

BRAIN INJURY AND CHILD WELFARE BEST PRACTICE GUIDE: INFORMATION AND TOOLS FOR STATE AGENCIES

Prepared by the
Administration for Community Living TBI State Partnership Grant
Ad Hoc Workgroup on Child Welfare

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Table of Contents

Introduction to This Guide.....	1
Overview of Brain Injury as A Risk Factor.....	2
Overview of The Child Welfare System	4
Loss of Parental Rights & Financial Considerations.....	5
Child Welfare System Engagement Model: Possible Entry Points.....	6
Components of a Brain Injury Screening and Identification Approach	8
Considerations for Screening	8
Resources for Screening for Lifetime History of Brain Injury.....	10
Screening for Evidence of Cognitive Impairment.....	10
Neuropsychological Screening Tests for Mental Health Clinicians	11
Resource Facilitation.....	12
Support and Referral Protocol.....	12
Modifying Programming/Accommodating For Impairment.....	13
School-Specific Resources.....	14
Training and Education for Child Welfare Personnel and People Served.....	15
Training Resources.....	16
Brain Injury Education.....	18
Data Collection and Outcomes Evaluation.....	22
Consent/Releases of Information.....	23
Dissemination Strategies.....	24
Sustainability and Funding Strategies.....	25
Setting the Stage for Success.....	25
Key Takeaways.....	27
References.....	28

Introduction to This Guide

In the fall of 2020 the Iowa Department of Public Health, Iowa's lead state agency for the Administration for Community Living's State Partnership Program (ACL-SPP), asked the Technical Assistance Resource Center (TARC) to conduct a literature review and reach out to ACL grantees to find out the extent to which the intersection of traumatic brain injury (TBI) among adults involved in the child welfare system is being addressed. The request came after a child advocate, in Iowa, told us "You need to screen adults with child abuse or neglect allegations for a brain injury because many of the parents/caretakers have a brain injury."

The results revealed no ACL Grantee states were specifically addressing this intersection. Some states, (e.g., Tennessee) are providing training to case managers, direct support personnel, foster parents, and other stakeholders to increase their awareness of brain injury but were not using this awareness to intervene in child welfare cases to modify case permanency plans to provide accommodations and/or compensatory strategies to improve the likelihood that parents/caregivers will be able to retain custody/guardianship of their children.

A group of states expressed interest in forming an ongoing workgroup to address this issue. Iowa and Tennessee agreed to serve as co-facilitators for this work group. Initial states included: Iowa, Tennessee, Colorado, Connecticut, Pennsylvania and Alabama.

The workgroup has been recognized by ACL as an ad-hoc workgroup and will be working over the 2021-2026 grant cycle to develop products in support of this intersection. The workgroup products are designed to provide information and resources to state agencies working with families, in the child welfare system, to identify undiagnosed brain injuries ensuring case permanency plans are person centered and include accommodations/compensatory strategies that will give families the best opportunity to stay together.

This guide has been modeled after the [Criminal and Juvenile Justice Best Practice Guide](#) by Judy Dettmer. Organization and wording have been used with permission to ensure consistency between documents.

The term *state brain injury program* is referenced throughout this manual. This term refers to the state agency designated as the lead state agency on brain injury via the state's governor or the agency that the lead agency designates to implement this work. State brain injury agencies are the target audience of this guide.

Acquired brain injury is an umbrella term that encompasses both traumatic and non-traumatic brain injuries. Each state determines the criteria of what defines brain injury related to the services and supports available within the given state. For the purposes of this guide, unless citations are included, *brain injury* is used.

An acquired brain injury is an injury to the brain that is not hereditary, congenital, degenerative, or induced by birth trauma. The injury results in a change in the neuronal activity, which affects the physical integrity, the metabolic activity, or the functional ability of the nerve cells in the brain. The definition of an acquired brain injury can be considered the umbrella definition as it

includes not only injuries caused by the trauma of external physical force applied to the head or neck, but also internal insults to the brain.¹

A traumatic brain injury (TBI) is defined as “a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head, or penetrating head injury”.² It is important to recognize the difference between a TBI and a non-traumatic brain injury, which both fall under the umbrella term “acquired brain injury.” A non-traumatic brain injury is damage to the brain caused by a disruption of internal factors, for example, lack of oxygen, exposure to toxins, an infectious disease, or the presence of a tumor.³

In 2014, more than 812,000 children and 1.7 million adults were treated for a TBI.⁴ However, 25-42% of individuals that meet the criteria for TBI are likely to go undiagnosed.^{5 6} This may be caused by a reluctance to self-report, minimization of the severity of the head injury, or because cognitive and behavioral symptoms caused by TBIs may not appear immediately.⁷ The table below shows TBI Classification of Injury Severity.⁸

Brain injury is a chronic condition. It is often a multi-occurring condition with mental health, substance abuse, unemployment, corrections involvement, homelessness, and may be a factor in child welfare cases.

Mild	Moderate	Severe	
*Normal structural imaging	*Normal or abnormal structural imaging	*Normal or abnormal structural imaging	LOC = loss of consciousness AOC = alteration of consciousness PTA = posttraumatic amnesia GCS = Glasgow Coma Scale (score)
LOC = 0-30 min	LOC > 30 min and <24 hr	LOC > 24 hr	
AOC = from a moment up to 24 hr	AOC > 24 hr severity based on other criteria		
PTA = 0-1 day	PTA > 1 and <7 days	PTA > 7 days	
GCS = 13-15	GCS = 9-12	GCS = 3-8	

Kolakowsky-Hayner S, Reyst H, M A, editors. The Essential Brain Injury Guide. 5th ed. Vienna, VA: Brain Injury Association of America; 2016.

¹Kolakowsky-Hayner et al., 2016

² CDC, 2021

³ Brain Injury Association of America

⁴ CDC, 2014

⁵ Setnik & Bazarian, 2007; Sosin et al., 1996

⁶ Sosin et al., 1996

⁷ Buck, 2011

⁸ Kolakowsky-Hayner et al., 2016

Overview of Brain Injury as a Risk Factor

A barrier to accurate brain injury prevalence data is that they are often misdiagnosed in a variety of patients. This is especially common for those with mental health diagnoses because of the similarities in how symptoms may present.⁹ Human service professionals are often unaware individuals entrusted in caring for children may have a lifetime history of brain injury and treatment success or lack thereof may depend on this awareness. When brain injuries are undiagnosed or misdiagnosed, it is challenging for those in the child welfare system to have appropriate insight into the prevalence of this issue which can lead to a general misunderstanding of brain injuries and their long-term symptoms.

Because brain injuries often go undiagnosed, it is reasonable to expect there are parents/caregivers who have experienced one or more brain injuries in their lifetime that are suspected to have committed child abuse or neglect of children in their care. Without screening for possible brain injuries, it is not feasible to provide comprehensive support to families involved in the child welfare system. Recognizing the symptoms of brain injury will enable child welfare professionals to provide appropriate support for children and parents/caregivers with a brain injury. Brain injuries are often accompanied by long-term cognitive, emotional, and behavioral difficulties.¹⁰ Some of these difficulties include impulsivity, aggression, emotional reactivity, language deficits, impaired attention, processing speed (slowed thinking, responding and/or understanding information), and memory loss.¹¹ These difficulties can have a substantial impact on children and parents/caregivers involved in the child welfare system.

Parents/caregivers who have experienced a brain injury may also have impairments, which may affect the ways they interact with and care for their children. Impulsivity can present as an inability to control their negative emotions or influence their patterns of misusing substances.¹² Changes in processing speed may impair a parent/caregiver's ability to understand the information provided by courts and the child welfare system. Increased memory loss can cause parents/caregivers to forget court dates, lose track of time, or arrive late to meetings, along with having difficulty remembering information from these court dates or meetings. Long-term symptoms of brain injury may negatively affect a parent/caregiver's ability to follow directions and succeed within the child welfare system. These executive functioning challenges may also impact a parent/caregiver's ability to prioritize and organize to meet their children's basic needs. This can ultimately lead to legal substantiations of neglect. When we understand the reasons behind the actions of these parents/caregivers, better accommodations can be provided to

⁹ Iverson, 2006

¹⁰ Finnanger, et al., 2015

¹¹ Rabinowitz & Levin, 2014

¹² Wood & Thomas, 2013

improve outcomes for children and families. Brain injuries have profound effects on individuals and their actions, but they are often overlooked in a child welfare setting.

In children, brain injuries increase the risk of impaired executive functioning and cognitive ability, decreased self-esteem, and increased peer victimization.^{13 14 15} These factors can potentially affect how children respond to new environments.¹⁶ For example, children removed from their homes may appear defiant or unable to form healthy attachments, and the presence of an unknown brain injury may help explain and/or exacerbate these common symptoms. Along with difficulties in adjusting to environments, brain injury can have long-lasting cognitive effects. These impacts might be noticed in the child's academic performance or in symptoms that imitate those of a mental health concern. The full impact of a brain injury occurring in childhood may not be known until young adulthood,¹⁷ and may be a risk factor for involvement in the justice system.¹⁸ Early identification and interventions for brain injury can help decrease the likelihood of these long-term effects.^{19 20}

Overview of the Child Welfare System

The child welfare system is not a single entity. The systems are complex with procedures varying widely by state. The child welfare system is composed of a group of services designed to promote the well-being of children by ensuring safety, achieving permanency, and strengthening families. Public agencies, such as departments of social services or child and family services, often contract and collaborate with private child welfare agencies and community-based organizations to provide services to families such as in-home family services, foster care, residential treatment, mental health care, substance use treatment, parenting skills classes, domestic violence/intimate partner services, employment assistance, and financial or housing assistance. While the primary responsibility for child welfare systems rests with the states, the federal government supports states through program funding and legislative initiatives.

The Children's Bureau within the U.S. Department of Health and Human Services' Administration for Children and Families holds the primary responsibility for implementing federal child and family legislation. The Children's Bureau works with state and local agencies to develop programs that focus on preventing child abuse and neglect by strengthening families, protecting children from further maltreatment, reuniting children safely with their families, and finding permanent families for children who cannot safely return home.

Most families first become involved with the child welfare system when reports of suspected

¹³ Levin & Hanten, 2005

¹⁴ Hawley, 2012

¹⁵ Hung et al., 2017

¹⁶ Gagner et al., 2018

¹⁷ McKinlay, et.al 2009

¹⁸ McKinlay, et.al 2014

¹⁹ Ponsford et al., 2001

²⁰ Middleton, 2001

child abuse or neglect by a parent or primary caregiver are received by child protective services. Child maltreatment can include abuse and/or neglect in various forms defined by individual state statute. Reports and/or incidents involving child maltreatment by a stranger or acquaintance not responsible for providing care or custody of the child are generally the responsibility of law enforcement.

Each state has its own laws that define abuse and neglect, the reporting obligations of individuals, and the required state and local child protective services (CPS) agency interventions.

Child welfare systems typically take the following actions:

- **Assess and screen reports** - Child welfare receives and evaluates reports to determine response for further action.
- **Investigate reports** - Investigate reports of possible child abuse or neglect.
- **Support families** - Provide prevention services to families that need assistance protecting and caring for their children to prevent entry into foster care.
- **Provide temporary safe shelter** - Arrange for children to live with kin, fictive kin, or foster families when they are not safe at home.
- **Seek to return children to their families when safety has improved, or find other permanent arrangements** - Arrange for reunification, adoption, or other permanent family connections for children leaving foster care.

Loss of Parental Rights & Financial Considerations

In 2019, parental rights were terminated 71,335 times in the United States.²¹ While there are circumstances that require the removal of children for their safety and well-being, it is necessary to recognize that this can still be an emotionally traumatic event for those children. A study that focused on the experience of children removed from their homes highlighted a sense of feeling apprehended as if they were at fault, fear, bewilderment, loss, abandonment, and feeling unsupported, misunderstood, and helpless.²² It is likely that fewer children would experience the trauma of being removed from their homes if appropriate interventions are implemented for parents/caregivers with brain injury. There are many social and emotional benefits of keeping families together, along with financial benefits. Every year, around \$124 billion dollars are spent on the treatment and care of children in the foster care system.²³ The direct cost for each child can range from \$150,000 to \$250,000 per year in placement services alone.²⁴ Ultimately, keeping families together can improve cognitive and emotional outcomes for children, while simultaneously decreasing state costs.

²¹ Children's Bureau et al., 2020

²² Folman, 1998

²³ CDC, 2012

²⁴ Nielsen et al., 2019

This guide provides the following:

- Overview of the child welfare system.
- Overview of how brain injury in parents/caregivers and children is a unique risk factor for involvement in the child welfare system.
- Loss of parental rights and financial considerations.
- Possible entry points to engage brain injury screening, training/case consultations and referral to resource facilitation.
- Components of best practice in brain injury screening and identification.
- Resource facilitation support and referral protocol.
- Suggestions for modifying programming/accommodating for impairment.
- Training and education for child welfare personnel and people served.
- Considerations for data collection and evaluating outcomes.
- Sustainability and funding strategies, and identifying strategic partnerships.

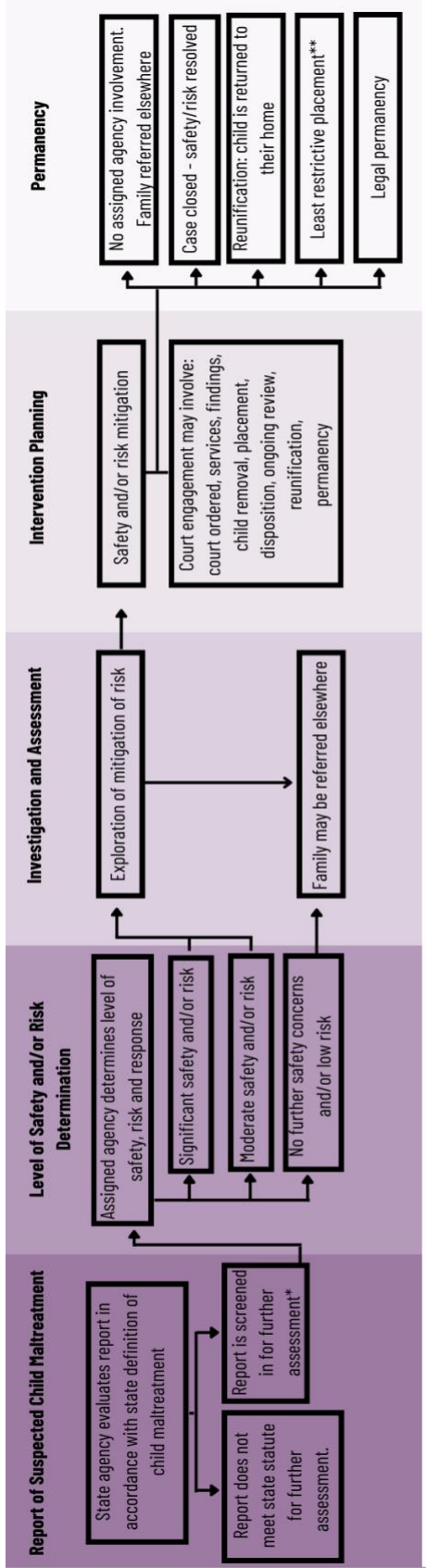
This guide is intended to not only provide information but to be a practical tool for states that are considering working with the child welfare system. This guide references the following tools which can be found in the [Brain Injury and Child Welfare Best Practice Supporting Materials](#):

- An executive summary on the Brain Injury and Child Welfare Best Practice Guide.
- An infographic template summarizing the need for screening.
- Evidence-based screening tools.
- Signs and symptoms handouts.
- Concussion/brain injury guides.
- School-specific resources.
- Fact sheets and tools.
- Example of legislation for screening.
- Videos.
- Sample trainings.
- Supports for when the parent has a brain injury.
- Social media supports.
- Referral options.
- Sample memorandum of understanding.
- Literature review.

The Child Welfare System Engagement Model: Possible Entry Points

The Child Welfare System Engagement Model inspired by the [Sequential Intercept Model](#)²⁵, illustrated in the diagram below, provides states the opportunity to evaluate entry points to engage brain injury screening, brain injury related training, technical assistance or referrals to brain injury services programs or resource facilitation services.

²⁵ Griffin, P. A., Munetz, M., Bonfine, N., & Kemp, K. (2015)



State agency evaluates reports of suspected child maltreatment to determine if additional assessment is required. *States must engage in the Indian Child Welfare Act (ICWA) federal requirements for individuals with Native American heritage.

The assigned agency completes an assessment to evaluate safety and/or risk factors.


The assigned agency explores mitigation risk efforts for safety and/or risk. Families that do not present additional safety and/or risk concerns may be referred elsewhere.

Safety and/or risk mitigation efforts are recommended by the agency that may include voluntary or involuntary services, possible removal of child(ren) from the family home. Court engagement when necessary will determine next steps with the goal of reunification of the family. These steps may include engagement with community based organizations.

Goals in a child welfare system are to mitigate concerns related to safety and/or risk with child welfare have varying outcomes. Reunifying family units as a permanent solution is ideal, when this is not possible other permanent solutions are evaluated. **Permanency options may include seeking placement for children with kin, fictive kin, foster or adoptive homes.

Entry points to engage brain injury screening, brain injury related training/ case consultation/ technical assistance or referrals to Resource Facilitation Services.

Child Welfare System Engagement Model



Natural supports

- Birth families
- Educational services and supports
- Foster families
- Permanency resources

Community based organizations specializing in:

- Behavioral/ mental health
- Foster/ Adoptive parent organizations
- Human service agencies
- Intimate partner violence
- Parent skill development
- Primary health physician or other health care
- Substance use treatment

Judicial related services:

- Attorneys
- Court Appointed Special Advocate (CASA)
- Family/Specialty court programs
- Guardian Ad Litem (GAL)
- Law enforcement

Components of a Brain Injury Screening and Identification Approach

Considerations for Screening

To screen for a lifetime history of TBI, the Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID)²⁶ is one of the most widely used screening tools. This tool is a structured interview that asks a series of questions designed to help the participant to recall and report events that could have resulted in a brain injury throughout their lifetime.

Because of the prevalence of other non-traumatic causes of acquired brain injury, such as stroke, anoxia from unintentional overdose, brain tumor, and others, a number of researchers recommend adding an additional set of questions to this inquiry. The [modified OSU TBI-ID](#) is offered as an example of a screen that asks about events that could have caused either a traumatic or a non-traumatic brain injury and can be found in the [Brain Injury and Child Welfare Best Practice Supporting Materials](#). Some states have endorsed the use of a specific screening tool. Check with your state's lead agency: <https://www.nashia.org/state-program-directory>.

If screening confirms an event that could have resulted in a brain injury, there is an opportunity to present an additional questionnaire that elicits whether the person is experiencing symptoms that people with brain injury often experience, and if so, how frequently they experience them. The Adult Symptom Questionnaire and the Juvenile Symptom Questionnaire were developed by *MINDSOURCE* in Colorado, and also have an accompanying set of simple accommodations that can be recommended to address the symptoms brain injury survivors may experience in memory, concentration, delayed processing, and other challenges caused by TBI. These accommodations will likely improve the person's ability to effectively engage in the child welfare process. The Adult Symptom Questionnaire and the Juvenile Symptom Questionnaire are available in the [Brain Injury and Child Welfare Best Practice Supporting Materials](#).

Many states already have extensive intake forms which may make them reluctant to commit to adding a brain injury screening tool until they fully understand the pervasiveness of brain injury. As an interim step, before the agency adopts a more formal tool, it may be helpful for them to make slight modifications to their existing intake.

Recommend that they:

- Put a symbol, such as an asterisk (*) next to all items that **indicate a brain injury could have occurred**. Example items include: physical assault/abuse, domestic violence, anoxia from overdose, exposure to toxins, stroke, prior infections of the brain, and/or serious injury.

²⁶ Corrigan and Bogner, 2007

- Put a double asterisk (**) next to all items that **indicate possible after-effects of a brain injury**: learning disability, developmental delays, behavioral issues, mental health challenges, alcohol/drug misuse, court actions, etc.
- Place a key on the intake form explaining the symbols:
 - * Indicates an incident where a brain injury may have occurred.
 - ** Indicates possible after-effects of a brain injury.
- Add a note stating: Further brain injury screening, evaluation, education, treatment and/or accommodations may be necessary.

See the [Temporary Alternative Screening Approach document](#) in the Brain Injury and Child Welfare Best Practice Supporting Materials in the screening section for more information. Keep in mind that the preferred approach is to have the state child welfare system adopt a formal brain injury screening tool and symptom tool and to screen all children and caregivers.

Screening for brain injury in children and adults within the child welfare system is a critical step to create successful outcomes. Identifying the injury as soon as possible allows for intervention and lifelong monitoring to prevent undue stress and struggle, as well as to prevent the downstream consequences that are common following brain injury. In the case of a parent or older child who was injured years earlier, co-occurring problems must be screened for so that appropriate interventions and referrals can be recommended for those concerns, as well as, the brain injury. Common downstream problems include:

- Domestic violence.
- Homelessness/housing instability.
- Pain.
- Substance misuse.
- Mental health issues, including increased risk of suicide.
- Juvenile and criminal justice issues.

Generally, child welfare programs will assess a family's history and explore familial patterns. The Adverse Childhood Experiences (ACEs) screen may be utilized to identify physical and emotional trauma experienced by the child as well as the parent/caregiver during their own childhood. ACEs can negatively impact brain development and converge with health issues and the downstream problems listed above. A history of physical trauma may trigger a brain injury screening. Screening for ACEs and brain injury empowers child welfare professionals to create informed and meaningful family treatment plans from a client centered approach. Examples of [ACEs screening tools](#) can be found online.

Resources for Screening for Lifetime History of Brain Injury

The following resources can be found in the [Brain Injury and Child Welfare Best Practice Supporting Materials](#):

- HELPS Brain Injury Screening Tool
- Ohio State Traumatic Brain Injury Identification Method and explanatory document and training module: Ages 13 and above
- Ohio State Traumatic Brain Injury Identification Method - Modified by the Brain Injury Association of Pennsylvania
- Brain Check Survey Colorado State University: Ages 5 to 21
- SAFE CHild Screening Tool: Birth to 3 Years Old
- SAFE CHild Screening Tool: 3 Years Old to Kindergarten
- Brain Injury Screening Questionnaire (BISQ): School-aged through adult. There are costs for this tool.
- TBI Identification Flow Chart: For use in schools. Colorado Department of Education, page 78, “Brain Injury in Children and Youth, A Manual for Educators.”

Screening for Evidence of Cognitive Impairment

Neurocognitive screening is a way to understand, once a lifetime history of brain injury has been established, whether there are on-going cognitive impairments that could affect the individual’s functioning and play a role in child welfare involvement. Neurocognitive screenings are brief, objective, performance-based techniques that can give additional information about cognitive functioning, can suggest potential areas for accommodations/strategies, or can be the basis for referral for a full neuropsychological evaluation.

According to a 2014 Working Group on Screening and Assessment (WGSA), a collaboration of the American Psychological Association's Board of Professional Affairs and the Committee for the Advancement of Professional Practice of the American Psychological Association,²⁷ screening tests: (a) can be used for the early identification of individuals at potentially high risk for a specific condition or disorder; (b) can indicate a need for further evaluation or preliminary intervention; (c) are generally brief and narrow in scope; (d) may be administered as part of a routine clinical visit; (e) may be used to monitor treatment progress, outcome, or change in symptoms over time; (f) may be administered by clinicians, support staff with appropriate training, an electronic device (such as a computer), or self-administered; (g) can be used by support staff who follow an established protocol for scoring with a pre-established cut-off score and guidelines for individuals with positive scores; and (h) are neither definitively diagnostic nor a conclusive indication of a specific condition or disorder.²⁸

²⁷ American Psychological Association Services, Inc. (2014, December)

²⁸ Roebuck-Spencer, et al. 2017

Neurocognitive screening is a good approach to use when child welfare personnel need a more in-depth understanding of the cognitive impairments an individual is experiencing. Once these deficits are identified, targeted interventions can be applied. Additionally, appropriate screening can lead to eligibility of brain injury specific resources in some states. There are a variety of screening batteries that can be implemented. The qualifications required to implement neurocognitive screening vary depending on the battery/tools being administered. The Colorado Department of Education has developed a comprehensive [matrix based on the building blocks of brain development](#), which can be used as a guide to determine appropriate assessments for children/youth.

Neuropsychological Screening Tests for Mental Health Clinicians: An Intensive Short Course

NASHIA collaborated with Dr. Kim Gorgens at the University of Denver to develop an on-demand, on-line course designed to train community-based mental health providers how to conduct neuropsychological screening. This 3-hour, three-part course is designed for Masters-level professionals who are interested in learning about the use of neuropsychological screening batteries for clinical practice. This course is geared towards community providers, behavioral health workers, social workers, vocational rehabilitation counselors, community rehabilitation provider staff, addictions professionals, etc. To access information on this training please visit this link: [Neuropsychological Screening Course](#).

This **first module** will briefly review the incidence and physiology of acquired and traumatic brain injuries and the most common after-effects, including emotional and cognitive problems, and the related accommodations for each. Best practices for screening for reported brain injury history will be reviewed.

A **second module** covers the important differences between full neuropsychological assessment batteries and neuropsychological screening batteries, including their indications for use and the benefits of each. Participants will be exposed to neuropsychological screening batteries and a cognitive screening test. That includes a computerized neurocognitive test [CNT] called the Automated Neuropsychological Assessment Metric [ANAM], a paper and pencil test called the Neuropsychological Assessment Battery, and a readily available single-page screening tool called the Montreal Cognitive Assessment [MoCA]).

In the **third module**, interpretation and report writing will be addressed in the context of the Colorado TBI screening model which will be covered in detail. Research on the Colorado TBI Model will be reviewed. Example reports and client summaries will be available to participants.

Resource Facilitation

One of the main reasons to screen for history of and brain injury impairment is to guide targeted interventions to improve outcomes for children and parents/caregivers in the child welfare system. Resource facilitation (RF) is designed to help people with brain injury get to the right kind of brain injury services and supports. RF is a method of identifying brain injury needs, assisting people in applying for the services they need, and then ensuring they get started with these services. It has been shown to increase both community participation and employment among individuals with brain injuries.^{29 30} Additionally, research³¹ in an offender population shows preliminarily that identifying brain injury and connecting individuals to resources resulted in decreased recidivism and increased productive activity such as employment, education, volunteerism, etc.

Incorporating service coordination/RF supports into the protocol is ideal. Some states may not have a robust service coordination/RF system of services, but they may provide information and resource support which can be helpful as well. However, it is recognized that not every state has one or either of these models of RF. When that is the case, it will be important for state brain injury programs to work with the child welfare system to ensure that parents/caregivers and children with brain injury have the compensatory strategies they need for home, work and/or school.

It would be ideal for child welfare systems to designate personnel to become their internal RF experts. They would learn what brain injury referrals and supports are available in the community and would be in a position to ensure that families connect with those resources. Training child welfare staff in RF avoids overwhelming often already over-taxed state RF systems.

States should also determine if there are existing infrastructures that they could train so they can support brain injury, for example, schools, mental health and substance misuse providers and Vocational Rehabilitation.

When community-based service coordination/RF services are available, it is important to ensure the providers of these services are trained on the unique nature of working with children and parents with brain injury in the child welfare system. This training can include but is not limited to, understanding how the child welfare system works. It is best to engage the child welfare personnel to provide this training.

NASHIA's [criminal and juvenile justice resource library](#) contains articles regarding the return on investment of resource facilitation.

²⁹ Trexler, Parrott, & Malec, 2016;

³⁰ Trexler, Trexler, Malec, Klyce & Parrott, 2010

³¹ Nagele, Vaccaro, Schmidt & Keating, 2018

Support and Referral Protocol

A child welfare agency could develop a support and referral protocol that staff can follow in order to take the appropriate actions once a person is identified as having a brain injury. A referral to a state affiliate of either the [Brain Injury Association of America](#) or the [United States Brain Injury Alliance](#) should be made for resource facilitation, to ensure these individuals with brain injury are receiving appropriate and specific brain injury services and supports. States without an Association or Alliance affiliate may have a network or foundation in place. This may result in more specific referrals for brain injury rehabilitation services, or connection with educational/vocational brain injury supports. Identification followed by intervention is necessary to better support families involved in the child welfare system.

Modifying Programming/Accommodating for Impairment

It is important to ensure the modifications/accommodations being recommended are feasible within the child or parent/caregiver's setting (home, school, work). It is also important to keep it contextually relevant and easy to employ. It is important to train child welfare personnel how to adapt their expectations for parents and children with brain injury, identify and implement compensatory strategies for them, and in addition, how to work with their clients to teach them how to successfully utilize the strategies.

The following tools from the [Brain Injury and Child Welfare Best Practice Supporting Materials](#) can be used to develop modifications/accommodations:

- Model Systems Knowledge Translation Center has [videos and fact sheets](#) that could be useful.
- The Ohio Valley Center for Brain Injury Prevention and Rehabilitation, with contributions from the MN Department of Human Services, developed a booklet called, "[Accommodating for the Symptoms of Brain Injury](#)". Ohio Brain Injury Program has also developed an [accompanying training](#) that can be accessed online.
- The Rehabilitation Hospital of Indiana has developed an extensive [catalog of fact sheets](#) that can be useful to share with child welfare personnel.
- [Brainstorming Solutions Tool](#) - For direct service/support providers, like rehabilitation therapists, case managers and in-home support providers to capture cognitive, behavioral, psychosocial and other information about the person served (best used with the Strategies and Accommodations Tool below). Brain Links, TN
- [Strategies and Accommodations Tool](#) - Links difficulty identified by the Brainstorming Solutions Tool (above) with potentially helpful strategies. Brain Links, TN

School-Specific Resources

CDC

- [Returning to School After a Concussion](#) - Form for including important information from healthcare provider to the school.
- [A Fact Sheet for School Nurses](#)
- [Heads Up to Schools Know Your Concussion ABCs Returning to School After a Concussion: A Fact Sheet for School Professionals](#)
- [Heads Up to Youth Sports](#) - To those involved in youth sports to help ensure their health and safety.

CBIRT, University of Oregon

- [504/IEP Accommodations and Modifications in the Classroom for a Student with Traumatic Brain Injury](#)
- [Sample IEP Goals](#)
- [Accommodations & Modifications in the Classroom for a Student with a Traumatic Brain Injury](#) - Use this to help develop a personalized accommodation and modification plan for a student with a traumatic brain injury.

Brain Links, TN

- [Symptom Tracker](#) - Use to track symptoms to help in communication and planning with healthcare providers and teachers.
- [Hospital to School Transition Protocol](#)
- [School Lingo](#) - For parents and rehabilitation professionals to better understand special education terminology used in the schools.
- [Traumatic Brain Injury Supporting Materials for School Nurses](#) - Tools for School Nurses for use in office, to send home, reference, and to share with teachers and related service providers.

Colorado Department of Education

- [Brain Injury in Children and Youth: A Manual for Educators](#) - Information on neuroanatomy, developmental stages, assessing functional behavior, learning implications and intervention strategies as they relate to youth with a brain injury.
- [Building Blocks of Brain Development](#) - Explains typical impacts of brain injury, a wide range of suggested assessment tools, and intervention strategies for students with acquired brain injury.
- [Get Schooled On Concussions Symptom Wheel](#) - Helps match symptoms with possible accommodations.

MINDSOURCE – Brain Injury Network has developed a self-report symptoms questionnaire which is implemented when a person screens positive for brain injury. This tool is completed by the individual and then the child welfare personnel inputs the person’s answers into an on-line portal. Adult link: <https://mindsourcencolorado.org/adult-symptom-questionnaire/> Children’s Link: <https://mindsourcencolorado.org/juvenile-symptom-questionnaire/>. Once done, the child welfare personnel receive a set of [customized tip sheets with strategies](#) which they can share with the individual. It is important to note that this tool was developed based on literature but has not yet been validated.

Training and Education for Child Welfare Personnel and People Served

Training is an integral component of comprehensively implementing brain injury screening, support, and referral protocols. Training and education on brain injury within the child welfare system could be a stand-alone intervention that could serve to support individuals with brain injury, but it is best included as part of the overall protocol.

Most child welfare personnel have had little to no training on brain injury. Ideally, training should be conducted as the first part of the protocol. It will be most effective if this training is embedded within existing training infrastructures such as new employee orientation and the in-service training process.

Anyone working within the child welfare system should be trained on the basics of brain injury including: administrators, case managers, intake/assessment staff, direct support staff, nurses (and any other medical staff), behavior and mental health teams. Juvenile justice personnel should also be trained if they are a part of the state’s child welfare department. See also NASHIA’s [Criminal and Juvenile Justice Best Practice Guide: Information and Tools for State Brain Injury Programs](#) for information on training and support within that system. Not everyone will need in-depth training. For that reason, state brain injury programs should consider a tiered approach to training. The following are suggested levels of training. Each level builds on the last:

Level 1: All child welfare personnel.

Goal of the training: gain a basic understanding of brain injury, how it affects a parent/caregiver or child with a brain injury, and learn basic strategies for supporting an individual with brain injury.

- Definition of brain injury.
- Mechanisms of brain injury.
- Prevalence of brain injury.
- What brain injury looks like.
- Brain injury and behavior (unable vs unwilling).
- Simple compensatory strategies.

Level 2: Those involved with implementing the protocol.

- Overview of each component of the protocol (screening, support, referral).
- Overview and practice with the screening tool being used.
- Case studies and practice identifying compensatory strategies.
- Introduction to psycho-educational curriculum (if applicable).
- Overview of community-based resources.
- Overview of referral protocol to community provider (e.g., community-based brain injury service coordination and/or specific providers).

Level 3: Train-the-trainer.

To help ensure sustainability, state brain injury programs might consider implementing a train-the-trainer approach. This involves teaching child welfare personnel to conduct the training elements of level 1 and 2 and to provide case consultation for their direct support providers, case managers and nurses.

After initial training, it will be important to follow up with sites/personnel who are implementing the protocol and provide consultation as they implement the protocol. Staff benefit from ongoing education and consultation to identify and understand needs, and to trial and tailor accommodations to fit a child's or parent/caregiver's unique needs. Ongoing training to provide a review of the protocol is helpful. Child welfare settings tend to have high staff turnover rates, and new staff will require training.

Below you will find resources that may be used as they are or used as examples to draw from to meet the individual needs of each state. Additional resources can be found at the National Association of State Head Injury Administrators website in the Brain Injury Child Welfare Best Practice Supporting Materials: <https://www.nashia.org/acl-child-welfare>.

Training Resources

Trainings

These may be used as is or used as examples to draw from to meet each state's unique needs.

- The National Association of State Head Injury Administrators (NASHIA) has tools available for state customization: <https://www.nashia.org/customized-state-tools>
- Brain Links' Trainings for Tennessee Department of Children's Services
 - [Concussion, TBI and Abusive Head Trauma: Supporting Children and Families](#)
 - [Supporting Children with Cognitive Changes and Their Families](#)
 - [Supporting Brain Health](#)
 - [What Foster Parents Need to Know about Concussion](#)
 - [Brain Links YouTube training channel playlist for TN DCS](#)
- [AlabamaTBI.org](#) - Certificates of completion available.
 - TBI: What is TBI?

- TBI: Impairments and Strategies
- TBI: Screening and Assessment
- Pediatric TBI
- Substance Abuse and TBI
- Cognitive and Behavioral Consequences of TBI
- The Justice System and TBI
- [What if there's a TBI?](#)
- [Brain Injury Association of America](#)
 - [Brain Injury Fundamentals Certified Brain Injury Specialist](#)
- BrainSTEPS Brain Injury School Consulting Program-Pennsylvania- trainings on brain injury & children/teens.
 - [BrainSTEPS Trainings](#)
- Center on Brain Injury Research and Training's (CBIRT) trainings Many excellent webinars on topics in brain injury.
 - [Recorded Webinars](#)
 - [Staff TBI Skill Builder training](#) -

- Colorado Department of Education
 - [The Building Blocks of Brain Development: Brain Based Strategies](#)
 - [Colorado Kids with Brain Injury Presentations](#)
 - Brain Injury 101
 - Brain Injury and Behavior
 - Juvenile Justice
 - Instructional Strategies for Elementary Students with Traumatic Brain Injury
 - Instructional Strategies for Secondary Students with Traumatic Brain Injury
 - Brain Injury and Executive Functioning
 - Intervention for Students with mTBI
 - Challenging Behavior and Executive Function
- [Ohio State University Wexner Medical Center training modules for professionals](#). Must register to begin modules. Topics:
 - Incidence and Prevalence
 - Neurobehavioral Impairments
 - Impact on Lives
 - Accommodating the Symptoms of Brain Injury

Videos

- [Videos on Memory, Depression and Relationships after TBI](#) - Model Systems Knowledge and Translation Center
- [Brain Links' Youtube Training Channel Playlist](#) - Trainings developed for the TN Department of Child Services.

Brain Injury Education

Education for Parents/Caregivers with Brain Injury

Knowledge is power and can be life-changing for a parent/caregiver who has a history of brain injury and/or their family members. This is especially true for those who may not have previously understood they had a brain injury or how their brain injury is affecting their parenting. This new awareness is often transformational and offers parents/caregivers a new understanding of their behavior as well as new resources for improving their success as parents/caregivers.

Once a parent/caregiver screens positive for a lifetime history of brain injury and associated impairments, it is important to provide that individual with education and tools so they can begin to change the downward trajectory they are finding themselves in currently, experience positive change and adjust self-concept with increased sense of self-efficacy. It is important to convey the message that a history of brain injury does not mean they cannot parent effectively. The message should be that there are compensatory strategies they can learn to address the deficits they are experiencing so that they can be successful and there are resources that can help.

Psychoeducation can range from tip sheets, guides and booklets shared with the parents/caregivers, to connection to parenting groups and resources, to social media supports and referral options, to supports for their children.

Educational Resources/Materials

Resources will be most effective if they are customized to the deficits that the individual is experiencing, e.g., short-term memory loss, problem solving, speed of processing.

Psychoeducation should include the following:

- Overview of brain injury.
- Overview of effects of brain injury.
- Tools and strategies for compensating for effects of brain injury and building a community of services and supports.

Resources should be presented with positive messaging highlighting that individuals with brain injury can learn to compensate for deficits.

- Written materials need to be written at the lowest grade level possible.
- Materials should be available in Spanish in addition to English.

The resources in this section can be used to educate:

- **Child Welfare staff** about various aspects of brain injury.
- **Parents with brain injury** about their injury, strategies and supports.

- **Parents of children with brain injury** about their child’s injury and how to best support them.

Choose which tools best fit the individual needs of each case. The tools can be used as they are. Many can be modified to include another state’s logo and contact information with permission from the state that developed it.

Signs and Symptoms Handouts

To alert direct service providers and caregivers to the signs and symptoms of an injury. The handouts can also be used after the fact as a guide to help parents think back to whether a concussion may have occurred in the past.

- Brain Links, TN
 - [Brain Injury in Young Children](#) - Adapted with permission from the Nebraska Brain Injury Advisory Council’s Task Force on Children and Youth, Brain Injury in Young Children
 - [When Your Child’s Head Has Been Hurt \(School-aged Child\)](#)
 - [When Your Head Has Been Hurt: Signs & Symptoms \(Adults\)](#)
 - [Recognizing Concussion In People Who Communicate without Words](#)
- [Concussion Signs & Symptoms Checklist](#) - For School Nurses – CDC
- [Signs and Symptoms of Concussion](#) - Focuses on student athletes – The Center on Brain Injury Research and Training (CBIRT), University of Oregon.

Concussion/Brain Injury Guides

- [R*E*A*P](#) - An interdisciplinary community-based concussion management approach which stands for “Reduce, Educate, Accommodate & Pace.” Iowa Concussion Consortium and the Brain Injury Alliance of Iowa.
- [Get Schooled On Concussions](#) - Free downloads of a rotating tip sheet. Schools, districts and states can purchase a subscription, including download of 30+ tip sheets, videos, lesson plans for classroom teachers and lesson plans for related service providers. Each subscription gives unlimited access to the Teacher Acute Concussion Tool (TACT) which provides full staff return to learn (RTL) training (in 20 minutes - with 4 weeks of email "inbox" delivery of customized RTL guidance based upon the teacher's teaching style) and also provides use of the TACT in "real-time" - when a student with a concussion is returning to the classroom imminently.
- Brain Links, TN
 - Guides on what to look for when concussion symptoms should have resolved, but have not. Divided by age.
 - [When Concussion Symptoms Are Not Going Away: A Guide for Parents of Children 5 and Under](#)
 - [When Concussion Symptoms Are Not Going Away – A Guide for Parents of School-Aged Children](#)
 - [When Concussion Symptoms Are Not Going Away – A Guide For Adults With Concussion](#)

- Guides used after discharge from the hospital, surgery, brain injury rehabilitation, to help families know what problems may still occur over the child or adult's lifetime.
 - [A Guide to Possible Changes After a Brain Injury: For Young Children](#)
 - [A Guide to Possible Changes After Brain Injury: For School-Aged Children and Adults](#)
- [Personal Guide for Everyday Living After Concussion/Traumatic Brain Injury](#)
Explains some typical cognitive challenges following mTBI and some solutions, with room for personalization.

Fact Sheets and Tools

- Brain Links, TN
 - [6 Types of Concussion Infographic and Fact Sheet](#) - Infographic used with permission from the University of Pittsburgh Medical Center Sports Medicine Concussion Program.
 - [Concussion/Brain Injury Alert and Monitoring Form](#) - Assists with tracking the student with a brain injury through the school system so the injury is not forgotten.
 - [Brainstorming Solutions Tool](#) - For direct service/support providers, like rehabilitation therapists, case managers and in-home support providers, to capture cognitive, behavioral, psychosocial, etc., information about the person served (best used with the Strategies and Accommodations Tool below).
 - [Strategies and Accommodations Tool](#) - Links difficulty identified by the Brainstorming Solutions Tool (above) with potentially helpful strategies.
 - [Concussions and Mental Health](#) - Modified with permission from Ontario Neurotrauma Foundation.
 - [Mental Health and Brain Injury Quick Guide](#) - Modified with permission from the Brain Injury Association of Virginia.
- [Concussion Fact Sheet for Parents](#) - CDC
- [Brain Injury and Opioid Overdose: Fast Facts](#) - National Association of State Head Injury Administrators
- [Cognitive Strategies for Community Mental Health](#) - MINDSOURCE Brain Injury Network Colorado & University of Denver Graduate School of Professional Psychology
- [Traumatic Brain Injury Factsheets](#) - A variety of subjects related to Brain Injury. Model Systems Knowledge and Translation Center.

Social Media Supports

- [Traumatic or Acquired Brain Injury Support](#) - Private group. There may be other public or private support groups in the person's specific community or state.
- [Post Concussion Support](#) - Solutions focused, not emotional support. Private group.
- [Pink Concussions](#) - Nonprofit for women with brain injury.
- [Concussion Discussions](#) - Public group.

- Also check county, [State-specific Brain Injury Associations](#), [State-specific Brain Injury Alliances](#).

Supports Specifically for When the PARENT Has a Brain Injury

- [Parenting After a Brain Injury](#) - By Dr. Alex Goody (Booklet), Headway - the Brain Injury Association (UK)
- [Parenting a Second Time Around](#) - (PASTA) “PASTA is a parenting program designed for relative caregivers who are not the biological parents of the children in their care. PASTA provides grandparents and other kinship caregivers with information, skills, and resources designed to enhance their ability to provide effective care for the young relatives they are parenting. PASTA consists of eight sessions that focus on topics including child development, discipline and guidance; caring for oneself as a caregiver; rebuilding a family; living with teens; legal issues; and advocacy.”
- [The Association for Successful Parenting](#) - TASP is a national non-profit organization "dedicated to enhancing the well-being of at-risk parents with learning difficulties and their children." TASP has training for professionals, too.
- [Children’s Services Practice Notes for North Carolina’s Child Welfare Workers](#), Vol. 9, No. 2, January 2004: Child Welfare Practice with Parents Who Have Cognitive Limitations. Article from the North Carolina Division of Social Services and the Family and Children’s Resources Program.
- [Parents with Intellectual Disabilities](#) - Article by The Arc, State of Connecticut Embrace Hope Expect Change.
- [Connecticut Parents with Differing Cognitive Abilities Workgroup](#) - “Training to assist providers in identifying and working more effectively with parents with cognitive limitations and their children.”
- [Job Accommodation Network](#) - Brain injury section lists accommodations for use on the job for a variety of issues often present after brain injury.
- [Supporting Children When a Parent Has Had a Brain Injury \(Booklet\)](#)
- [Children of a Parent with a Brain Injury](#)
- [Concussion Discussions Website](#) - Great interview series.
- [Traumatic Brain Injury Law Blog: How does a Parent’s Brain Injury Impact the Children?](#) - By Bruce Stern of Stark and Stark Attorneys at Law
- Brainline - <https://www.brainline.org/>. A national multimedia project offering information and resources about preventing, treating, and living with TBI for people with TBI, caregivers, professionals, military and veterans, and children with TBI.
- [Supporting Parents with Disabilities for Child Welfare Professionals: A Desk Reference Guide](#) - Oklahoma Department of Human Services

Note that three of these resources are geared toward helping the child of a parent with a brain injury: *Supporting Children When a Parent Has Had a Brain Injury*, *Children of a Parent with a Brain Injury* and *Traumatic Brain Injury Law Blog: How does a Parent’s Brain Injury Impact the Children?*

Note that one resource is specifically geared toward the child welfare worker when working with a parent with cognitive limitations: *Children's Services Practice Notes for North Carolina's Child Welfare Workers – Child Welfare Practice with Parents Who Have Cognitive Limitations*.

Referral Options for an Injured Parent or Child

The following documents contain information about referring a parent/caregiver or child to a symptom-specific specialist. When possible, provide the parent with a specific referral in their community.

- Brain Links, TN
 - [Six Types of Concussion Infographic and Fact Sheet](#) - Infographic used with permission from the University of Pittsburgh Medical Center Sports Medicine Concussion Program.
 - [Concussion Management Protocol](#)
 - [When Concussion Symptoms Are Not Going Away: A Guide for Parents of Children 5 and Under](#)
 - [When Concussion Symptoms Are Not Going Away – A Guide for Parents of School-Aged Children](#)
 - [When Concussion Symptoms Are Not Going Away – A Guide for Adults with Concussion](#)
 - [A Guide to Possible Changes After Brain Injury: For School-Aged Children and Adults](#)
 - [A Guide to Possible Changes After a Brain Injury for Young Children](#)

Data Collection and Outcomes Evaluation

State brain injury programs are skillful at ensuring that evaluation measures are in place regarding contract monitoring, specifically, looking at process evaluation. However, there are not always the resources, both time and money, to implement comprehensive outcomes evaluation across systems. In the context of child welfare there has been little work to date to examine if the brain injury screening, support, and referral to service coordination/resource facilitation (RF) have a positive effect on intermediate outcomes such as the parent/guardian's compliance with conditions of child welfare and family preservation. Additionally, there has been little work to evaluate the effect of this protocol on long-term outcomes such as reducing re-engagement with the child welfare system. To ensure sustainability and to scale up the protocol system-wide, brain injury programs will have to develop data collection protocols and research methodologies to demonstrate effectiveness and improved outcomes. Outcomes can include, but are not limited to: compliance with treatment, compliance with conditions of child welfare, and reduced out of home placements. It is important that the program work with the child welfare system to define these outcomes.

State brain injury programs can benefit from establishing relationships with universities to help implement outcomes-focused research. Often graduate or doctoral students need research

projects as requirements of their degrees. Additionally, faculty are seeking opportunities for their students and to be a part of research that can lead to publications. Programs that are well-suited to support research involving brain injury and child welfare include but are not limited to: neuropsychology and social work. It is recommended that state brain injury programs, if they have not already, seek these partnerships prior to implementing a brain injury screening, support, and referral protocol.

Steps prior to implementation:

- If lacking time or skills to implement a research protocol, solicit a partnership with a university.
- Develop research questions.
- Identify data that will need to be collected.
- Determine where data will be collected by sites.
- Develop a consent/release of information form.
- Obtain approval from the Institutional Review Board.
- If the state agency does not have access to university support, at minimum, the state agency should develop a database to consistently collect data that the stakeholders define as meaningful and data that can be used with policy and lawmakers to help ensure on-going funding.

There are many data elements that could be collected. It is recommended that the state brain injury program coordinate with the child welfare system to determine what outcomes they feel are important (and may already be collecting) as this will help ensure these efforts are sustained long-term. What is ultimately collected will depend on the research questions/outcomes being evaluated.

Some examples can include:

- Number of individuals who screen positive for history of brain injury.
- Number of individuals who screen negative for history of brain injury.
- Number screening positive for impairment.
- Number screening negative for impairment.
- Psychosocial vulnerabilities such as co-occurring substance abuse disorder and mental illness.
- Demographic data.
- Treatment completion.
- Compliance with conditions of child welfare.
- Reduced out of home placements.
- Reduction in length of stay in out of home placement.
- Reduction in placement disruptions.
- Reduction in re-engagement in the child welfare system.
- Connection to community-based service coordination/resource facilitation.
- Goal achievement such as sustained employment, stable housing, independence with finances, stability in family or significant other domain, and stable health/medical status.

Consents/Releases of Information

In order to collect data for program and outcome evaluation, there will need to be an approved consent/release of information. This consent may need to be approved through an Institutional Review Board as well as through the child welfare department where the data will be collected. Often there will be a central entity that will be responsible for approval, e.g., state department of human services, department of children/youth services, etc. An [example of a release of information](#) can be found online.

Dissemination Strategies

Publication: State brain injury program personnel do not traditionally think of publishing. However, the programs are often developing novel programming that would lend to increasing best practice development. It is critical that brain injury programs begin publishing the work they are engaged in. Again, partnering with a university will help increase the likelihood that the work being done, and the evaluation being completed, will result in publications that will advance the field of brain injury.

Presentation: State brain injury programs should focus dissemination efforts on child welfare-related conferences and meetings to increase awareness of the needs and possibilities regarding brain injury within their systems.

Sustainability and Funding Strategies

Although the last section of this guide, plans for sustaining protocol efforts need to be developed from the beginning, even prior to implementation. Funding these initiatives can be challenging. Therefore, it is important to build a model that is cost effective and relatively easy to administer. Additionally, it is important to build the capacity of personnel within child welfare to ensure they have the skills necessary to support children and parents/caregivers with brain injury within their given child welfare system. Finally, sustainability and generating funding is a strong argument for why it is critical to evaluate efficacy of the model and to determine if the implementation of the model improves intermediate and long-term outcomes for individuals involved in the child welfare system.

Setting The Stage for Success

As has been indicated throughout this guide, there are several steps states can take to set the stage for sustaining these efforts. The following are strategies for increasing the likelihood that these activities will be sustainable.

1. Establishing effective partnerships.

Developing and implementing a brain injury screening, support, and referral protocol requires many partners to be effective. The lead state agency on brain injury is a natural fit to oversee these activities, however, to be successful, partnerships are key. The following entities are important partners to have on board while developing, implementing, and evaluating these protocols:

- Child welfare personnel - it will be important to engage the child welfare system in identifying gaps, prioritizing a target population, and determining the best point to implement the protocol. Child welfare personnel should also be engaged when choosing the screening tools and establishing the protocol.
- Child welfare-related organizations such as the National Child Welfare Workforce Institute, Court Appointed Special Advocates (CASA), statewide organizations, and leadership groups - these groups can offer support and guidance, as well as access to critical players. They can also serve as “translators” and advisers.
- Individuals engaged in the child welfare system - it would be beneficial to gain insight from individuals with brain injury who have engaged with the child welfare system as these protocols are designed and implemented. This can be accomplished by inviting these individuals to be members of your advisory boards or organizing an advisory team specific to these initiatives.
- Universities - as indicated previously, partnering with universities can be beneficial to ensure effective evaluation design, implementation of research, and publishing results. All of this is important to justify funding for these initiatives long-term.
- Brain injury advocacy organizations – as indicated previously, service coordination/RF is an important element to this protocol. As a result, it is important that state agencies engage the partnership of entities that provide these services, e.g., brain injury associations/alliances.
- State agency leadership - it is important to have the support of your state agency. It is helpful to demonstrate how this initiative fits within the department’s broader goals.
- State policy makers/legislators - consider having legislators on your advisory board, work with your state advocacy organizations to ensure they are supportive of this initiative and so they can help advocate for on-going funding and support. An example of universal screening legislation can be found in the [Brain Injury and Child Welfare Best Practice Supporting Materials](#).

2. Formalizing partnerships through memorandums of understanding (MOU).

Developing MOUs which outline the expectations of the partnership ensures all players are on the same page. MOUs are particularly helpful when working with sites that will implement the model. MOUs should include:

- Background/justification for the work.
- An outline of what is expected of the site.
- An outline of what the state agency will provide.

- Expected outcomes.

[Sample MOU](#)

3. Produce a body of evidence.

As indicated previously, it is important to evaluate the efficacy of the brain injury screening, support, and referral protocol. It is also important to evaluate if the protocol leads to improved intermediate and long-term outcomes. Use the results to:

- Publish results in journals (brain injury and child welfare journals).
- Develop policy statements.
- Justify sustainability.
- Justify funding.

4. Communicating results.

This topic is of interest to many including the public, child welfare systems, state agencies, policy makers, and legislators. It is important to get the information out to these audiences. Each audience is interested in this information for a variety of reasons. Messaging should include how the protocol:

- Improves outcomes for children engaged in the child welfare system.
- Has a positive return on investment.
- Reduces re-engagement in the child welfare system.
- Improves overall outcomes, e.g., school, employment, and prosocial engagement.

5. Build the capacity of the child welfare system.

Three of the most important things a state brain injury program can do to help ensure sustainability are:

- Blend the protocol within the existing framework of the system in which the protocol will be implemented.
- Choose brain injury screening, support, and referral protocol that child welfare personnel can administer.
- Ensure the protocol is cost and time effective.

Key Takeaways

Child welfare systems are complex and vary across states. These factors make it a challenge to be able to simply point state brain injury programs to where to implement a protocol to identify child welfare-involved individuals with brain injury and connect them to appropriate resources. This guidebook was designed to provide states with the opportunity to do a comprehensive

evaluation of your child welfare system and evaluate opportunities for engagement. These key takeaways may support systems change in your child welfare system(s) related to its intersection with brain injury in order to enhance the stability and reunification of children with their families.

- Research the design of your state’s child welfare system, who are the key players and what agencies are responsible for overseeing these activities as they relate to both federal and state legislation and implementation within your state. Partnering with the leadership of your state’s child welfare system and/or their professional organizations will be critical.
- Leverage existing frameworks previously developed for other co-occurring conditions such as behavioral health. Evaluate your state infrastructure to determine areas that may align with embedding brain injury initiatives. E.g., specialty courts, mental health, substance abuse treatment programs, etc.
- Engage partners and evaluate opportunities to embed training opportunities to support understanding how a brain injury impacts an individual’s ability to comply with court ordered services.
 - Develop meaningful relationships with key people in your state’s child welfare systems. Engage with partners to learn about their systems, culture, and frameworks before developing a plan.
 - Select screening and assessment tools in partnerships, keeping in mind the importance of tool validation and considering target site resources.
 - Avoid asking child welfare systems to “treat” brain injury, rather provide opportunities to consider accommodations so the individual can compensate for their brain injury deficits and meet their requirements, or referral resources to brain injury providers where more intensive rehabilitation treatment is indicated.
 - Evaluate opportunities to fit brain injury screening, services and supports, and referral protocols into existing child welfare frameworks.
 - Evaluate opportunities to embed warm handoff referrals from the child welfare setting to a community-based brain injury service coordination/resource facilitation program.
- Training on brain injury is a critical component to implementing a new screening, support, and referral protocol.
 - Having knowledge of brain injury and their impairments can be important tools to ensure success in the future. It is important to reassure individuals with brain injury that they are not “broken” people.
 - Brain injury strategies need to be contextually relevant, tailored to the individual’s needs, and easy to employ.
- Data collection and evaluation are critical components that should be planned prior to implementation. They should be an integral part of the screening, support, and referral protocol. Coordinate with the child welfare system to determine what outcome measures are meaningful to them.
 - Partner with universities to support an evaluation and publication process that can advance the field.

- Dissemination of information learned is also important both to establish need for continued support and promote the adoption of these practices in other child welfare settings/states.

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