Attachment, Self-Regulation, and Competency (ARC) Learning Collaborative 2016-2017

DCF CONNECTICUT

Yale SCHOOL OF MEDICINE

Child Health and Development Institute of Connecticut, Inc.

Connecticut Office of Early Childhood

Introduction

Connecticut is one of only a few states whose access to care in the children's mental health system lags significantly behind the adult system. Children under 7 suffering from trauma exposure have even greater disparities in service access and use compared to the general population. There are several trauma-focused EBPs available for children aged 7-17 in Connecticut, but very few services are available for children under 7 years of age. The Early Childhood Trauma Collaborate (ECTC) is a SAMHSA-funded initiative aimed at addressing this gap in services by expanding trauma-specific services for children under 7 years of age. A component of the ECTC initiative, the Attachment, Self-Regulation, and Competency (ARC) Learning Collaborative will disseminate the ARC model of intervention to four (4) participating Outpatient Clinics for Children (OPCC) and support the development of collaborative relationships between participating OPCCs and early childhood provider agencies in Connecticut.

The ARC model of intervention is a flexible, components-based intervention for children who have experienced complex trauma and their caregiver(s). ARC has three primary domains: Attachment, Self-Regulation, and Competency, and a fourth, Trauma Experience Integration, that incorporates the skills for the three primary domains to support the child in the development of a life narrative. ARC can be applied to children aged 0-21 across all levels of developmental functioning. Though participants of the ARC Learning Collaborative will be trained to provide ARC services to youth aged 0-21, an emphasis will be placed during the Learning Collaborative on identifying children under age 6 for intervention.

This packet contains information that will guide you and your agency in understanding the Learning Collaborative approach and prepares your team for the first learning session. The first section of this document describes the Learning Collaborative methodology and provides general information about the Faculty, participating teams and activities. The second section is a preparation guide for teams prior to the start of the Learning Sessions.

Section A: The Learning Collaborative Methodology and Components

I. Background: What is a Learning Collaborative?

A Learning Collaborative is probably different than other trainings you have attended. It is based upon the Breakthrough Series Collaborative model developed by the Institute for Healthcare Improvement, which focuses on a quality improvement methodology that promotes system-wide transformation and rapid adoption of evidence-based practices in outpatient community-based behavioral health settings. The Learning Collaborative Model involves much more than training alone. It brings together teams from multiple sites to work on improving a process, practice, or system, with team members learning from their collective

experiences and challenges. It also requires ongoing participation by all the stakeholders involved, including, clinicians, supervisors, and administrators both during and between the Learning Sessions.

The **Learning Sessions** are in-person trainings that combine clinical training with experiential activities focused on helping agencies share with one another their strategies for implementing an evidence based treatment. Learning Sessions are highly interactive, and involve a range of activities designed to inspire you to learn from the experiences of each other. You will be encouraged to be creative and try out techniques with other participants. Between Learning Sessions are the **Action Periods**, in which teams test and implement changes related to the Collaborative Change Framework, and start implementing ARC services with identified clients. Teams also start collecting data to measure the impact of changes. During the Action Periods the expert faculty provides monthly clinical consultation calls to support the implementation of ARC. Senior Leaders of each team also join together on a monthly consultation call to discuss administrative issues related to implementing evidence-based practices. Finally, the Project Coordinator holds implementation calls with the agencies' coordinators to support non-clinical issues that might arise when integrating the new model as well as the collaboration processes of the agencies.

II. Elements of the Learning Collaborative Methodology

The intention of the Learning Collaborative is not to create an entirely new body of knowledge. Instead, it is intended to fill the gap between what has been identified as evidence-based practice (EBP) and what is actually practiced in the field. The key of the LC is using a variety of techniques to bridge this gap between what is known and what is done. There are several critical characteristics of the LC methodology that help agencies to learn the intervention, quickly test, and fully implement these practices in ways that are appropriate for your agency as well as sustainable over time:

I. All the work of the LC is grounded in a comprehensive **Collaborative Change Framework (CCF)**, which guides the work of the teams. This CCF has been developed with input from the expert faculty and identifies components for the adoption and implementation of ARC. This CCF will be used to guide the teams participating in the LC towards improving and sustaining the integration of ARC into your agency's practice.
II. **Anyone can have and test ideas**. Ideas for practice and system improvement do not come only from management. Practitioners have a great deal of experience and knowledge, and they all have good ideas they can test.
III. **Consensus is not needed**. The LC encourages every participant to test ideas in the field. Instead of spending time trying to convince one another of a better way, participants discuss the results of the ideas they have tested.
IV. **Changes happen at all levels not just at the top**. It is important that every person

involved is willing to test and make changes.

V. **Ideas are stolen shamelessly**. Each participating team can benefit greatly from the successes and learning of all the others. Learning sessions, conference calls, and input on an intranet site are opportunities for teams to capitalize on the successes of others and learn from their mistakes as well.

VI. **Measurement is for improvement, not for research**. Measurement is a critical aspect of the LC methodology, as the LC strives to gauge improvements over time. Teams will be required to track and report on several specific metrics on a regular basis. Even if the numbers are small, teams can tell if they are making progress toward implementing ARC services to make an impact on young children's mental health in Connecticut.

VII. **Collaboration with external partners**. Collaborating with external service providers not only helps to develop a full range of services for young children, from identification of trauma needs to referral for clinical assessments, it also creates strong partnerships between community agencies, which make the community stronger. Senior Leaders in the Learning Collaborative will establish these collaborations by reaching out to early childhood providers in their community to inform their staff about trauma and options for making referrals for clinical trauma assessments.

In this Learning Collaborative, we will create a group experience and environment that promotes the best opportunity for collaboration, as well as adoption and implementation of data-driven decision making within each team participating in the Collaborative.

III. ARC Learning Collaborative Experience

- **Pre-Work Phase**:
  - Identifying a core team of 4-7 team members to include the following:
    - At least one clinical supervisor
    - 2-5 clinicians (who can receive ARC supervision from a clinical supervisor on the team)
    - 1 senior leader
    - 1 site coordinator (who can also fill another role on the team)
  - Participating in an initial site visit by CHDI's project staff and ARC faculty;
  - Completing the *Collaborative Change Framework,* an initiative goals resource;
  - Completing baseline clinician survey (to be sent by The Consultation Center at Yale University);
  - Participating in conference calls with CHDI as needed; and
  - Working with their clinic team to establish weekly meeting times;
  - Clinicians and supervisor(s) working together to identify weekly meeting time;
  - All participating agency staff will also be required to read the ARC book (available to teams at no cost and distributed at site visit), 2 ARC articles, and an ARC pamphlet prior to Learning Session 1. This will provide team members with foundational training in the ARC model.
  - Senior Leader identifies early childhood agencies (Headstart, Home Visiting

Agencies, pediatricians, DCF) in the local community to begin planning for providing training on trauma and how to refer young children for trauma assessments to early childhood agency staff (must train at least 2 early childhood agencies during the learning collaborative)

- Collaborative Learning Sessions
  - The core teams from the ARC clinics will come together for two Learning Sessions, a 2-day training January 26-27 and a 1-day training in June-July (date TBD). Team members will learn from each other, CHDI, ARC trainers, and a family partner about the ARC model, how to improve collaboration across providers, how to share progress reports and data, and how to outreach to early childhood systems.

- Action Periods
  - Based on areas of the Collaborative Change Framework, Action Periods focus on supporting teams to more closely and intentionally focus on improving their implementation of ARC between Learning Sessions

Activity	Purpose	Frequency of Occurrence	Who Facilitates	Members Expected to Participate
Internal meeting with ARC Team at each participating agency	Discuss components of ARC as they are learned; discuss cases and implementation issues	At least bi-weekly (*note:* weekly meetings are suggested for the first six months)	Site Coordinator on Core Team	Clinicians, Clinical Supervisor(s), Senior Leader for first two months (then on a monthly basis)
Implementation Consultation	Support for agencies; feedback for faculty	Twice-monthly 15-30 minute phone call	Site Coordinator & CHDI Project Coordinator	Site Coordinator
Clinical Consultation Calls	Discuss ARC cases with Developers	Monthly	ARC Developer Faculty	Clinicians, Clinical Supervisor(s)
Senior Leader Calls	Discuss Systems Level Implementation Strategies	Monthly	CHDI Faculty	Senior Leader

NOMS/TRAC data entry	SAMHSA-required submission of demographic data (additional instruction to be provided)	Monthly	Clinicians, Supervisors with active cases	Clinicians, Supervisors with active cases
EBP Tracker Data Entry	To measure and provide direction in client treatment and agency implementation of model.	Baseline, Monthly and Closing	EBP Tracker—Database maintained by CHDI	Clinicians, Supervisors with active cases
Connect with local early childhood provider agencies (Headstart, Home visitors, DCF)	Train local early childhood providers on trauma and how to access trauma assessments for young children (3-6 yo)	Train at least 2 early childhood agencies by the end of the Learning Collaborative	Senior Leader or designee	Senior Leader or designee

IV. Goals, Objectives, and Target Population

- Build providers' capacity to implement ARC with fidelity for youth through application of the LC methodology and the creation of a sustainable learning community;
    - Objective 1: ARC Clinicians will provide ARC to at least 5 children and their caregivers by the end of the Learning Collaborative
    - Objective 2: ARC Supervisors will provide ARC to at least 2 children and their caregivers by the end of the Learning Collaborative
    - Objective 3: ARC teams will provide ARC to at least 2-3 children of military families (National Guard, Active Military, Veteran)
- Improve the well-being of children and caregivers who receive ARC
    - Objective 1: At least 80% of children completing ARC demonstrate significant reduction in PTSD or other trauma-related symptoms
    - Objective 2: At least 80% of caregivers completing ARC demonstrate significant reduction in PTSD or other trauma-related symptoms
- Develop collaborative and cooperative relationships between outpatient providers, clinicians, caregivers, and other early childhood community systems to assure effective referral, assessment, and treatment of young children;

- Objective 1: Senior Leaders (or their designee) will provide training on trauma and referral of young children for trauma assessments to at least 2 local early childhood agencies by the end of the Learning Collaborative

- Build providers' capacity to utilize data and implement evidence-based practices through application of a LC methodology and the creation of a sustainable learning community.
- Build provider opportunities for obtaining family/caregiver input on the ARC practices and procedures.

The target population for this initiative is children aged 0-6 years old, who have experienced trauma and their caregivers. An emphasis should be made on providing ARC services to children with caregivers who are military-involved (active military, veterans, National Guard, etc.).

V. Learning Collaborative Roles and Responsibilities

- Faculty
  - Organize the logistics related to the collaborative experience: will establish a timeline for all activities before the start of the collaborative. Active collaborative participation and availability hinges on the effective communication of dates, times, and locations to LC participants.
  - Promote the key elements of the Learning Collaborative model: although learning the competencies related to the intervention are imperative to successful adoption, it is one element of the Learning Collaborative methodology and the Collaborative Change Framework. The faculty are instrumental in expending the understanding for participants that in order to change practice, there must be a change in the system also.
  - Utilize innovative teaching methods in Learning Sessions and Action Periods: faculty will be guided by adult learning principles in the design of both the Learning Sessions and the activities during the Action Period. Interactive, experiential Learning Sessions immediately begin to promote the concept of shared learning and the dynamic use of the concepts being presented in session.
  - Share expertise regarding the intervention and its implementation: the faculty serves as advisor and coach to teams as they implement the newly learned intervention within their community. The knowledge and expertise of faculty in implementing and supervising the implementation of the intervention in different settings is valued by teams as they are challenged in their implementation process throughout the collaborative experience.
  - Share expertise regarding family engagement and involvement in the implementation process.
  - Foster and cultivate the transition of participant-learners to participant-experts in implementing improvements related to the adoption of the intervention: a

gradual transition occurs within the collaborative experience as early adopters share their expertise and facilitate the learning of other teams in the process of adoption. Faculty will provide the environment and strategic opportunities for innovators to highlight their skills and share their experiences with the collaborative membership.

- Develop flexibility in response to emerging needs of collaborative teams: although the LC methodology recommends a certain approach and implementation of the process, faculty members need to be flexible and adaptive based on the unique teams in the collaborative and the challenges and strengths they bring to the experience.

- Agency
  - Provider Administrator:
    - Provide leadership and direction for the agency and their Learning Collaborative team
    - Inspire a vision of quality care for young children and their families, who experience trauma
    - Integrate the Learning Collaborative goals into the strategic initiatives of the agency
    - Select a dedicated, part-time ARC Site Coordinator
    - Select the members of the core team to include a Senior Leader, Clinical Supervisor(s), Clinicians, and a designated team member to enter data directly to SAMHSA on a monthly basis
    - Provide the core team with resources necessary to succeed
    - Provide time for staff to participate in ARC Learning Sessions and Action Period activities, including consultation calls
    - Allow adjustments to schedules, productivity hours, and other productivity issues (e.g., productivity credit for trainings and case preparation)
    - Provide physical resources such as meeting facilities
    - Provide equipment such as telephones and computers and ensure that all team members have access to and use of e-mail and the Internet
    - Account for expenses such as travel and productivity loss for participating in ARC Learning Sessions
    - Promote a supportive environment that encourages creativity and continuous quality improvement
    - Promote the work of the core team within the agency
    - Review the Collaborative Change Framework, in partnership with the core team Senior Leader
    - Facilitate the removal of barriers that inhibit change
    - Commit to spreading successes of the core team quickly throughout the agency/group practice

- Provider Senior Leader:
  - May also be a Provider Administrator
  - Participates in the completion of the Collaborative Change Framework and reviews in partnership with Provider Administrators
  - Attends portions of the Learning Sessions, as applicable to roles and responsibilities (maximum 3 Learning Session days) and participates in Learning Session activities specific to Senior Leaders
  - Supports and encourages the supervisor(s) and clinicians in quality improvement activities during the Action Periods
  - Communicates regularly with team members through attendance at weekly team meetings (for at least the first two months and then monthly thereafter)
  - Communicates regularly with provider agency administrators about team implementation of ARC
  - Participates in monthly calls for Senior Leaders, as arranged by CHDI
  - Reviews and monitors metrics to assess progress, and discusses at team meetings
  - Promotes the adoption of successful practices within the agency/group practice
  - Assures clinicians receive ARC clinical supervision
  - Plans and conducts basic training with at least 2 local early childhood agencies (Headstart, Home Visitors, DCF) about trauma and making young child referrals to clinical trauma assessments

- Provider Site Coordinator:
  - May also be a Senior Leader, Clinical Supervisor, or Clinician on the team
  - Assumes responsibility for overall project management
  - Possesses relevant education, training and behavioral health experiences, preferably a masters level clinician with experience working with young children and families
  - Knowledge trauma in young children and treatments related to these conditions
  - Strong organizational and teamwork skills and dedicates required time necessary to achieve the project goals
  - Develops strategies, support structures, process capabilities, and resources, in partnership with the Senior Leadership and the core team to achieve objectives
  - Is an enthusiastic champion for evidence-based practice who can run weekly ARC core team meetings throughout the training year
  - Is comfortable managing and interpreting data (e.g., assessments, implementation data)
  - Maintains monthly/every other month communication with CHDI

project staff about implementation challenges and successes
    - Coordinates activities relating to studying, testing, and implementing at the clinic site in a timely manner
    - Arranges for resources to meet the needs of the core team
    - Collects data, as requested by evaluators, and disseminates to Senior Leadership/core team
    - Monitors and reports on team progress to Senior Leader, including successes and challenges
    - Identifies and advocates for solutions that support institutionalization of the practice, including spreading information about ARC throughout the clinic
    - Those who are also Clinician/Supervisor/Senior Leader on the team must also meet the expectations for that role

- Provider Clinical Supervisor and Clinicians:
    - Participate in the pre-work activities
    - Complete the Collaborative Change Framework, as part of core team
    - Participate in all Learning Sessions (3 days) with team members
    - Participate on clinical consultation calls once per month, including presenting cases when assigned
    - Supervisors participate in quarterly supervisor call, in addition to monthly clinical consultation calls
    - Participate in quality improvement activities with core team during action periods
    - Communicate regularly with team members and faculty regarding implementation
    - Engage in collaborative problem solving with other clinic's team members
    - Participate in core team ARC meetings
    - Enroll (assessment and 1 clinical session) a minimum of five (5) ARC cases per clinician and two (2) ARC cases per supervisor by the end of the Learning Collaborative year
    - Share ideas and lessons learned on a regular basis with Learning Collaborative members
    - Enter and track clients served with ARC in EBP Tracker database (e.g., intake, monthly, every 90 days, and discharge) to assess clinical treatment progress and guide data-driven decision making with clients and families
    - Enter monthly demographic data as required by SAMHSA into the NOMS/TRAC data system (training to be provided)

Period/Goal	Clinician	Clinical Supervisor	Senior Leader
Pre-work	Begin considering children who may benefit from ARC	Meet with clinical staff to arrange agency supervision	Begin to identify local early childhood providers
By Learning Session 1 (LS1)	**Team** comes to LS1 with 1 child in mind who may benefit from ARC; Team develops storyboard for presentation at LS1	Identify areas of success and challenges in practicing ARC and using EBP Tracker	Begin to contact local early childhood providers to discuss plans for training
By Learning Session 2	3-5 ARC cases (children 3-6 yo) enrolled	1-2 ARC case enrolled (children 3-6 yo)	Conduct training with 1-2 early childhood providers
By the End of the Learning Collaborative	At least 5 ARC cases enrolled; Intake, Monthly, Periodic, and Discharge Assessment Measures completed **Team** has enrolled at least 2-3 children of military families	At least 2 ARC cases enrolled; Ensure the completion of Intake, Monthly, Periodic, and Discharge Assessment Measures	Conduct trauma/referral training with at least 2 early childhood providers

Instructions for Organizational Storyboard Assignment

Purpose of the Storyboard Assignment

The storyboard is used to help each site form a cohesive team and to help the team begin thinking about how their collaborative will work toward identifying young children who need ARC and implementing ARC with them. In this Learning Collaborative, it is important to start thinking about young children (ages 0-6) and their caregivers as clients. The storyboard

assignment is an important component of the Learning Collaborative process and should be completed by all team members together. The storyboard will be shared at Learning Session I (January 26-27) to introduce your team to the Faculty and other Learning Collaborative participants. You will have approximately **5-7 minutes** to present your storyboard to the other teams and faculty. In order to reserve as much time for your presentation it is suggested that you choose 1 person from your team who will present the storyboard, rather than planning to have your whole team participate in the presentation.

Preparing a Storyboard

Each Learning Session is designed to create an environment conducive to sharing and learning. At each Learning Session we will be asking you to share information about the work you have done, and the improvements you have made to help your community identify young children and their caregivers who would benefit from ARC and begin implementing ARC. One way that we plan to do this in Learning Session 1 is by having each team design a storyboard (or video). A storyboard is a way for you to provide information about your team through a graphic depiction to the others in the Collaborative, including faculty and other teams and to introduce your community and its youngest members. It may be created from a collection of letter-sized sheets or one large poster or be some other means of introducing your team (You will need to transport it with you to the Learning Session, so keep it manageable!) You may use photographs, pictures, or other graphic representations to illustrate your organization. Use of electronic media (laptop/ipad pictures, videos to project) is acceptable, but be sure to make them concise and brief. Your audience will be the other participating teams and faculty who are not familiar with your site, your team, or the priorities of your team. Therefore, your storyboard should be as clear and concise as possible.

Recommended Storyboard Outline

- Provide a brief description of your site with the site's name shown prominently
- List your team name, all team members, and their titles
- Include your team priorities for identifying clients who may benefit from ARC and for beginning the implementation of the model
- Help us know your team and their strengths! Be creative!
- Introduce us to your community, culture, region — we want to know the context in

which your team is working together to identify children in need of ARC. Since this Learning Collaborative is focused on working with young children (ages 0-6) and their caregivers, and a special emphasis is placed on serving children of military families, be sure to include information about early childhood services and any connections your agency may have to the military (National Guard, active military, veterans) families in your community.

Family Partner Description

What is a Family Partner?

The family partner role is a parent who represents the family or "consumer" voice on the ARC Learning Collaborative faculty. The family partner is a consultant to the teams about inclusion of family input in the implementation of ARC. As the team makes changes to implement ARC, particularly in training community early childhood staff on the availability of the model, the family partner can be a resource for locating local early childhood caregiver groups and can serve as a sounding board about how implementation of ARC looks from a family's perspective.

Doriana Vicedomini serves as the family partner for the ARC Learning Collaborative. She brings to the Learning Collaborative her own experience as a parent and many years' experience as a family advocate in Connecticut. For consultation on issues related to the inclusion of the family's perspective in your ARC implementation process, you may contact Doriana Vicedomini at Dmv35@aol.com.

Section B: Establishing a Baseline, Setting the Stage for the Year Ahead

I. Collaborative Change Framework

All teams are asked to complete the Collaborative Goals Framework and submit to the Project Coordinator by December 16, 2016.

Here are some suggestions for facilitating:

- The Collaborative Change Framework should be completed by all team members together, based on the team's consensus.
- The items in the Collaborative Change Framework are intended to serve as a guideline for suggested **end goals** for each team. Completion of this component will require each team to think through how you will accomplish the goals. Use the questions as an opportunity to discuss with your team your readiness for change to begin screening, assessing, and implementing ARC (as individual team members and as a collaborative with local early childhood provider agencies). **The PROCESS of thinking together about the questions is most important**. It is expected that at baseline, your team is not yet doing most

of the activities listed.

- Identify and discuss challenges, which relate to Expectations of Provision of Clinical Services and how they will impact the Collaborative Changes.

II. Data-Driven Decision Making

Using data for implementation and quality improvement is fundamental to the Learning Collaborative approach to dissemination. In the LC, data includes measures and metrics. Measures are used to assess and track client progress in treatment. Metrics are used to assess and track implementation progress by ARC providers involved in the Learning Collaborative. Both Measures and Metrics are used to provide YOU with continuous feedback that will assist you in improving your knowledge and use of screening, assessment and treatment with the ARC model. Clinicians will be responsible for gathering the metric information monthly including data about supervision time, referrals, screens, and the total number of ARC cases within your agency. They will submit it by the fifth of the following month using the EBP Tracker database.

ARC providers will continue using EBP Tracker to enter data of their ARC cases including the face sheet, assessments and monthly session information. Technical assistance will be provided as needed by CHDI.

The following **Measures** will be used with each ARC client:

Measure	What is Measured	Reporter	Frequency		
			Intake	Periodic	Discharge
Trauma History Screen (THS)	Trauma exposure and frequency	Child & Caregiver (ages 7+)	X		
ARC Fidelity Measure	Tracks clinician use of ARC model components	Clinician		monthly	
Young Child PTSD Checklist (YCPC) Items #1-13	Trauma exposure, frequency, and associated stress	Caregiver (ages 3-6)	X	Every 3 months	X
Child PTSD Symptom Scale (CPSS)	Traumatic stress symptoms associated with trauma exposure	Child & Caregiver (ages 3-6)	X	Every 3 months	X
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Measure of caregiver depression	Caregiver	X	Every 3 months	X
Parenting Stress Scale	Measures caregiver capacity	Caregiver	X	Every 3 months	X
PTSD Checklist for DSM-5 (PCL-5)	Measures PTSD symptoms in caregiver	Caregiver	X	Every 3 months	X

Attachment, Regulation, and Competency (ARC) Framework

Learning Collaborative Change Framework

INTRODUCTION

The Attachment, Regulation, and Competency (ARC) Framework Learning Collaborative is part of the Early Childhood Trauma Collaborative (ECTC) initiative funded by SAMHSA as part of the National Child Traumatic Stress Network (NCTSN). The Child Health and Development Institute (CHDI) is the coordinator for the grant, in partnership with Connecticut's Office of Early Childhood (OEC) and Department of Children and Families (DCF), the Consultation Center at Yale University, and family partners. The ARC Framework Learning Collaborative builds on Connecticut's history of developing trauma-informed systems of care for children, which has included the expansion of trauma-informed practice in DCF and the dissemination of trauma-specific evidence based treatments (EBTs) for children in Outpatient Psychiatric Clinics for Children.

Despite substantial progress that has been made in the development and dissemination of evidence-based treatments (EBTs) for posttraumatic reactions in children and adolescents in Connecticut, interventions for addressing trauma exposure in young children (ages 3-6) remain limited. The National Center for Child Traumatic Stress (NCTSN) Learning Collaborative Model was developed to address the challenge of making EBTs widely available to the children and families who need them. Learning Collaboratives integrate best practices in training and consultation with methods from implementation and improvements science designed to help community agencies rapidly implement and sustain evidence-based psychotherapies. This document, the Collaborative Change Framework (CCF), governs and guides a Learning Collaborative, specifying the overall goals of the collaborative and describing what organizations must do to implement the selected intervention in an effective and sustainable manner.

COLLABORATIVE MISSION

The Attachment, Regulation and Competency (ARC) Framework is a flexible, components-based intervention designed specifically for children and adolescents (ages 0-21) impacted by complex trauma and their caregiving systems.

The mission of the ARC Framework Learning Collaborative is to use the NCTSN Learning Collaborative Model to foster the *rapid*, *broad* and *sustained* implementation of ARC delivered with *fidelity* in participating organizations.

COLLABORATIVE GOALS:

The Learning Collaborative has three overarching goals integral to achieving the collaborative mission. Participating organizations are expected to make substantial progress toward each of these goals over the course of the collaborative.

Learning Collaborative Goals:

- Build providers' capacity to implement ARC with fidelity for youth through application of the LC methodology and the creation of a sustainable learning community;

  Objective 1: ARC Clinicians will provide ARC to at least 5 children and their caregivers by the end of the Learning Collaborative

  Objective 2: ARC Supervisors will provide ARC to at least 2 children and their caregivers by the end of the Learning Collaborative

  Objective 3: ARC teams will provide ARC to at least 2-3 children of military families (National Guard, Active Military, Veteran)

- Improve the well-being of children and caregivers who receive ARC
    - Objective 1: At least 80% of children completing ARC demonstrate significant reduction in PTSD or other trauma-related symptoms
    - Objective 2: At least 80% of caregivers completing ARC demonstrate significant reduction in PTSD or other trauma-related symptoms
- Develop collaborative and cooperative relationships between outpatient providers, clinicians, caregivers, and other early childhood community systems to assure effective referral, assessment, and treatment of young children;

  Objective 1: Senior Leaders (or their designee) will provide training on trauma and referral of young children for trauma assessments to at least 2 local early childhood agencies by the end of the Learning Collaborative
- Build providers' capacity to utilize data and implement evidence-based practices through application of a LC methodology and the creation of a sustainable learning community; and
- Build provider opportunities for obtaining family/caregiver input on the ARC practices and procedures.

Change Objectives for Achieving the Collaborative Goals

Clinical competence in delivering ARC is a critical component of effective adoption. However, organizational support and capacity and family engagement also are essential. To successfully adopt an evidence-based treatment, an organization must have the infrastructure in place to appropriately implement the practice (e.g., identify and screen referrals, provide supervision, collect and use data) and have addressed implementation barriers in the organizational culture. Additionally, implementation of ARC with young children requires an understanding of the effects of trauma on early childhood development and family systems and a commitment to family engagement.

To support progress toward the 6 goals Learning Collaborative goals participating organizations are expected to affect improvements in three domains (a) *clinical competence in delivering ARC* (b) *effective family and youth engagement* and (c) *ongoing organizational commitment, support, and capacity for implementation of ARC*. The tables below specify objectives in each of these domains. Formulated by individuals in a range of roles integral to successful adoption of ARC, including clinicians, supervisors, agency administrators, and consumers, these objectives are designed to serve as a roadmap for achieving the collaborative goals. As such they will guide the organizational and practice changes collaborative participants test to make progress toward those goals.

DOMAIN A – CLINICAL COMPETENCE	
Objective	**Progress toward Objective**
a.1 Relevant staff are trained to screen youth for ARC using a standard protocol that assesses a range of trauma exposures and posttraumatic reactions	1 2 3 4 5
a.2 Clinicians achieve and maintain the skill to administer, score, and use standardized assessments to guide ARC treatment	1 2 3 4 5
a.3 Clinicians receive formal training in ARC (i.e., two day in-person training or equivalent) prior to delivering the treatment	1 2 3 4 5
a.4 Clinicians receive at least two hours per month of ARC supervision through their agency until they are able demonstrate a high degree of skill and fidelity in delivering the practice	1 2 3 4 5
a.5 Clinicians document ARC components used in each ARC session, using the monthly fidelity report form	1 2 3 4 5
a.6 Clinicians skill and fidelity are regularly assessed through supervisor rating, monthly fidelity report form, and/or other systematic procedures determined by the agency	1 2 3 4 5
a.7 Clinicians enter data for all ARC clients into EBP Tracker database and use data to inform their development of ARC skills and their work with clients	1 2 3 4 5

DOMAIN B – FAMILY & YOUTH ENGAGEMENT	
Objective	**Related Goals**
b.1 Therapists/staff offer caregiver/child a rationale for any assessments administered and review findings with family	1 2 3 4 5
b.2 Therapists actively engage caregiver and child in treatment planning, including identification of specific needs, strengths, and resources	1 2 3 4 5
b.3 Supervision regularly addresses caregiver and child engagement in ARC, including strategies for addressing issues related to attendance and caregiver involvement	1 2 3 4 5
b.4 Supervision regularly addresses how to flexibly sequence and adapt treatment model based on the history, culture, and developmental capacities of the caregiver and youth being served	1 2 3 4 5

DOMAIN C – ORGANIZATIONAL SUPPORT AND CAPACITY	
Objective	**Related Goals**
c.1 Organization/leadership educates staff at all levels about the nature and benefits of ARC and discusses how implementing the practice could affect employees' work/responsibilities	1 2 3 4 5
c.2 Organization/leadership provides resources necessary to systematically screen youth for ARC using a standard protocol and use standardized assessments to inform treatment and monitor client outcomes	1 2 3 4 5
c.3 Organization/leadership has developed procedures and allocated resources for sustaining and spreading ARC including mechanisms for training additional staff to deliver and supervise the practice (e.g., to address staff turnover)	1 2 3 4 5
c.4 Organization/leadership provides access to ARC training and resources necessary to support the acquisition of skill in the practice (e.g., release time for training, modified productivity requirements)	1 2 3 4 5
c.5 Organization/leadership has instituted consistent supervision/consultation that addresses ARC implementation, skills, and fidelity	1 2 3 4 5
c.6 Organization/leadership has established guidelines/procedures for monitoring the skill, fidelity and flexibility with which ARC is being delivered and allocated resources necessary to implement and maintain monitoring procedures	1 2 3 4 5
c.7 Organization/leadership actively addresses reimbursement and cost factors related to implementing ARC (e.g., assessment costs, session duration)	1 2 3 4 5
c.8 Organization/leadership uses data to monitor implementation of ARC and to "make the case" for sustaining and spreading the practice	1 2 3 4 5

DOMAIN D – COLLABORATION WITH EARLY CHILDHOOD PROVIDERS	
Objective	**Related Goals**
d.1 Organization/leadership actively educates referral sources, funders, and other key stakeholders about the nature and benefits of ARC, including the effectiveness of the practice	1 2 3 4 5
d.2 Organization/leadership educates local early childhood staff about trauma and young children and how to refer children for a trauma assessment	1 2 3 4 5
d.3 Organization/leadership conducts a trauma forum with their community's early childhood collaborative to share information about trauma and young children and intervention services available for young children in their community	1 2 3 4 5

Child Health and Development Institute
Training and Consultation
Attendance Policy

CHDI has established an attendance policy for participants at all sponsored training activities. This attendance policy is intended to reflect the importance of completing all training requirements and applies to trainings, learning sessions, conferences, consultation calls, and other related meetings.

This policy also meets the criteria for the granting of CEUs by the CT Chapter of the National Association of Social Workers (NASW).

1. Participants at live trainings must personally sign themselves in and sign out at the beginning and end of each training day. Participants may not have someone else sign them in or out.
2. Each participant must complete a registration sheet with the time they enter and the time they leave. No information can be modified or added after the training days.
3. Participants that do not attend the entire training day, or who fail to sign in or out, will be ineligible for CEUs.
4. Completion of a training day is defined as completing registration sign in/sign out within an hour of the beginning or end of the training day.
5. Attendance at the clinical training for a total of 6 days is a requirement of the ARC Learning Collaborative. CEUs will only be granted for completion of all days.
6. CEUs are awarded at the end of the Learning Collaborative sessions or multi-day clinical training only for participants who complete the entire training. No partial CEUs will be granted.