as coping groups following critical incidents and ongoing groups to address issues of secondary traumatic stress, burnout, and psychological safety.

  To support DCS Specialists, Program Supervisors, Case Aides and other front line staff experiencing secondary trauma, DCS continues to offer its peer-to-peer support program, Workforce Resilience. This program seeks to enhance a healthy workforce and provide staff a safe and supportive environment when coping with the experiences inherent in child welfare and help address burnout staff may experience.

  Arizona has completed Systemic Critical Incident Reviews (SCIR) on fatality or near fatality reports for six years. A case is eligible for a SCIR if the family involved in the fatality or near fatality report has a history of DCS involvement in Arizona in the past three years. These cases are discussed and selections for a SCIR are made at a monthly Multidisciplinary Review Team. Cases selected for a SCIR receive a thorough case review as well as voluntary debriefings with staff involved in the prior reports, as well as the current assessment. The case review and voluntary debriefings allow for a better understanding of what occurred and what influences may have been present for the staff during decision making. The debriefings are also trauma informed. Examples of influences may be lack of supervisory support, production pressure, fatigue and stress. The learning from the SCIR process is presented to leadership on a fixed interval and actions are taken to address any systemic barriers that have been identified.

  Examples from other states include, New Jersey, who developed the Worker2Worker program provides three levels of peer support — prevention/training, intervention, and crisis response — to address secondary traumatic stress. In New York City, the Restoring Resiliency Response model integrates education, emotional expression, cognitive restructuring, and healing, along with self-care and coping skills, into its crisis debriefing

services. These supports are tailored to address child fatalities, bereavement, grief and loss, threats and assaults on employees, and incidents of severe child abuse or neglect and domestic violence.

By identifying these cases and improving practices as a result, prospective adoptive parents will receive better and enriched case management services that will better prepare them for and assist them with the transition to being adoptive parents after the finalization of adoption.

MECHANISMS WITHIN THE DEPARTMENT FOR SUSPENDING PARENTAL RIGHTS

The Department is required to describe mechanisms within the Department for suspending parental rights when the adoptive child is a danger to the family as corroborated by law enforcement while maintaining the goal of permanency as required by federal law or other alternatives to terminating parental rights. There are only a small number of adopted children who are re-removed from their homes due to being a danger to their family. Rather, the majority of children in this situation are re-removed due to allegations of neglect or abuse, as defined in A.R.S. § 8-201.

This question addresses whether the Department has access to methods whereby parental rights can be suspended rather than terminated for adoptive parents only whose child returns to the Department's custody due to being a danger to the family as corroborated by law enforcement while still maintaining federal permanency goals. The question also queries as to alternative methods to terminating parental rights for adoptive parents only. There are practices within the Department that could be interpreted as a suspension of parental rights.

Dependency Action

A.R.S. § 8-821 requires the Department to take a child into temporary custody when there is an order of the superior court; exigent circumstances exist; or the parent consents. Parental rights remain intact while the parent is offered an opportunity to participate in services in order to reunify with their child[3].

A.R.S. § 8-841 permits the Department or any interested party to file a dependency petition to commence proceedings in the juvenile court alleging that a child is dependent.[4] The juvenile court will review the petition and enter appropriate orders granting temporary custody to a person or the Department. Again, the parents are provided with an opportunity to participate in services in order to reunify with their child.

Guardianship

A.R.S. §8-871 permits any party to a dependency action to file a motion for permanent guardianship whereby a permanent guardian is appointed which divests the adoptive parent of legal custody but does not terminate parental rights.[5] There is a process for parents to maintain visitation rights[6] Furthermore there are procedures in place for a parent to revoke the permanent

[3] A.R.S. § 8-846 (D) contains a list of aggravating circumstances where, after a hearing, a parent will not be provided reunification services.
[4] A.R.S. § 8-841 (B) addresses a separate procedure for a child who is delinquent rather than dependent.
[5] A.R.S. § 8-871 (D).
[6] A.R.S. § 8-872 (I).

guardianship,[7] as well as appointing successor permanent guardians if the original guardian is unable to continue as guardian.[8]

90-Day Voluntary Agreement

A.R.S. § 8-806 permits the Department to accept a child for voluntary placement for up to 90 days if the provision of services is likely to remedy the circumstances that bring the child into care within the 90 day period. This option may only be used if the Department intends to return the child to the parent or the parent is making arrangements for an alternative living arrangement for the child. Section G specifies that a voluntary placement does not constitute abandonment, abuse or dependency.

There are other mechanisms available to biological and/or adoptive to transfer care of their child or children to another individual(s).

A.R.S. § 14-5204 permits the appointment of a temporary guardian for a minor wherein parental rights are suspended by circumstances or prior court order as long as the appointment is in the best interests of the minor. The jurisdiction of such a temporary guardianship is through probate court, rather than the juvenile court, and as the name suggests, it is meant to be a temporary resolution for situations when a parent is unable to care for a child for a specific reason, such as when military parents are deployed overseas. The temporary guardianship is based on the consent of the parent and is dissolved when a parent revokes that consent. It should be noted that the Department cannot engage in facilitation of this form of guardianship.

Adoptive Child Is Danger to Family, As Corroborated By Law Enforcement

Jacob's Law

In 2016, this law was passed in an effort to improve care for Arizona's foster, kinship, and adoptive families receiving behavioral health services. There are several components of this law but the ones pertaining to adoptive families are as follows:

> A.R.S. § 8-201.01 (B) states that an adoptive parent may not be considered as having abused, neglected or abandoned their adoptive child solely for seeking in-patient treatment or an out-of-home placement if the child's behavioral health needs pose a risk to the safety and welfare of the family. *(It should be noted that this does not permit a parent from merely asking the Department to take custody of the child due to behavioral issues. The Department must still investigate to make a determination whether the circumstances being alleged are consistent with statute.)*
>
> A.R.S. § 8-512.01(B) allows adoptive parents to directly contact the behavioral health agency in order to obtain services and mandates an expedited timeline by which providers must provide services to the adoptive family.

[7] A.R.S. § 8-873.
[8] A.R.S. §8-874.

A.R.S. § 8-515.05 (E) states that the Department is prohibited from removing a foster child from a license foster parent because the foster parent dissolved a previous adoption if the dissolution occurred because the foster parent was unable to obtain services for the adopted child or the adopted child posed a risk to the health and safety of the family.

Permanency Goals Required By Federal Law

The Adoption and Safe Families Act (AFSA)

ASFA was enacted in 1997 in order to address issues raised when adoptions were deferred for children with special needs. It did so by amending Title IV-E of the Social Security Act to require, among other things, the following provisions:

- States must move to terminate parental rights (TPR) for children who have been in foster care for 15 out of the last 22 months, with some exceptions when there are compelling reasons that an adoption would be detrimental to the emotional well-being of the child. However, states and tribes may not develop a standard list of compelling reasons for not filing for TPR that exempts groups of children. Such a practice is contrary to the requirement that determinations regarding compelling reasons be made on a case-by-case basis. States and Tribes may, however, provide case workers examples of such for training purposes. One example may be that an older youth has expressly demonstrated a close bond with a parent and has adamantly voiced his objection to being adopted. The parent may not have demonstrated any effort to engage in the reunification process or services and other permanency options may be in the child's best interest.

- A Permanency hearing must be held every 12 months.[9]

Other Alternatives to Terminating Parental Rights

In-Home Interventions

Pursuant to A.R.S. § 8-891 the Court may order an In-Home Intervention where a dependency petition is filed but the child has not been removed from the parents pursuant to A.R.S. § 8-821 or § 8-841; The family must agree to participate in a case plan and services and is given a specific amount of time, not longer than one year without court review and approval, to address their issues. If the family has successfully completed services at the conclusion of the specific time period, the court will dismiss the dependency petition without a ruling that the child is dependent. If, however, the family violates the in-home intervention order, the court may take whatever steps it deems necessary to obtain compliance or rescind the order and convert the case to a traditional dependency action, including adjudicating the child dependent.. This procedure is in contrast to

[9] State law requires that a permanency hearing be held within the first six months of a case for a child under three years of age. *See* A.R.S. § 8-533 (B)(8)(b).

an in-home dependency where a child is adjudicated dependent and their case is reviewed in court on a regular basis.

Equal Protection concerns

There is a high likelihood that the consequences of establishing separate standards for terminating parental rights of adoptive children would violate the Equal Protection Clause of the United States and Arizona Constitution. Further, this will also create a sub-class of adopted children who do not have the same legal protections as non-adopted children.

Summary of Mechanisms within the Department for Suspending Parental Rights

There is a risk attached to developing any further statutes or rules which would provide the parent of an adoptive child with a way to suspend their parental rights that does not pertain to any other class of parent. As noted above, there are various statutory remedies currently in place to assist an adoptive parent who is unable to manage the behavior of their adoptive child short of terminating parental rights. Additionally, in 2016, the state legislature passed Jacob's Law which already addresses the situation contemplated by SB1018 by specifically finding that an adoptive parent will not be found to have abandoned, neglected, or abused an adoptive child if they seek an out of home placement when a child poses a danger to the health and safety of their family. Developing any further protections would come at the cost of the well-being of the adopted children who can no longer remain in their adopted families. They are equally entitled to the permanency mandated in federal law and allowing the adoptive parents to avoid having their parental rights terminated would prolong the amount of time those children will remain in foster care.

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