

The Atlas Project: Integrating Trauma-Informed Practice into Child Welfare and Mental Health Settings

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Although children in foster care are disproportionately affected by trauma, few child welfare agencies fully integrate trauma knowledge into their practices or have trauma-specific interventions available for children who could benefit from them, either internally or through partnerships with mental health providers. The Atlas Project has built on foster care-mental health partnerships to integrate trauma-informed practices into New York City Treatment Family Foster Care programs. This paper provides detail on the elements of the Atlas Project model, their implementation, and implications for trauma-informed child welfare practice.

In 2015, more than 670,000 children spent time in foster care in the United States (Children's Rights, n.d.). These children are disproportionately affected by trauma (Bramlett & Radel, 2014), as most have been exposed to multiple traumatic events (Aarons, Brown, Hough, Garland, & Wood, 2001; Ko et al., 2008), including abuse and/or neglect, being removed from their home, and experiencing multiple placements (Halfon, Zepeda, & Inkelas, 2002). As many as 70% of children in foster care meet the criteria for complex trauma (Greeson et al., 2014), which is defined by the chronic and cumulative experience of abuse, neglect, and parental loss (Courtois & Ford, 2009; Spinazzola et al., 2013; Wamser-Nanney & Vandenberg, 2013).

Although reactions to traumatic events vary based on coping responses (Riebschleger, Day, & Damashek, 2015), exposure to complex trauma can increase the likelihood of adverse traumatic symptoms (Ko et al., 2008). More than 19% of youth in foster care have been shown to have clinically significant post-traumatic stress symptoms (Kolko et al., 2010), and children with complex trauma have been found to have higher rates of internalizing problems, post-traumatic stress and clinical diagnoses than other children (Greeson et al., 2014). Pecora and colleagues (2006) found that foster care alumni had much higher rates of post-traumatic stress disorder (PTSD) (21%) compared to the general population (4.5%). Many more children who have experienced traumatic events may exhibit symptoms of traumatic stress without meeting full criteria for PTSD (Kolko et al., 2010). The Adverse Childhood Experiences Study (Felitti et al., 1998) and other research (e.g., Cook et al., 2005) has shown that, if left undiagnosed and untreated, exposure to traumatic events in childhood can have short- and long-term developmental, psychological, physical, and behavioral consequences, including but not limited to an increased risk of cardiovascular disease, cancer, obesity, alcoholism, drug use, depression, and suicide attempts in adulthood.

Although the child welfare system has historically lacked a systematic approach to addressing the impact of trauma on children (Beyerlein & Bloch, 2014; Ko et al., 2008), there is growing

recognition that trauma-informed practices, including close partnerships with mental health providers trained in trauma-focused interventions, should be integrated into child welfare settings (Beyerlein & Bloch, 2014), and several local and national efforts have been designed to do so (Bartlett et al., 2016; Ko et al., 2008). Some of these efforts have focused on a specific domain such as trauma-informed parenting workshops (Sullivan, Murray, & Ake, 2016) or trauma-informed screening and assessment (Kerns et al., 2016), while others have taken a broader approach, simultaneously focusing on areas such as workforce development, trauma screening, policy change, and improved access to evidence-based, trauma-focused treatments (Lang, Campbell, Shanley, Crusto, & Connell, 2016).

A National Child Traumatic Stress Network (NCTSN) Breakthrough Series Collaborative (BSC) focused on using trauma-informed practices to improve placement stability for youth in foster care. The teams participating in this BSC, which included foster care providers and their mental health partners, tested policy and practice changes related to five themes: (1) knowledge building and developing practice; (2) trauma-informed mental health screening and assessment; (3) case planning and management; (4) trauma-informed services; and (5) cross-system partnerships and system collaboration (Conradi et al., 2011).

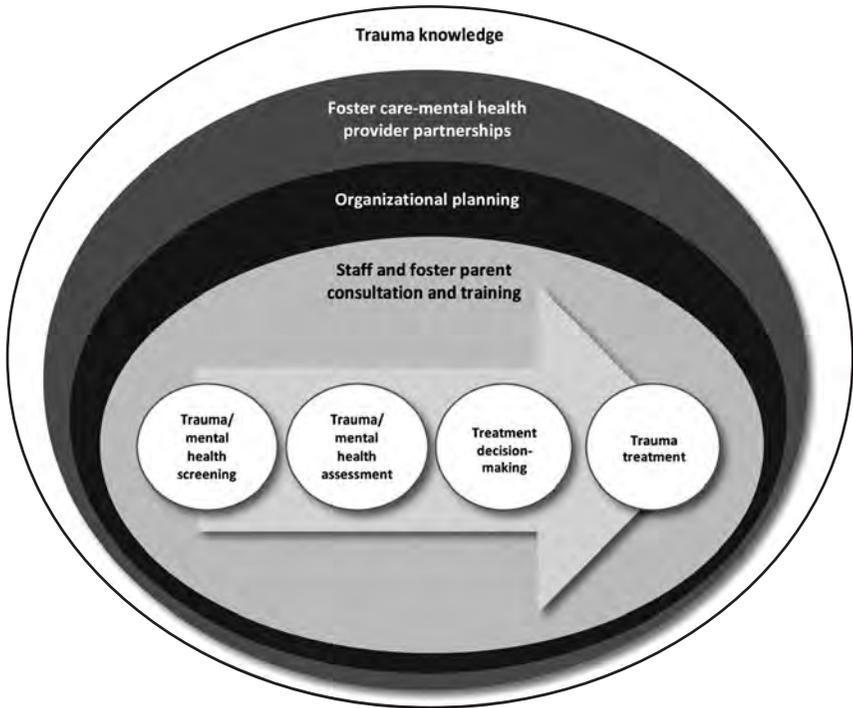
Another broad-based effort to incorporate trauma-informed practice into child welfare settings was an Administration for Children, Youth and Families (ACYF)-supported funding opportunity that sought to study the implementation of trauma-informed practices in child welfare settings and the broader service array, and to assess their effectiveness in improving mental health and child welfare outcomes, in 20 settings across the country. In response to this funding opportunity, we used both the NCTSN themes and the ACYF structure to develop and implement the Atlas Project, which sought to improve mental health outcomes (reducing mental health symptoms, psychiatric hospitalizations and psychotropic medication use) and improve placement stability (reducing moves between foster homes and to

higher levels of care). This paper describes the components of the Atlas Project and our initial experiences with their implementation with Treatment Family Foster Care (TFFC) programs in New York City, and discusses aspects of the Atlas Project that can inform future integration efforts. Future papers will detail the process and outcome evaluations from this work.

The Atlas Project

The Atlas Project has focused its work on children served by New York State-based foster care programs. While the project initially included children in both urban and rural settings, this paper will focus on Atlas implementation in New York City Treatment Family Foster Care (TFFC) programs, which serve youth whose mental health and behavioral needs require a more intensive level of services than family foster care typically provides. Atlas aims to better address trauma experienced by TFFC clients through the implementation of systematic trauma screening and assessment, treatment decision-making tools, and trauma-informed mental health treatment. As illustrated in Figure 1, each of these discrete components is supported through staff and foster parent consultation and training, organizational planning, and foster care-mental health provider partnerships, all of which are grounded in increased knowledge and understanding about trauma.

Over a period of four years, we have worked with five TFFC programs, which in total have 135 foster care staff and serve nearly 300 children, and their mental health partners to implement this model. Each site was trained in and received consultation on trauma and its impact on children, assessing children for trauma-related mental health needs, and determining the appropriate level of trauma-related treatment. Following is a more detailed description of each Atlas Project component, with additional information about our implementation approach and related successes and challenges.

Figure 1. Atlas Project Components

Foster Care-Mental Health Partnerships

Each Atlas Project site was a partnership between a TFFC program and either an internal (i.e., housed in the same agency) or external (i.e., community-based) mental health provider. In order to participate in Atlas, each TFFC site had identify a mental health partner that was willing to fully participate in the project.

Prior to Atlas implementation, most of our partner sites described cross-system communication and collaboration as a source of frustration; for example, TFFC staff often waited long periods of time for clinical paperwork, and mental health staff struggled with getting foster parents to attend collateral sessions. Even at agencies that had both services in-house, the level of coordination between staff was often minimal. This is in line with Darlington's (2005) finding that even when mental health

and child protection professionals believed that collaborative practice is necessary, efforts to achieve this collaboration were hindered by a lack of supportive structures and practices at the organizational level.

These agency-level partnerships required each agency's leadership to make a commitment of time and flexibility that in some cases was outside of the norm, but led to creative solutions that maximized the amount of time staff could spend collaborating on different project components. For example, one mental health provider carved out a weekly "office hour" that their clinician reserved to meet with TFFC staff on shared cases; as long as each meeting was at least 30 minutes and the TFFC staff member was included in the given child's treatment plan, under New York State regulations it could be billed as a collateral session and therefore did not create a financial loss for the mental health program.

Having better collaboration between foster care and mental health has been connected to improved mental health service access and outcomes (Bai, Wells, & Hillemeier, 2009). Most of our partner sites have reported that their involvement in Atlas has improved their collaboration and effectiveness in engaging both children and foster parents, and cite it as one of the biggest gains from their participation in the project.

Organizational Planning

Prior to the implementation of the below-described Atlas components, the leadership from each foster care-mental health partnership worked with the Atlas Project team to identify a lead "champion" for the project and develop a joint organizational plan. This plan was a roadmap for internal agency workflows, inter-agency collaborations, and integrating the various aspects of the Atlas model with current agency structure and practice. This planning and customization was essential: as no two agencies or partnerships are alike, a "cookie cutter" approach to implementation would make new practices much less likely to be sustained over time. Perhaps most importantly, the organizational plan was where the partnerships' functioning was clarified, and it was repeatedly returned to as needed over the course of the project.

Trauma/Mental Health Screening and Assessment

One of the Administration for Children, Youth and Families' central foci has been the implementation of universal mental health screening and assessment, including measures that address trauma. It is important to understand children's trauma histories because the same symptoms can be the result of traumatic experiences or mental illness (Griffin et al., 2011; Rayburn, McWey, & Cui, 2016). Without concrete information about trauma experienced by children and related trauma responses, other work to address trauma will likely be less effective.

To be utilized in Atlas, we decided that screening and assessment tools had to be validated, brief, easy to use and available in the public domain, thus ensuring sustainability. We also sought tools that captured both general mental health symptoms and trauma exposure and symptoms. Based on these criteria we chose the following tools:

- *Pediatric Symptom Checklist (PSC)*: The PSC is a self-report tool that measures cognitive, emotional, and behavioral problems, has established validity (Jellinek et al., 1988) and has been sufficiently consistent across groups and locales (Jellinek et al., 1999). We used the observer/caregiver, youth (for children 9 and older) and preschool versions of the form, which are available in English and Spanish.
- *Child Stress Disorder Checklist (CSDC)*: The CSDC is a self-report instrument that measures trauma exposure and symptoms of PTSD in children, with evidence to support its reliability and validity (Saxe et al., 2003). The CSDC has observer/caregiver versions available in English and Spanish, and a youth version (for children 12 and older) available in English. Because the CSDC was initially developed by a member of the Atlas team, we had the opportunity to revise its youth version, which we did in collaboration with youth from our TFFC partners to improve its clarity and accessibility.

The Atlas protocol included trauma/mental health screening within 30 days of admission to the foster care program, followed by trauma/mental health assessment for those children with elevated screening scores. Although all TFFC and clinical staff were trained in the tools' administration, with over 400 trained to date, each agency was given the flexibility to determine who was the most appropriate person (i.e., a caseworker or a clinician) to implement the tools with each caregiver and age-appropriate youth. As children served by TFFC programs have already been identified as having mental health-related needs, these children began the Atlas protocol with trauma/mental health assessment, which was to be repeated semi-annually for those children receiving treatment through Atlas partner providers. (Shorter versions of these tools were used with Atlas sites that also conducted screening.)

To facilitate the delivery of our screening and assessment tools, and to track the results of repeated assessments over time, one of the Atlas Project goals was to develop an online data capture system called Web-Based Screening for Trauma and Resilience (WEBSTR), to house all of our trauma/mental health tools. Our local partners were very enthusiastic about WEBSTR's potential to facilitate the tracking and sharing of information among foster care and mental health staff, and inform their overall work through aggregate data. Given technical challenges in developing this system, and substantial negotiation with our state partners to ensure its security and appropriate management of confidential information, WEBSTR's launch was delayed until the last year of our project, and its full potential was not realized. In the meantime, we established systems for collecting and tracking "paper and pencil" versions of the trauma/mental health tools, which though effective was more cumbersome for our partners.

Another challenge we faced in implementing the Atlas screening and assessment protocol was competing and time-intensive priorities such as court hearings. In response to workload-related concerns, we adjusted the Atlas protocol to have assessments repeated less often (they were initially repeated quarterly, and we changed the schedule to

semi-annually), adjusted our implementation schedule, and worked with supervisors to integrate the completion of tools into staff's regular work. As a result of these changes, fidelity to our protocol improved markedly among our second and third cohort sites.

Some staff also expressed concern that asking questions about past traumas could be destabilizing for youth. In response, our training included a review of signs that it may be time to pause or stop the process, and provided staff with opportunities to role-play introducing the tool and explaining its purpose (providing more effective support to children in care) with each other. Given the shame and secrecy that can accompany certain kinds of traumatic experiences, we also emphasized the power of acknowledging and validating young people's experiences, and cited research that has shown that the overwhelming majority of youth do not find such questions uncomfortable or distressing (Finkelhor, Vanderminden, Turner, Hamby, & Shattuck, 2014; Zajac, Ruggiero, Smith, Saunders, & Kilpatrick, 2011).

Our partner sites have reported important benefits from incorporating systematic screening/assessment into their practice. For children who are new to a TFFC program, it provided a mechanism for collecting full information about the child's experiences and current level of functioning, which is often not included in referral or historical materials. But even among children who had been in a given program for months or years at the point of assessment, staff often reported learning new things about the child's experiences and current sources of stress. Additionally, collecting information from both the child and the caretaker—or caretakers, when both a foster parent and biological parent were available—provided information about different, at times conflicting, perspectives that were helpful for ongoing treatment planning. Foster parents are often most aware of a child's externalizing symptoms, but may miss or misinterpret internalizing symptoms that are causing significant distress for the child. For example, a subsample analysis of our CSDC data suggests that caregivers underestimate youth's experience of avoidant behaviors, and the two groups of informants are not significantly correlated on this domain ($p = .1378$).

Having a better understanding of foster parents' view of children's behavior can provide staff with an opening to conduct psychoeducation around trauma and explore alternative intervention approaches.

Treatment Decision-Making Tools

We used the Child Ecology Check-In (CECI) to identify children's mental health treatment needs. This tool, designed to be completed by the child's team, integrates the information learned during the mental health assessment process with other information known about the child, his or her caretaker, and other involved agencies/systems (school, court, etc.), providing a fuller picture of strengths and needs. The abbreviated version of the CECI has four domains, which ask questions about the child's level of (1) emotional and (2) behavioral dysregulation, and the ability of the child's (3) caretakers and (4) larger service system to effectively manage this dysregulation.

As part of the Atlas model, we developed an algorithm that used CECI scores to categorize children based on their identified needs. Children who exhibited high levels of dysregulation and have caretakers and/or providers that are unable to manage that dysregulation were prioritized for Trauma Systems Therapy, the treatment model described in more detail below. Children identified with other mental health or caretaker/provider concerns received different types of services. The CECI and its algorithm were also included in WEBSTR, which provided the team with a report summarizing the PSC, CSDC and CECI scores, and the accompanying recommendation, which could be shared with the family and (with appropriate permissions) other service providers.

While one of the advantages of the CECI is that it incorporates the perspectives of multiple team members, coordinating schedules to complete the tool can be difficult. Some agencies also found it challenging to rate foster parents—and even themselves—on the CECI, when they felt that everyone was trying their best to support a given child, even if that support was not yielding positive outcomes. In

coaching the teams, we emphasized that the CECI is designed to be a judgment-free tool, focusing on the effectiveness of foster parent, staff and service system efforts, rather than the intention behind those efforts.

Our partner sites have reported benefits of having a systematic way to get input from all members of the child's team. On many occasions, during CECI discussions it became clear that different members of the team had different pieces of information about the child and his or her social environment that had not previously been shared. The scoring process also allowed the team to identify the most pressing concern(s), prioritize needed follow-up and allocate scarce resources where they were most needed.

Trauma-Informed Mental Health Treatment

As noted earlier, as part of the Atlas Project we implemented Trauma Systems Therapy (TST) with our partner sites. TST is a phase-based treatment model designed for children that have experienced trauma that is having an ongoing, negative impact on their functioning and well-being (Saxe, Ellis, & Brown, 2015). TST addresses the two components of the *trauma system*: (1) a child that is unable to regulate his or her own emotional state; and (2) a social environment and/or service system that is not sufficiently able to help the child regulate those states (Saxe et al., 2015). Research examining the effectiveness of TST has found that it increased the likelihood of remaining in treatment and reduced posttraumatic stress and aggression among participants (Saxe, Ellis, Fogler, & Navalta, 2012); decreased rate and length of stay of psychiatric hospitalizations in a community-based treatment program (Ellis et al., 2012); and improved child functioning, behavioral regulation, and placement stability (Brown, McCauley, Navalta, & Saxe, 2013; Murphy, Moore, Redd, & Malm, 2017).

Children receiving TST are identified as being in one of three treatment phases based on their current functioning and environment: Safety-Based Treatment, which focuses on establishing the child's physical and emotional safety; Regulation-Based Treatment, which

focuses on building the child's regulation skills and sharing those skills with others; or Beyond Trauma Treatment, which helps the child put their trauma history in context and addresses ongoing trauma-related cognitions. TST is designed to have all of the involved treatment providers (foster care, mental health, Medicaid waiver services, school, etc.) work off of a shared treatment plan that identifies strategies for minimizing trauma reminders in the child's environment and building the child's capacity for managing trauma-related reactions. While this approach is ideal for youth who are multi-system-involved, the level of coordination required to develop and implement TST treatment plans can pose challenges for providers that are stretched for time, juggling competing priorities and responding to crises. We managed this by limiting the number of children receiving TST to those who have the highest need, and providing intensive support and coaching to supervisors around integrating TST language and tasks into their regular staff supervision. To date, 42 children have received TST treatment, which represents approximately 15% of the children served by Atlas sites.

As our partner sites became more fluent in the TST model, they reported that their staff and foster parents have a better understanding of trauma, heightened awareness of children's trauma-related behavior patterns, and tools to more effectively intervene. The TST model also provided the agencies a common language through which they could communicate the child's trauma experience, to each other and with children and families.

Staff and Foster Parent Consultation and Training

All of the above activities were supported through weekly on-site consultation with staff and supervisors, and training of foster care and mental health staff, and foster parents. During weekly consultations with Atlas staff, which are a central component of the TST model, the team reviewed the activities that took place with a given child and family, and were provided feedback and suggestions about modifications. Supervisors received separate weekly coaching from Atlas staff that

enhanced their ability to integrate the model into their regular supervision, and prepared them to ultimately to take the lead in team meetings. Once staff felt comfortable enough with the model, foster parents were invited to join consultations on children in their care, so they could provide input and be part of the discussion around interventions.

When possible, we also involved foster parents in staff trainings, reinforcing the fact that they are part of the team serving children in care, and often have the most impact on children's day-to-day functioning. Joint training also provided a common language and approach to case conceptualization, which was particularly helpful as teams sought to better understand children's trauma triggers and reactions and, for those children receiving TST, moved to working off of a single treatment plan.

With our first cohort of sites, we provided training on all of the Atlas components included in Figure 1 together, in a single multi-day training. Given the time it took staff to become comfortable with each of these components, the gap between the training and implementation of certain activities required repeated trainings. Given this, for our second and third cohorts we broke the training into segments delivered over time, allowing people to master each step before moving on to the next one. Based on trainees' feedback, we also integrated more opportunities for staff to apply each skill/task to a sample case, and to practice doing them with each other. Our training evaluations indicate that people appreciate having this iterative, hands-on approach, with 92% of participants stating they felt prepared to implement the different practices covered in the training.

One challenge that we encountered around training was staff turnover. Over the last year, our foster care partners lost an average of 58% of their staff. This meant that at any point in time there were staff working with children and their families who had not been fully trained in the model. As a result, Atlas administrators planned additional, ad-hoc trainings, and identified internal trainers at each agency that will be able to train new staff in all aspects of the Atlas model as they are hired going forward.

Implications for Trauma-Informed Child Welfare Practice

Two aspects of the Atlas Project that we have come to believe are critical to trauma-informed child welfare practice are (1) partnerships between foster care and mental health providers; and (2) partnerships between staff and foster parents.

On the provider level, developing protocols and processes for collaboration and information-sharing ensures that all team members have needed information about the child's trauma history and related symptoms, that the service plan is informed by multiple perspectives and is focused on addressing the child's most pressing problems, and that important tasks do not fall through the cracks.

On the individual level, considering foster parents as part of the child's team that is supporting children in care can be transformative. This level of engagement ensures that there is mutual support and respect between the foster parent, casework and clinical staff, and serves to reduce the level of stress that exists between staff and foster parents, which can contribute to secondary trauma and negatively impact children in care. Working as equal members of the team, foster parents can provide critical information about the child's behavior and needs, learn from others' perspectives, and receive strategies and tools they need to safely parent the child. Being a team-based model, Trauma Systems Therapy provides a ready mechanism for engaging foster parents in a more meaningful way, but there are many other ways to involve foster parents—in joint training with staff, in identifying children's trauma history and trauma triggers, in developing trauma-informed service plans, etc.—that can improve the care provided to children.

As noted throughout this paper, flexibility in implementing the Atlas model was also critical to our efforts. In addition to making the uptake of new practices more manageable for overburdened staff and agencies, making needed adjustments demonstrated our commitment to truly working *with* our partners. Such flexibility is essential to the

success of projects in systems as dynamic as child welfare; model adaptations should be not only be allowed, but *expected* by funders of such projects in the future.

This level of flexibility also helped us manage some unexpected delays in our project, such as those associated with the development and launch of WEBSTR, our online data capture system. Agreements around information-sharing and other legally complex issues should be addressed as early as possible in the course of such cross-system projects. Although it is unrealistic to expect that such agreements will be in place when funding proposals are submitted, the development of such agreements should be considered a key planning activity. Given the challenges of establishing such agreements, we would also recommend that a back-up system for collecting, tracking, analyzing and sharing data is in place from the outset.

Another project component that has proved to be central to our efforts' success was the early identification of an internal champion at the program level. This person, who must have decision-making authority within the agency, should be the primary partner on overseeing implementation and developing a plan for sustaining the new practice from the outset. This is in line with the implementation literature, which has found that the use of internal change champions is one of the factors crucial to the success of program implementation (Damschroder et al., 2009; Titler, 2008). Following the Trauma Systems Therapy implementation approach, which includes a train-the-trainer component, we have also encouraged our sites to identify a core internal trainer from the outset, so that that person would have the opportunity to co-train along with our team until he or she developed the capacity to hold independent internal trainings on all Atlas components going forward. This type of co-ownership is essential to eventual model sustainability.

An additional factor for consideration is the level of turnover among TFFC staff. While turnover among child welfare agencies is a well-documented phenomenon (Nittoli, 2003), we have gained a heightened understanding of its impact on the implementation of new

practices. The resignation of a staff person increases the workload of his or her supervisor and peers, which limits their ability to learn and manage new tasks; disrupts relationships with children and caretakers, which may result in back-tracking on different elements of a service plan; and requires training for their replacements. Although our hope is that trauma-informed practice will ultimately increase staff effectiveness, satisfaction and retention, we do not yet have data that demonstrates this, and the lack of organizational stability and consistency in the meantime reinforces the importance of having a flexible implementation plan and a strong internal champion who can keep the work moving forward in the midst of staff changes.

Introducing new protocols into agencies is always complex, and there are additional challenges with implementing trauma-informed practices that require leadership, staff, foster parents and other stakeholders to reconsider how they do their work. However, implementing trauma-informed practices into foster care is critical, so that children's needs are identified, understood and effectively addressed by child welfare professionals, family members and the larger service system. Importantly, such efforts should be comprehensive, both ensuring that children's needs are identified and met (though trauma-informed screening and assessment, decision-making tools, and treatment) and that foster care caretakers and staff and mental health clinicians have trauma-related knowledge and skills (though trauma training and consultation) needed to deliver coordinated and effective care.

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