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"I need help" Recommendations for a Trauma Informed Care Training for Resource Parents

Jaspreet Kaur Bola
University of San Francisco, jkbola@dons.usfca.edu

"I NEED HELP"

RECOMMENDATIONS FOR A TRAUMA INFORMED CARE TRAINING

FOR RESOURCE PARENTS

By

Jaspreet Kaur Bola

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Primary Advisor: Dr. Kelly L'Engle
Secondary Advisor: Dr. Kathleen Raffel

Abstract

This report discusses the need for extensive trauma informed care training for resource parents (formerly known as foster care parents). A review of the literature and collection and analysis of data during group interviews with case managers and one-on-one interviews with resource parents was conducted. The review and data analysis found that resource parents are experiencing several challenging behaviors as a result of trauma from the foster child(ren) in their care and resource parents want more specific and detailed trauma informed care training that will help foster parents better address behavioral issues of the foster children in their care. Resource parents and case managers identified barriers to trainings including resource parents having a busy schedule while, working around the clock, and supervising their children which made it difficult for them to attend trainings. Coordinating a time that was convenient for a majority of resource families and BWC staff was challenging. Furthermore, it was challenging to choose a central location for case managers and all resource parents could commute to for training, due to resource families being located in several different districts, miles apart. A mobile application is recommended as a convenient, easy to access resource for additional trauma informed care training.

KEY WORDS: Trauma Informed Care; foster care; resource parents; training

Executive Summary

Introduction

Children in foster care have been exposed to multiple traumas. Trauma occurs when a child experiences an intense event that threatens or negatively affects adolescent self-esteem, coping skills, school performance, self-regulation and motivation, and the ability to build healthy relationships (Beyerlein & Bloch, 2014; Fratto, 2016). The consequences of not treating trauma in childhood are substantial and have long-term effects that can be harmful for the foster child and resource family. Resource families (formerly known as foster care parents) greatly impact a child's trauma recovery, however trauma related needs are significant and resource parents require regular training to sufficiently understand and competently manage trauma related complexities. Resource parents currently receive specialized training on trauma informed care but these trainings generally contain limited information on trauma, and how to provide trauma informed care. Furthermore, the limited trauma informed care training might cause additional traumatic experiences for foster children if resource families are unable to understand the source of behaviors occurring in reaction to traumatic experiences. These challenges are present among resource parents at the Bill Wilson Center-- a non-profit community based organization in Santa Clara County serving foster youth and families.

Needs Assessment

The Bill Wilson Center provides extensive certification training to all new foster parents and continuous case management to ensure resource parents are equipped to provide the best care for the foster children in their care. Despite the continuous care offered, the Bill Wilson Center would like to offer additional trauma informed care

resources to current and new resource parents. Resource parents have identified a need

for more trauma informed care training and prefer training through in person classroom

formats, online, video format, or a self-guided format. All participants in the needs

assessment conducted for this project reported often having trouble making it to Santa

Clara for training due to scheduling or traveling restrictions. Bill Wilson Center staff has

also reported having trouble scheduling trainings or events that are convenient for all

resource families. To meet the needs of resource families and Bill Wilson Center staff, a

recommendation for a mobile application trauma informed care training is presented.

Recommendations for FosterTIC

Based on current efforts identified in the recent published literature, data collected

during interviews with resource parents, and Bill Wilson Center case managers' input,

recommendations for a mobile application were created to offer specific trauma informed

care training to all resource parents called FosterTIC. The app will address a variety of

trauma related challenges through specific and detailed trainings and resources that

include suggestions by current and past resource parents, demonstration videos on trauma

related behaviors and reactions, goal setting, interactive online games for practicing

problem solving skills and social-emotional control, and setting stress relief goals.

Implementing this project will provide the BWC with more findings on how trauma

informed care can support resource parents to better address behavioral issues of their

foster children, which should yield higher engagement and increase retention of foster

youth in their care, possibly leading to permanent adoption.

Review of the Literature

Trauma Among Children

Approximately five million children each year in the United States experience

some type of traumatic experience (Fratto, 2016) and one in every four children will

suffer from a traumatic experience before the age of 16 (Beyerlein & Bloch, 2014).

Trauma occurs when a child experiences an intense event that threatens or affects

adolescent self-esteem, coping skills, school performance, self-regulation and motivation,

and the ability to build healthy relationships (Beyerlein & Bloch, 2014; Fratto, 2016).

According to The National Child Traumatic Stress Network (NCTS), trauma can be

experienced in different forms including: community and domestic violence, medical

trauma, natural disasters, neglect, physical and sexual abuse, terrorism, bullying, or

homelessness (NCTSN, 2016).

Trauma is a widespread, harmful and costly public health problem that affects all

backgrounds regardless of age, gender, socioeconomic status, race, ethnicity, geography,

or sexual orientation (Leonelli, 2014). Early childhood trauma can affect children from 0-

5 years of age, even if they don't understand what is happening to them; in fact children

of this age group are at a particularly high risk for exposure to traumatic events (Buss et

al., 2015; NCTSN, 2016). Data suggest that children who are experiencing an extreme

stressor at such a young age may be in need of help. Children are being exposed to

trauma frequently and intensely early in their lives that could possibly affect their

psychological state as they grow up.

Children in foster care are at a higher risk of being exposed to trauma. According

to the U.S. Department of Health and Human Services 2015 AFCARS report, on any

given day there are nearly 428,000 children in foster care and more than half of children

entering the U.S. foster care system were young people of color (2015 AFCARS report).

Approximately 90% of children in foster care have experienced a traumatic event of

which nearly 1 in 4 children reported exposure to four or more traumatic events (Fratto,

2016).

Health and Developmental Concerns of Childhood Trauma

The consequences of not treating trauma in childhood are substantial and have

several long-term effects. Toxic stress, a response from experiencing strong, frequent, or

prolonged adversity from childhood trauma, can damage the structure and function of the

developing brain and if left untreated can last into adulthood (Muranishi, 2016).

If an individual experiences or has exposure to several traumatic experiences, the

individual may be linked to increased risky health behaviors, chronic health conditions,

low life expectancy, and early death (CDC, 2016). According to the Alameda County

Behavioral Health Care Services (ACBHC) and the CDC, someone who has experienced

trauma is more likely to experience health concerns including: obesity, diabetes,

depression, suicide attempts, STD's, heart disease, cancer, stroke, COPD, broken bones;

behaviors including smoking, alcoholism, and drug use; decreased life potential due to

low graduation rates, academic achievement, and lost time from work (ACBHC, 2013 &

CDC, 2016). Furthermore, the ACBHC report documented that up to 53% of adults

diagnosed with a severe mental disability report childhood physical or sexual abuse; 80%

of adults in psychiatric hospitals have experienced sexual abuse; 81% of adults have been

diagnosed with Borderline Personality Disorder; 90% diagnosed with Dissociative

Identity Disorder have experienced child abuse; and 66% of adults in substance abuse treatment report child abuse or neglect (ACBHC, 2013).

Treating Trauma though Trauma Informed Care Practices

With trauma being widespread and impactful, trauma informed practices have been recognized as safe and best practices to address childhood trauma; however, literature suggests that health care providers lack training in trauma-informed care practices (CDC, 2016). The National Child Traumatic Stress Network describes trauma informed care as maintaining awareness on the impact traumatic experiences have on children and caregivers that leads to the application of training, practices, and policies (Beyerlein & Bloch, 2014). Trauma informed care acknowledges the role that trauma has played in the lives of foster children, shifting the focus from "what is wrong with you" to "what happened to you?" Trauma-informed care within the child welfare system needs to be improved (Beyerlein & Bloch, 2014).

The Adverse Childhood Experiences (ACEs) Study is one of the largest trauma informed care study of childhood abuse and neglect and later life health and well being. The ACEs Study found that childhood trauma is very common and offered a tool to measure ACEs. ACEs scores can be calculated by adding the number of traumatic events or experiences a person has been exposed to (Stevens, 2014). ACEs can tremendously impact future violence victimization and perpetration, and lifelong health and opportunity--thus proving that childhood trauma and ACEs are an important public health issue (CDC, 2016). The ACEs screening tool is available for use in a variety of settings including health care practices settings for children and families in particular, but also other child-focused settings such as schools and foster care.

Childhood Trauma in Healthcare

Although there have been new developments in the ACEs study that are prompting increased awareness of child trauma, asking about ACEs is not standard of practice (Alarcon, 2015). Many physicians are not implementing ACEs in their practice or asking families about them because they are uncomfortable prying into the personal lives of their patients, lack time or resources to address concerns, or fear the patient may have a mental collapse when questioned (Alarcon, 2015). More training needs to be given to physicians and health practices regarding ACEs to improve services to trauma victims and prevent re-traumatization. Individuals and organizations must understand trauma's impact and consequences before they can attempt to address it. Once trauma can be identified, organizations and individuals must learn how to provide trauma informed care. Therefore, not only does trauma informed care training apply to practitioners and health care providers but to all professionals in the legal, judicial, behavioral health, and social services fields so they can understand how their specific role can improve health care for foster children and prevent retraumatization (Stevens, 2014).

Childhood Trauma and Schools

Furthermore, teachers could also benefit from trauma informed care training to use in classroom settings. For some children, trauma can lead to cognitive distortions that can translate into thoughts like: the world is not safe, I am not good enough, or things will never get better (Holmes et al., 2015). These thoughts and experiences can be a barrier to a child's educational environment and learning. Often times in the absence of specific treatment, the child may develop physical pain (stomach ache or headache) or may display aggressive behaviors such as tantrums, verbal abusiveness, or hitting that

affect not only the child but also teachers and other children in the classroom (Holmes et al., 2015). Children affected by trauma need a safe, caring, and consistent environment, which can be provided through preschool programs such as Head Start (Holmes et al., 2015). Head Start provides early on-site treatment and prevention by creating a trauma informed culture to meet the needs of young children aged 3-5 in a preschool setting. The Head Start program utilizes several different training strategies based on the Attachment, Self Regulation, and Competency (ARC) Model and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

The ARC model is an evidence-informed practice used to treat complex trauma in children and adolescents utilizing three core domains impacted by exposure to chronic interpersonal trauma: attachment, self-regulation, and developmental competencies (Arvidson et al., 2011; Holmes et al., 2015). Within these three domains, the framework is organized around 10 core targets (Figure 1) or building blocks of intervention: caregiver affect management, attunement, consistent response, routines and rituals, affect identification, modulation, affect expression, executive functions, self development, and lastly trauma experience integration (Arvidson et al., 2011). A recent study reported that implementation of the ARC Model was associated with improvement in both child and caregiver functioning including changes in child symptoms included reductions in internalizing, externalizing, post- traumatic stress, depression, anxiety, anger and dissociative symptoms from pre- to post-treatment gains (Hodgon et al., 2016).

Figure 1: ARC Model- 10 Core Targets

Kinniburgh and Blaustein 2004
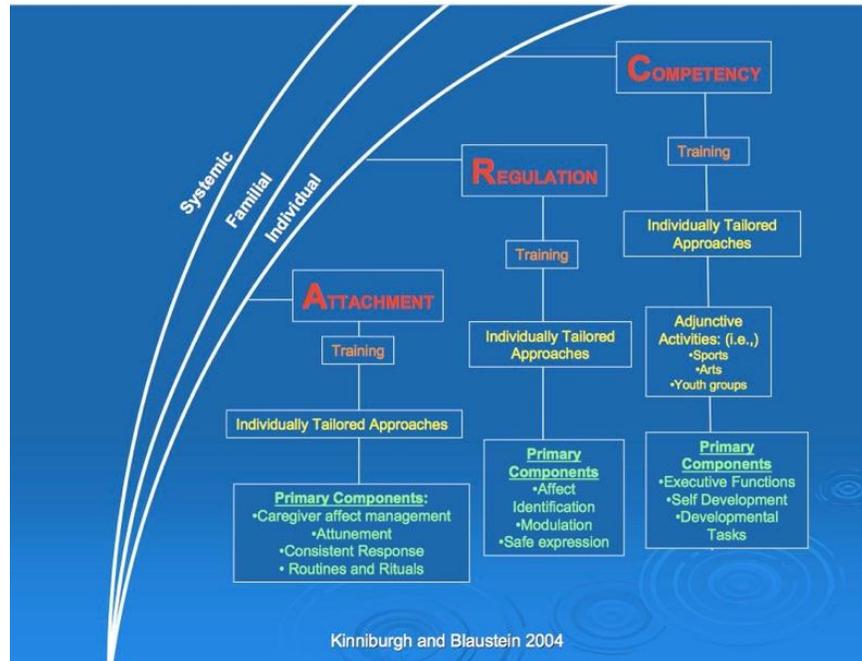
TF-CBT is an evidence- based psychosocial treatment for children identified as the only well established treatment to significantly improve symptoms of post-traumatic stress disorder for children and youth (Holmes et al., 2015). TF-CBT consists of a set of trauma-specific components that include: psycho-education, parenting skills, relaxation skills, affective modulation, cognitive coping, trauma narration and processing, invivo mastery, conjoint parent child sessions, and enhancing safety (Holmes et al., 2015). However, there is a need for more research on TF-CBT implementation with a broad range of children as only two randomized controlled trials of TF-CBT involving pre-school children have been reported and both trials focused specifically on children who had been sexually abused (Holmes et al., 2015).

Childhood Trauma in Foster Children and Resource Families

Although school specific trauma needs are important, resource families are frequently the ones who have the most impact on a child's trauma recovery; however, the lack of trauma informed care training within the child welfare system creates additional

traumatic experiences for children (Beyerlein & Bloch, 2014). Resource families include

foster parents, foster-to-adopt families, and kinship caregivers (U.S. Department of

Health & Human Services, 2017). Resource parents who care for a foster child on a full-

time basis have chances for healthy interactions to promote positive behaviors and

functioning for foster children (Greeno et al., 2016). However, trauma related needs are

significant and resource parents need better trauma informed training to understand

adopted children's needs (Mariscal et al., 2015). Enhancing the quality of foster parent

training to serve foster children could have a profound effect within the child welfare

system if resource parents are provided training that focuses on more than just typical

knowledge of parenting and normative child development (Greeno et al., 2016).

Furthermore, trainings and services should focus on making resources available to

families on trauma exposure, impact, and treatment by engaging families impacted by

and vulnerable to trauma (Beyerlein & Bloch, 2014). If a foster child has severe

behavioral and emotional problems, the foster parent and child may be unable to connect,

causing the caregiver to feel hopelessness and failure (Lieberman, 2003). The NCTSN

urges resource parents to promote resilience in foster children by first understanding

trauma's impact on the children in their care (NCTSN, 2017). Although resource families

receive specialized training, these trainings generally contain little specific information

on trauma and how to provide trauma informed care (Child and Family Services Review,

2017). Resource parents frequently report that child welfare agencies have not provided

enough training, support, and information related to their foster child (Mariscal et al.,

2015; Greeno et al., 2016). Recent qualitative studies suggest foster parents are aware of

and request the need for trauma specific training including specific problematic daily

child behaviors that include ''real life examples and situations that may arise during

foster parenting'' (Greeno et al., 2016).

Project Agency

Agency

The Bill Wilson Center is based in Santa Clara, California. Bill Wilson, Jr. was

one of the founders of the Bill Wilson Center, first known as the Webster Center. In

1973, Bill Wilson, Jr. worked closely with troubled youth in the Santa Clara County

while serving as Santa Clara City Councilman from 1963-1971 and as Mayor in 1965.

Bill worked hard in collaborating on a proposal with Santa Clara University for a

counseling center that would offer a combination of counseling of local students with a

family therapy program. In 1973, Bill's vision became reality when the Webster Center

opened for service. Bill went on to earn his Masters Degree in Counseling Psychology

and volunteered many hours as a counselor at the center. In May 1977, just 4 years after

the Webster Center opened, Bill died at the age of forty-one. As a tribute to Bill, the

Webster Center's name was changed to Bill Wilson Center (BWC). Bill's son, Alex

Wilson, presently serves as a board member at the center

BWC has several different office locations in Santa Clara, The location for my

internship, 1671 Alameda, offers several services including where the Medi-Cal office

clinicians offer therapy, Family and children services, transition services, SOS and SES

with probation use, and Foster Family Agency. Presently, BWC serves more than 5,100

children, youth, young adults, and families in Santa Clara County and reaches more than

32,000 clients through their Street Outreach and crisis line programs per year. The

mission is to support and strengthen the community by serving youth and family through

counseling, housing, education, and advocacy. Originally when BWC began, limited

programs were offered, however since then, the BWC has drastically improved the

programs being offered. Programs offered at the BWC include: adoption, center for living

with dying, treating victims of child abuse, contact cares (help hotline), crisis residential

center, critical incident stress management, drop-in center, family and individual

counseling, family advocacy services, foster care services, healing heart, juvenile justice

diversion services, LGBTQ outreach, maternity group home, mental health services,

parent-child interaction therapy, parenting classes, Peacock Commons (supported

housing), Quetzal House (group home for girls,) safe place (a place children can go if

they feel unsafe, identified by a large yellow and black Safe Place sign,) school outreach

counseling, SOS crisis hotline, transition age youth mental health services, transitional

housing placement program, volunteer case aide program, and youth and family mental

health services. With the in depth programs offered at the BWC, BWC aims to prevent

poverty in the next generation by connecting youth and families to education,

employment, housing and positive relationships and to end youth and family

homelessness by 2020.

      The BWC is a nonprofit organization primarily funded through government

contracts, and public and private funds. BWC 2014-2015 income included: Medi-

Cal/Mental health funding (33%), State and local (32%), federation contracts (25%), In-

Kind (3%), Contributors (2%), fees for services (2%), foundations and corporations (2%),

special events (1%), and other private funds (1%) (Annual Report, 2015). Those who

choose to donate can do so by mail, phone or online, by joining the annual holiday giving

program, shopping online at select retailers such as amazon, appreciated stock, used

vehicles, or through a will or other estate planning methods. Throughout the year, the BWC holds several fund raising events.

The BWC is staffed with several professionals from various categories including residential counselors, program managers, peer mentors, housing specialists, training managers, facility managers, transitional housing program directors, and several more. Professionals are a vital part of the BWC and the success of the BWC relies on their employees.

Problem and Gap Analysis

Methods

Questions/Aims

The director at BWC wanted parents to have a behavioral health trauma informed care manual so that parents could refer to the manual during difficult times or to be self sufficient in looking for answers to their questions. The trauma informed care manual would be a helpful tool to resource families when severe behaviors occur with their foster children and also help the resource family understand that some behaviors are the result of trauma. However, it was unclear if a manual will be the best training method for resource families at this time. The needs assessment conducted for this project aimed to identify gaps in the existing trauma informed care trainings resource parents at the BWC receive. Specifically, the needs assessment identified topic areas resource parents need to have knowledge about, in order to improve the care they provide their foster children. The project also aimed to make recommendations on trauma informed care tools and resources that could be provided directly to resource families utilizing a mobile application platform.

Data collection tools

The data collection methods used for the needs assessment was in person interviews and phone interviews with resource parents using a questionnaire to guide the interview flow. BWC staff reported that sometimes families have trouble completing any paperwork that is given to them on a timely manner; the families often need several reminders to complete and return paperwork. BWC staff reported that the only way they have completed paperwork in the past is when a staff members is present and asks the foster parent to complete the form. Some foster parents live in different county's and are far to visit while other foster families have a busy lifestyle and unable to meet in person. A phone interview option was therefore made available to these families.

The questionnaire form for the phone interview and in person interview are presented in Appendix A; it was developed based on research from literature reviews and contributions and review from BWC staff case managers who work directly with the foster families. The questions covered where resource parents are getting trauma informed care training, if they found those trainings helpful or not, what behavioral challenges resource parents are seeing most with the foster child(ren) in their care, and what behavioral challenges resource parents want more training on.

Case Manager group interviews were conducted on Tuesdays during scheduled staff meetings with case managers and Behavioral Health Director. Additionally, case managers reviewed and contributed to the development of resource parent interview questions through a shared online document.

Sampling and Design

Resource family participants were interested volunteers and formed a convenience sample. All resource parents must meet the BWC, minimum basic requirements to become a resource parent including: be over the age of 25, pass a criminal background check, have a regular source of income to support your own monthly expenses, have at least one available bedroom, have a car, valid insurance, and clean DMV record, home must pass a state required Home Safety Check, and must supervise foster child when they care not in school or supervised activities. Additionally, resource parents must have fostered at least one foster child to be considered eligible. BWC staff case managers sent an e-mail to each resource parent informing them of my (intern) role and to be expecting an email from me regarding a trauma informed care training interview. Each resource family was then sent an e-mail explaining my role, the purpose of the interview, and that participation would not affect them as resource families. Resource parents were also asked to sign up for a time convenient for them to complete the interview by selecting up to two time slots and then to choose an in person interview or phone interview.

All participants were resource parents and only one resource parent was required to participate in the study regardless of how many foster children they have in their care. For parents who signed up for phone interviews, consent forms were emailed to each family and requested for them to sign, date, and return the consent form prior to their phone interview.

Case managers were invited to participate during team meetings when trauma informed care training challenges were being discussed. Additionally, case managers

reviewed the interview questionnaire prepared for one on one interviews with resource

families and made suggestions for points to be addressed in the questionnaire.

Data Collection Procedures

The time period for data collection was from April 11 until May 16, 2017. Data

from resource parents was collected every Tuesday with either in person interviews or

phone interviews. However, to accommodate the needs for resource families and their

busy schedules, schedules for data collection were extended to Mondays, Tuesdays, and

Saturdays during the morning and evening. Each interview lasted approximately 15-20

minutes and was conducted by the behavioral health intern. The behavioral health intern

has been with the BWC since January 2017 and has received motivational interview

training, reviewed the BWC trauma informed care training, and reviewed each foster

child's report prepared by the case manager to familiarize herself with the foster family.

Informed consent, presented in Appendix B, was administered in person and via

e-mail. For families who signed up for in person interviews, the behavioral health intern

reviewed the consent form with the foster family prior to interview and welcomed

questions regarding consent. For foster families who signed up for phone interviews, the

behavioral health intern sent a copy of the consent form to each family prior to the

interview, reviewed the consent form with the foster family on the phone, welcomed any

questions regarding consent, and lastly asked the foster parent to sign the form and return

it through e-mail.

Case managers were interviewed across several staff meetings at the BWC. Staff

meetings consisted of discussing challenging cases, behaviors, and trainings. Interview

questions for one on one interview with resource parents were created after an extensive review of literature and recommendations from case managers.

Data Analysis Procedures

The behavioral health intern took extensive, handwritten notes during the interviews. After each interview, the behavioral health intern reviewed the notes, added any additional thoughts, and summarized the notes in each interview. After completing all interviews, the responses were summarized across the interviews by thematic area.

Strengths, Limitations, and Challenges to Data Collection

There were a handful of foster families who signed up for interview times however did not respond to the follow-up e-mail to go over the consent form. Additionally, some parents who signed up for in person interviews cancelled the interview due to last minute changes in their schedule. Some parents have a busy and specific schedule, which did not match the available time slots for interviews. Additionally, due to the interview addressing sensitive topics specific to foster children, parents could only complete the interview in a quiet and private space. Some parents were not able to coordinate a time and arrange for supervision that was away from the foster child. Participation was voluntary and no incentive was provided to complete the interview however some foster parents recognized this opportunity to improve current training methods for trauma informed care and wanted their interview to be conducted.

Findings: Findings from the interviews with case managers and resource parents are summarized and presented by theme.

Demographics of Participating Families: Approximately forty percent of resource families (11 out of 27) responded to the initial invite to participate. Of the 11 responses, 4

declined to participate due to schedule conflicts and 2 did not meet the eligibility

requirement of study participants due to being new to foster care and never fostering or

caring for a foster child. Data was collected from the remaining five participants. Of the

five participants, three identified as female and two identified as male. All respondents

were resource parents who have fostered at least one child and two who have adopted at

least one child. One participant has been a resource parent for at least one year, one for at

least two years, two for at least 3 years, and one for at least seven years. Four of the five

participants self-identified as Caucasian and all participants identified English as their

primary language.

Characteristics of Case Managers: Four Case Managers were part of the Foster

Care/Adoption services. Case Managers all identified as female and were about 30-40

years of age. All the Case Managers have at least a Masters degree or are a Licensed

Clinical Social Worker (LCSW). All Case Managers have previously completed other

social work employment? or have been employed by another organization in social work

prior to employment at the BWC. Three out of the four Case Managers had been working

at BWC for over a year and one Case Manager has been employed at the BWC for about

nine months.

Resource Parents Have Good Relationships With The Foster Child(ren)

Case Managers stated that ensuring the resource parents have a good relationship

with the foster children in their care is their top priority. Case managers reported they

take sensitive measures when considering what foster child to place with specific

resource parents. Once the foster child has been placed with a resource parent, case

managers regularly check in with both the foster child and resource parent to be certain

the transition is going smoothly. Case Managers recognize that foster children tend to have more behaviors when they are placed with a resource parents keeping in mind the foster child may have just been removed from dangerous or traumatic situations and away from their family.   Resource parents described their relationship with their past or present foster children as "excellent" and "good" but that they all have encountered some trouble with understanding challenging behaviors while fostering. One new resource parent described the relationship as being "past the honeymoon phase" describing challenging behaviors surfacing just after the first month of fostering their foster child.

All participants reported having some form of TIC training. Four of the five resource parent participants received TIC training from BWC and all of those participants also received TIC training from an additional source (such as the Family and Community Engagement in Addressing Childhood Trauma Webinar, online research, City of Santa Clara in-person training, and one received TIC training from a College (West Valley College, in person lecture). None of the participants reported receiving additional or refresher trainings, although four participants stated they would like a refresher TIC course.

Resource family participants were asked to share their opinions about any of the trauma informed care trainings they received in the past year (Table 2, Where Are Resource Parents Getting TIC Training?). All participants reported the only training they received was when they first became a resource parent, which was more than a year ago; participants were asked to share their opinion on the last trauma informed care training they received instead. Participants reported positive feedback including "I learned a lot," "liked group discussion," and "founds videos helpful." Participants also included ways to

improve TIC training by "making BWC trainings more specific than general" by further

"breaking down complex behaviors," and by "providing tools, books, or visuals to refer

to during training."

Table 2. Where Are Resource Parents Getting TIC Training?

Resource Parent	Organization that provided TIC training	Was the TIC training Useful at these organizations?	Time (years) since last training	Interest in refresher course

1	BWC
	
	Work
		"TIC training through work was most helpful—the training is called - Family and Community Engagement in Addressing Childhood Trauma Webinar"
		
		Topics covered in this webinar include:
		•Why family engagement is important to responding to toxic stress
		    -trauma and toxic stress
		    -Childhood trauma
		
		•How to build partnerships
		    -parents and caregivers
		        •five protective factors: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need and social and emotional competence of children
		
		•How to engage parents and the impact of parent leaderships
			2 years ago	Yes

2	BWC	"I worked at BWC for 15 years… but the way we did trauma informed care training back then was different and maybe more effective"	"nothing since I've become a foster parent 3 years ago"	No "I worked at BWC for several years and many times delivered TIC trainings"
3	BWC City of Santa Clara Adult Education	"I did not find the BWC training useful… it mainly covered parenting styles" "The City of Santa Clara training was most useful to me… it was taught by a PhD."	6 years ago	Yes "Was told refresher courses are not required (at BWC)"
4	West Valley College		2 years ago	Yes "I haven't taken any refresher courses, I was told there weren't any

|					
					at BWC but I would like to"
5	BWC Online Research			2 years ago	Yes "Would be good if I could get refreshed"

Resource Parents Want To Learn More

Resource parents rated their knowledge on trauma informed care before becoming a resource parent on a scale of 0-10, zero having no knowledge or training on trauma informed care and ten having extensive knowledge or training on trauma informed care. One participant's data was not accounted for due to this participant previously being employed at BWC where the participant received extensive years of trauma informed care trainings and was responsible for delivering trauma informed care trainings as part of the job requirement. On average, participants rated their knowledge at 4 before becoming a resource parent and 7.5 after being certified as a resource parent.

Participants reported seeing several challenging behaviors in their care including avoidance (avoid engaging or partaking in family activities such as vacations) , numbing, attachment issues, attention/concentration issues (in school, ADHD, PTSD), impulsivity, oppositional behaviors (defiance, self injurious behaviors, aggression, physical harm to others including kicking, hitting, and biting), depression (anxiety, low self esteem or self worth, and suicidal ideation), lying, and cultural related behaviors (cultural competency/sensitivity). Participants believed that all the challenging behaviors observed and experienced in their care are a result or reaction of trauma. Figure 3 presents these behaviors, along with the behaviors for which resource parent's desire additional training. Resource parents identified in person trainings to be the preferred method for training due

to their learning styles being "visual" and "auditory", and utilizing "videos or demonstrations", however, there were several barriers to in person trainings. Resource parents had a busy schedule that made it difficult for them to attend trainings and coordinating a time that was convenient for a majority of resource families and BWC staff was challenging. Furthermore resource parents and the BWC case managers reported, it was "challenging to choose a central location" resource parents could commute to for training due to resource families being located in several different districts. Resource parents reported they needed a training method that was "easily accessible" and "convenient" while utilizing their learning styles.

Figure 3. Behaviors Participants Observed and Want More Training On
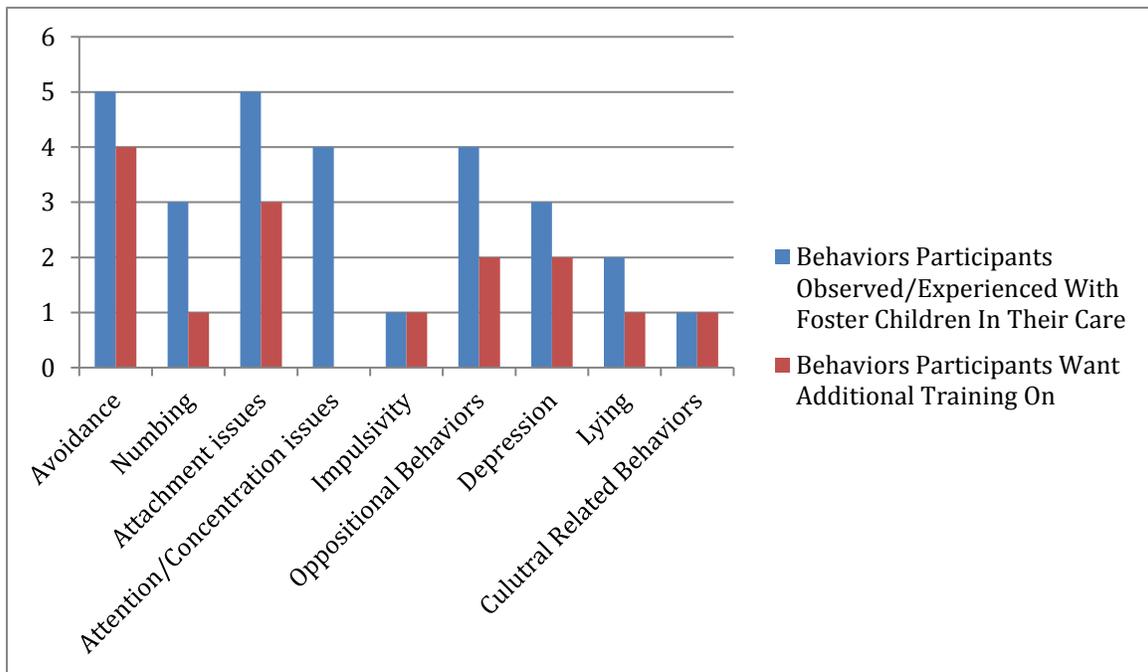
Discussion

Based on the literature review, trauma related needs are significant and adoptive parents need better training to understand adopted or fostered children's needs. Although

resource families receive specialized training, these trainings generally contain little specific information on trauma and how to provide trauma informed care. After assessing the training and needs of the Bill Wilson Center (BWC) resource parent population, it is clear that they, too, face similar struggles. The challenges observed through primary data collection align with those identified in the literature. Resource parents work around the clock while supervising for their child(ren). Resource parents need a training that is convenient and easily accessible to them due to challenges in scheduling and commute. As a result, the BWC chose to use these findings to create additional resources on trauma informed care for resource families through recommendations for mobile application trauma informed care training.

Research on evidence-based trauma informed care mobile applications was used to determine gaps in the current but limited mobile applications literature that is available to address trauma needs; identified mobile applications are presented in Appendix C. Recommendations for a mobile application were created to offer specific trauma informed care training to all resource parents, called FosterTIC, presented in Figure 2.

Figure 2- FosterTIC

If developed, the app should include a variety of demonstration videos on trauma related behaviors and reactions including: effective communication and problem solving, building trust through active listening and open communication, understanding and responding to problem behaviors, goal setting activities and resources, interactive online games for practicing problem solving skills, social-emotional control, and stress reduction. Suggestions from past and current resource families including parenting tips and personal success stories should also be included in the app. Implementing this project will provide researchers with more findings on how trauma informed care can support resource parents to better address behavioral issues of their foster children, which should yield higher engagement and increase retention of foster youth in their care, possibly leading to permanent adoption.

Limitations

There are a number of limitations within which findings from this project should be considered. First, results were collected through in person interviews and phone interviews with volunteer resource parents and case managers. These data do not represent a longitudinal view; they serve only as a point-in-time view of the issues described by a convenience sample of respondents.

Second, the study used a small sample of participants from a single setting and state. Although this sample included rural and urban participants and provided in-depth and rich responses, findings may not be generalizable to all resource families serving a different setting or state outside of California. The cultural and social contexts of this research may vary depending on the local traditions, geographic location, and populations. Racial and ethnic groups are underrepresented due to participation in the

interview surveys being voluntary. Further data collection and analyses with resource

parents from other settings and states would be beneficial.

Third, participation in the interview surveys was voluntary and no compensation

was offered to participants who volunteered; however, all resource families are required

to take trauma informed care trainings. Therefore, improving trauma informed care

trainings is in the best interest for the resource families in managing and caring for their

foster child(ren) and trauma related behaviors.

Fourth, trauma informed care is a relatively new approach for increased attention

and there is limited data available on best practices or rigorous research. Additionally,

there is limited information from evidence-based research on trauma informed care

mobile applications. Furthermore, evidence based research on trauma informed care

mobile applications designed specifically for resource parents, as a resource in supporting

the foster children in their care was unavailable.

Implications for Practice

Programs that have benefited resource families include the trauma informed care

training during certification, regular case manager check-ins, and support groups.

However, a number of programs could be altered to be more effective including the

trauma informed care trainings. Recently, the BWC trauma informed care training was

altered to meet Pressley-Ridge standards. This was done in order to have a higher number

of potential resource families during certification trainings at one time and to have more

rigorous trauma informed care training. However, there is still room for improvement in

the trauma informed care training and resources provided to resource parents; therefore,

this project focused on developing and making recommendations for that follow up.

Annual performance appraisals are administered to the resource families by the BWC through a survey. Surveys are voluntary and collected by the BWC staff once completed. However, it is unclear whether data from the annual performance appraisal surveys are being analyzed or utilized, although it is being collected and therefore this provides an opportunity for future data analysis.

Resource parents who care for a foster child on a full-time basis have chances for healthy interactions to promote positive behaviors and functioning for foster children (Greeno et al., 2016). However, trauma related needs are significant and resource parents need better trauma informed care training to understand foster children's needs and behaviors as a result of those needs. Resource parents have expressed a need for additional specific trauma informed care training. Enhancing the quality of foster parent training to serve foster children could have a profound effect within the child welfare system if resource parents are given training that focuses on more than just typical knowledge of parenting and normative child development (Greeno et al., 2016). These are growing needs that the BWC is well-situated to address; to take the lead on better addressing, and through innovative approaches such as a mobile phone application addressing specific trauma informed care training.

Suggestions for Future Research

Aside from the efforts that some institutions have already undertaken, researchers need to continue to address ways to offer resources and trainings on trauma informed care to resource families. Studies suggest that mobile applications have been highly successful for veterans and victims of posttraumatic stress, and findings of a qualitative feasibility study described participants as very satisfied with the app and perceived it as moderately

to very helpful with their PTSD symptoms (Miner et al., 2016; Kuhn et al., 2017; Arean

et al., 2017). Despite the success mobile applications have had with managing PTSD,

there has been limited development of mobile applications for foster care and for

resource parents to help the foster children in their care manage their traumatic

symptoms. More rigorous data collection with resource parents should be done, and

experimental tests of trainings to learn how to best help children and resource parents

utilize mobile applications to manage traumatic symptoms is recommended.

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Appendix A – Resource Family Questionnaire

1. Can you please describe the quality of your relationship with your foster child? (prompt: Would you say you get along all the time; do you often have trouble understanding the behaviors of the foster child in your care?)

2. Can you please tell me about the trainings you received around trauma informed care? (Prompt: what organization provided them; were they focused on foster kids; what topics were covered?)

3. What are your opinions about the trauma informed care training you received in the past year? (Prompt: does it cover the topics you were interested in; was it the right length; did you find the facilitators knowledgeable)

4. Has the training you received on trauma informed care enhanced your existing knowledge on trauma informed care?
(Prompt: From a scale of 1-10, how much did you know about trauma informed care before any training you received from the organization? (Prompt: From a scale of 1-10, how much has the trainings on trauma informed care enhanced your knowledge on trauma?

5. What are some of the challenging behaviors you have seen with the child(ren) in your care?
(prompt)
   o Avoidance
   o Numbing
   o Arousal
   o Attachment issues
   o Attention/concentration issues
   o Impulsivity
   o Oppositional behaviors

6. Which of these challenging behaviors do you think are the reactions of trauma?

7. Do you feel that you need more training in handling traumatic behaviors experienced in your care? If so, which ones?

8. How many days of the week do you use your trauma informed care training for handling traumatic behaviors experienced in your care? (Prompt: 0-7 days).

9. What are some of the behaviors you would like additional training or information on?
(Prompt)
   o Avoidance
   o Numbing

- o Arousal
- o Attachment issues
- o Attention/concentration issues
- o Impulsivity
- o Oppositional behaviors

10. What is your preferred method of training?
    (Prompt)
    - o Online, self-guided
    - o In person, lecture format
    - o Self-guided, hard copy of materials
    - o In person, classroom/workshop (instructor)
    - o Conference format

Appendix B- Informed Consent For Resource Families

This Informed Consent Form is for Resource Families (formerly known as Foster Parents) who want to participate in research on Trauma Informed Care Training.

Introduction
Hello, my name is Jessie Bola and I am a Behavioral Health Intern at the Bill Wilson Center.
I want to talk with you for 15-20 minutes regarding trauma informed care training or any behavioral challenges you may have experienced or are experiencing with any foster children in your care.
There are no right or wrong answers to my questions. I'm only interested in your opinion regarding any of the trauma informed care trainings you have received, and behavioral challenges you have experienced. I want to know what you think can be improved in trainings. You do not have to answer any questions you don't want to answer and you can ask for clarification on any questions you do not understand. We can stop this interview at any time.

Confidentiality
Any information you tell us will be anonymous- this means that you will not be asked to give us your name on any documents. Instead, you will be assigned an identification number. The information you give me during the interview will have a number on it instead of your name. No personal information will be released that can be traced back to you. Any reports from this research will never mention any participant by name.

Voluntary Participation
Your participation in the interview is entirely voluntary. It is your choice whether to participate or not. Whether you choose to participate or not, all the services you receive at the Bill Wilson Center will continue and nothing will change. You may change your mind later and stop participating even if you agreed earlier.

Certificate of Consent
I have read the information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate in the interview.

Print Name of Participant_____

Signature of Participant _____

Date _____
            Day/month/year

Print Name of person taking the consent_____

Signature of person taking the consent_____

Date _____
            Day/month/year

Participant Identification Number: _ _ _ _

Appendix C – Research on Mobile Applications for Foster Care/Training

App Name/ Research	APP features	Reference
An App the Foster Parent System Really Needs: What an Agile Rapid Prototyping Exercise Taught Us	• Foster parents, biological parents, and caseworkers need a dedicated app that streamlines communication about a particular child • The fact that some communication is urgent must be supported by the app. • Share placement information • information can be shared with case workers, county social workers, foster parents, bio parents	https://medium.theuxblog.com/an-app-the-foster-parent-system-really-needs-what-an-agile-rapid-prototyping-exercise-taught-us-1c3948762e80 https://chronicleofsocialchange.org/featured/foster-care-theres-an-app-for-that
Focus On Foster Families (website AND app)	FOCUS on Foster Families is designed to support foster youth and their caregivers. Through candid video interviews and online tools, FOCUS on Foster Families helps users improve their skills related to communication, emotional regulation, problem solving, and goal setting. FOCUS On Foster Families brings FOCUS Family Resilience Training skills to families where they live, work and play. FOCUS is a program that teaches families to use five related skills to build on strengths and overcome challenges. These skills are problem-solving, goal setting, communication, emotional regulation and managing trauma and stress reminders.	http://nfrc.ucla.edu/focus- on-foster-families
Foster Garden	interactive web based application designed to allow foster parents · to more easily communicate the needs of foster children with social workers and the court system · provide a mechanism, accessible from nearly anywhere, to upload, record and access important information about current and past foster placements. This could range from accessing an important mental health document while working with a school or documenting a complex behavior in real time · provides forums to discuss issues to get or give advice regarding behaviors that foster and adoptive parents are currently facing. Often no one can understand what you are going through like another foster parent · articles that will help you navigate the system, obtain	https://www.fostergarden.com

	resources · Access to the knowledge base and other foster parents in your community and around the world to inform, share past experiences and provide support · Information uploaded and downloaded to Fostergarden.com is all encrypted using industry standard technologies which better protect personal identifiable information and PHI (protected health information). The current norm is insecure email, text message, fax or verbal all which pose a variety of risks and problems.	
Know before you go App (B4UGO)	For older foster youth current and foster youth in LA. With a quick tap on your phone, you can be virtually linked to a lifeline of resources, tools, supports and advocates who know where and how to help you. Key Features: • GPS-based mapping of services near you no matter where you are in the county. This includes transitional housing, shelters, food banks, schools, jobs and more. You can find a location via your GPS or by inputting your location. • Links to helpful resources and organizations that offer programs for transition-age foster youth in Los Angeles County. • Optional sign-up for alerts and notifications when a new program opens up, special offers for foster youth, deadlines for school, dates for job fairs and other helpful tips. • Connect with us on Facebook, Twitter and Instagram, and our YouTube channel in development. • WiFi capable, so you can use it at a WiFi hotspot even if your data/voice plan is not on. • Available for both iPhone and Android phones.	https://play.google.com/store/apps/details?id=com.app_kidsalliance.layout&hl=en
Youth Matters Philly App	This app is designed to help Philly youth find and access local resources, like shelters, housing, foodbanks, healthcare providers, and more. Key features: • Search for resources and services.	https://chronicleofsocialchange.org/research-news/philadelphia-app-links-youth-resources-services/27072

	- See a map of local resources or switch to a list view. - Get important info on each resource, like hours, contact information, and location. - Get directions to any resource from your current location. - Text a resource to yourself or someone else. - Rate resources and services you've used.	And https://chronicleofsocialchange.org/research-news/philadelphia-app-links-youth-resources-services/27072
PTSD Coach	designed and user tested with veterans. The results were very successful. Data indicated that participants were very satisfied with PTSD Coach and perceived it as being moderately to very helpful with their PTSD symptoms. Analysis of focus group data resulted in several categories of app use: to manage acute distress and PTSD symptoms, at scheduled times, and to help with sleep. - would it be helpful if this was tailored to resource parents who then could help their foster children with PTSD.	Kuhn, E., Greene, C., Hoffman, J., Nguyen, T., Wald, L., Schmidt, J., & ... Ruzek, J. (2014). Preliminary Evaluation of PTSD Coach, a Smartphone App for Post-Traumatic Stress Symptoms. *Military Medicine*, *179*(1), 12-18. doi:10.7205/MILMED-D-13-0027