

5-2018

Trauma-Informed Care: Training and Implementation in the Foster Care System

Danielle Norgren

St. Catherine University, foot9492@stthomas.edu

Recommended Citation

Norgren, Danielle. (2018). Trauma-Informed Care: Training and Implementation in the Foster Care System. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/msw_papers/823

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact amshaw@stkate.edu.

Trauma-Informed Care: Training and Implementation in the Foster Care System

By

Danielle Norgren, B.S.

MSW Clinical Research Paper

Presented to the faculty of

the School of Social work

St. Catherine University and the University of St. Thomas

St. Paul, Minnesota

Master of Social Work

Committee Members

Rajean Moone, Ph.D. (Chair)

Lisa Borneman, MSW, LICSW

Sarah Breyette, MSW, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University – University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the University Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a master's thesis nor a dissertation

Abstract

In 2015, there were 14,680 children in out of home care, which was a 9% increase from 2014 (Minnesota Department of Human Services, 2016). All of the youth in the foster care system have experienced an Adverse Childhood Experience (Garcia et al., 2017), which makes them vulnerable to mental health illnesses and many different medical conditions. If a youth presents with behavioral issues and/or mental health illnesses, the common forms of interventions that they receive are medications and psychotherapy. Trauma-informed care (TIC) has been proven to be a beneficial approach when working with the youth in the foster care system. There is a gap in the literature on how much education the professionals in this system receive about TIC. Therefore, this study seeks to explore the education that social workers in the foster care system have received on TIC and how they implement it in their work with clients. This study used a qualitative research method to explore the research question: To what extent are social workers in the foster care system taught trauma-informed care and how do they implement it in their work with clients? Data was collected using semi-structured interviews and the data was coded and analyzed, which resulted in multiple themes and subthemes being discovered. The findings of this study support the need to implement TIC into social work curriculums and mandatory trainings for all professionals in the foster care system.

TABLE OF CONTENTS

INTRODUCTION	4
LITERATURE REVIEW	6
DEFINITION AND PREVALENCE OF TRAUMA	6
FOSTER CARE TRAUMA	7
THE EFFECTS OF TRAUMA ON YOUTH	10
TRAUMA-INFORMED CARE.....	12
SOCIAL WORKER’S EDUCATION OF TRAUMA-INFORMED CARE	14
CONCEPTUAL FRAMEWORK.....	16
METHODS.....	17
DESIGN/METHODOLOGY	17
SAMPLING	17
Convince and Snowball Sampling.....	17
PROTECTION OF HUMAN SUBJECTS	18
DATA COLLECTION INSTRUMENT AND PROCESS	19
DATA ANALYSIS PLAN	20
STRENGTHS AND LIMITATIONS	20
RESULTS.....	22
DESCRIPTION OF PARTICIPANTS.....	22
FINDINGS.....	23
Trauma-Informed Care as a Lens	23
Trauma Impacts All Facets of the Foster Care System.....	23
<i>The Impact of Trauma on the Brain.....</i>	<i>24</i>
<i>Trauma from Foster Care.....</i>	<i>24</i>
<i>The Social Worker’s Trauma.....</i>	<i>25</i>
Educating and Relationship Building is Critical to Trauma-Informed Care.....	26
<i>Educating the Clients and Foster Families</i>	<i>26</i>
<i>Focusing on The Relationship</i>	<i>26</i>
Mixed Access to Trauma-Informed Care Training	28
<i>Education Received in School.....</i>	<i>28</i>
<i>Education After Graduation</i>	<i>29</i>
<i>The Frequency of Training</i>	<i>30</i>
<i>Needs from Training</i>	<i>30</i>
Trauma-Informed Care Existed Before It Was Given A Name.....	31
DISCUSSION.....	33
SUMMARY OF RESEARCH.....	33
IMPLICATIONS FOR POLICY, PRACTICE AND RESEARCH	35
LIMITATIONS	37
REFERENCES	39
APPENDIX A.....	47
APPENDIX B.....	51

Introduction

In 2015, there were 14,680 children in out of home care, which was a 9% increase from 2014 (Minnesota Department of Human Services, 2016). It is important for providers to learn the best practices in which to work with their clients due to the growing number of youth in the foster care system. Understanding the issues that youth will face during their time in the system is imperative for these best practices to work. When best practices are misunderstood it can lead to detrimental impacts on the youth, such as misdiagnoses and ineffective treatment modalities.

There has been research into the rise of psychotropic medication in the foster care system throughout the last 20 years. Research has proven time and again that youth in the foster care system are more likely to be prescribed psychotropic medications than their peers who are not in out-of-home placements (Rubin, Matone, Huang, dosReis, Fuedtner, & Localio, 2014). The trauma that they experienced prior to entering the system and during their time within it can lead to behavioral, social, and emotional problems, which can present as negative behaviors (Narendorf, Bertram, & McMillen, 2011). These behaviors, if misunderstood, can lead to incorrect diagnoses, which in turn can result in unnecessary medications (Narendorf, Bertram, & McMillen, 2011). Using a trauma-informed approach when working with these youths can help providers better understand why they are acting the way they are, and it can help youth heal from their traumatic experiences.

Trauma-informed care (TIC) allows the professional to look past the presenting behaviors to understand where they are stemming from. The youth's traumas are analyzed along with the symptoms to gain a more in-depth understanding. It is important that the correct treatment modalities are used with the clients in order for treatment to be successful. Though modalities such as Cognitive Behavioral Therapy are very effective, if a Trauma-focused Cognitive

Behavioral Therapy is used, then it can focus on the root of the issue. TIC is also applied to the professionals who work with clients who experience trauma.

Though TIC is taught to social work students and professionals, it is unclear as to how in-depth these courses are and if they feel competent to practice this modality afterwards. Due to the important nature of TIC in a social worker's work, there should also be continued education into this subject. There are no concrete numbers or research into how often social workers attend TIC seminars or classes. The lack of research surrounding the coursework related to TIC in social work curriculums highlights the need for a study that will help the social work community better understand social workers levels of competence surrounding TIC.

To address this gap, the researcher investigated the following research question: To what extent are social workers in the foster care system taught trauma-informed care and how do they implement it in their work with clients?

Literature Review

This literature review outlines the definition of trauma and its prevalence in our society. It will also cover the trauma that youth in foster care generally face and how it impacts them. Trauma-informed care (TIC) will be described along with its application in a clinical setting. For the purpose of the study, the ways in which TIC is taught to social workers will be highlighted.

Definition and Prevalence of Trauma

Trauma has been in existence since humans first evolved. However, the impact trauma has on people was not entered into text until 1980, when it was first introduced in the American Psychological Association's third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). According to the DSM-5, trauma is "exposure to actual or threatened death, serious injury, or sexual violence if a person directly experienced it, witnessed it, learned of it occurring to a close family member or friend, or experiencing it repeatedly" (American Psychological Association, 2013, p. 143). There has been discussion in the field as to whether this definition fails to cover all the types of events that can be considered traumatic. Others believe that an event is considered traumatic if it is extremely upsetting, at least "temporarily overwhelms the individual's internal resources, and produces lasting psychological symptoms" (Briere & Scott, 2015, p. 9).

The DSM-III introduced trauma in the definition of Post-Traumatic Stress Disorder (PTSD) (American Psychological Association, 1980). Since its introduction into Psychological text, the definition and criteria to be diagnosed with PTSD has changed. Per the DSM-IV, in order to be given a PTSD diagnosis, a person must have experienced a traumatic stressor (American Psychological Association, 2013). After the stressor occurs, a person who has PTSD

will re-experience the event with either “intrusive thoughts, nightmares, flashbacks, emotional distress after exposure to traumatic reminders, or physical reactivity after exposure to traumatic reminders” (American Psychological Association, 2013, p. 143). A person will also gain negative thoughts or feelings after the trauma. For example, they may begin to feel isolated, forget key parts of the trauma and/or experience difficulty showing a positive affect. Behaviors or negative characteristics will arise, such as irritability, difficulty sleeping, hypervigilance, or a heightened startle arousal (American Psychological Association, 2013). With treatment, individuals who are diagnosed with PTSD have been successful in their recovery.

Although rates of full PTSD diagnoses are rare for children and adolescents, they are not exempt from experiencing trauma. Up to one-quarter of youth (ages 9-16) experience one potentially traumatizing event in their lives (Costello, Erkanli, Fairbank, & Angold, 2002). If there is mental illness present in the home, youth chances of exposure to a traumatic event can double (Costello et al., 2002). There are other factors that have led children to be vulnerable to exposure, including if a family member has a criminal record or if they live in poverty (Costello et al., 2002). Over half (61.8%) of adolescents ages 13-17 experience a potentially traumatic event in their lifetime (McLaughlin et al., 2013). Children who experience a traumatic event can present with posttraumatic stress symptoms, higher rates of psychopathology and some additional impairments (Copeland, Keeler, Angold, & Costello, 2007)

Foster Care Trauma

One-half to three-fourths of youth entering the foster care system exhibit behavioral and/or social competence issues (Marinkovic & Backovic, 2007). Up to 80 percent of youth with an active child welfare case have behavioral or emotional disorders, developmental delays, and

other health or mental health problems (Bellamy, Gopalan, and Traube, 2010). Many of those youth have been impacted by trauma, which may explain why that percentage is so high. The types of trauma these youths experience prior to entering the system include: sexual and physical abuse, neglect, parental mental illness, parent suicide and/or attempts, and unstable or unsafe living arrangements, which can be correlated with parental substance abuse (Marinkovic & Backovic, 2007). The experience of a parent being sent to prison may be as traumatic for a child as experiencing rape (Giaconia et al., 1995). As of 2015, eight percent of youth in the foster care system were placed there because of parental incarceration (US Department of Health and Human Services, 2016).

If we are to consider the trauma that youth in the foster care system face, it is important that we also focus on what happens to them in the system. While in the foster care system, youth deal with the loss of their families, they are isolated from their familiar surroundings, and must adjust to new families and living situations (Marinkovic & Backovic, 2007). While youth are in the foster care system they can experience physical and/or sexual abuse, neglect, separation from siblings or family, being forced to take unnecessary medications, and experiencing disrupted placements or adoptions (Riebschleger, Day, & Damashek, 2015). Unfortunately, many of the traumas that lead youth to be placed in the foster care system are perpetuated while they are in the system. Not only is there a possibility for these youths to become retraumatized, they are also vulnerable to different types of trauma, such as living instability.

Youth that have multiple placements throughout their time in the foster care system are thought to be in a state of constant loss (Geenan & Powers, 2007). The types of placements that youth are placed in can change the number of placements they experience (Hyde & Krammer, 2008). The two primary types of out-of-home placements are foster homes and congregate care.

Foster homes include traditional foster homes and kinship care whereas congregate care includes residential, treatment, and group homes (Hyde & Krammer, 2008). Youth who present with mental health needs tend to be placed in congregate care (Chow et al., 2014). Since 13% of youth in the foster care system were placed in congregate care during 2015 (US Department of Health and Human Services, 2016), it is important that its effects on youth are analyzed. Youth that are placed in congregate care are more likely to face multiple placements than those in foster homes (Hyde & Krammer, 2008). Youth in out-of-home care rather than kinship care, tend to have more detrimental mental health concerns (Shearin, 2007). On the other hand, if a youth's mental health concerns are not addressed, it may lead them to having multiple placements or lower rates of reunification with their families (Kerns et al., 2016). The trauma of moving from one home to the next generally begins when youth enter the system for the first time.

Youth in the foster care system have been affected by some form of trauma. If these traumas are not addressed, it can greatly affect the youth's adult life. Some youth who age-out of foster care become homeless or suffer from housing insecurities (Reibschlager, Day, & Damashek, 2015). If the trauma is untreated, there are higher rates of mental health problems that will continue into adulthood for youth in foster care (Dorsey et al., 2012). Research surrounding adverse childhood experiences (ACE's) has shown that early exposure to significant stressors can impact children's mental health into their adolescents and adulthood (Rebbe et al., 2017). Some examples of the impacts that ACE's have been shown to have are: risk of pulmonary and autoimmune disease, increased risk of anxiety and mood disorders, poor self-rated health, and increased use of tobacco, alcohol and illicit drugs (Mersky, Topitzes, & Reynolds, 2013). All the youth who enter the foster care system have been exposed to some form of ACE's (Garcia et al., 2017), so it they are all vulnerable to their negative impacts. Whether that trauma occurs prior to

their entry into the system or during, the use of TIC has been proven to significantly help both youth and the providers.

The Effects of Trauma on Youth

Trauma can manifest itself in a multitude of ways. The impacts range from psycho-emotional impacts to physical impacts. One of the more severe psycho-emotional impacts is Post-Traumatic Stress Disorder (PTSD). Though a full diagnosis of PTSD is rare (Copeland et al., 2007), youth can develop health and mental health issues from toxic stress (Byers, 2016). Toxic stress comes from prolonged and substantial stress, which activates the body's regulatory systems (Byers, 2016). Toxic stress is one example of the physical impacts trauma can have on the body. Not only can trauma recalibrate the brain's alarm system, it can also "increase the stress hormone activity and alter the system that filters relevant information from irrelevant" (Van der Kolk, 2014, p. 3).

Most children who enter the foster care system are more likely to present a higher number of behavioral health concerns. If a trial of evidence-based psychosocial treatment is unsuccessful or inaccessible then the American Academy of Child and Adolescent Psychiatry recommends that psychotropic medications be prescribed to the children (Fontanella, Hiance, Phillips, Bridge, & Campo, 2014). Unfortunately, less than half of the children in the foster care system who were prescribed these types of medications from 1997 to 2009 received a mental health assessment, psychotherapy visit, or visit to a psychiatrist (Fontanella et al., 2014). This could imply that there is a lack of follow-through when prescribing medications to this specific group of youth.

In 2001, the top therapy modality for PTSD used by 95 percent of medical practitioners was psychopharmacology (Green, Hawkins, & Hawkins, 2005). Though medications have been helpful, there has been evidence that has shown psychopharmacology on its own is not effective in treating PTSD (Keeshin & Strawn, 2012). Therapeutic modalities such as Cognitive Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and Art Therapy have shown rates of success for children who are diagnosed with PTSD (Racco & Vis, 2015). Even with this evidence, children ages three to four, who are in the foster care system, present with social-emotional behaviors are less likely to be treated with behavioral health services (dosReis, Tai, Goffman, Lynch, Reeves, & Shaw, 2014). They are also less likely to access mental health services than youth who are not in out-of-home placements. Data has shown that youth in the foster care system are 2-3 times more likely to be prescribed psychotropic medications than youth outside of the system (Rubin et al., 2014).

Many children in care receive a psychotropic medication with limited understanding of the impact these medications have on growing children. Anywhere between 13-52% of youth in the foster care system, depending on location, have been prescribed psychotropic medications compared to the 4% of youth outside of it (Tufts Clinical and Transitional Science Institute, 2010). Developmental and health concerns begin to arise when these statistics are coupled with the fact that 5.4% of youth in the foster care system across the country are prescribed a combination of three or more psychotropic medications (Rubin et al., 2014). There have not been many studies done that show what developmental effects these medications have on the young people that take them. Regardless, studies have shown that psychotropic medications can have negative metabolic effects (Rubin et al., 2014). There is also a lack of research into why these

youths are more medicated, but the trauma they face is generally much higher than youth who are not in the foster-care system.

Trauma-Informed Care

Trauma-informed care is a practice in which professionals maintain awareness of the impact of traumatic experiences to children, caregivers, and service providers. Being trauma-informed can entail providing a safe space, free from physical harm or re-traumatization (Wilson & Nochajski, 2015). It also is a collaboration of agencies and clients, and an acknowledgement of violence and the role it plays in a family (Wilson & Nochajski, 2015). It is a culturally appropriate evidence-based assessment and treatment for traumatic stress and mental health symptoms (Beyerlin & Bloch, 2014). An important aspect of TIC in application is to strengthen the resilience and protective factors of children and families impacted by trauma, as well as those vulnerable to it (Beyerlin & Bloch, 2014). Another important aspect of TIC is that it is not focused on symptom management, but rather skill building and education about trauma and its impact (Wilson & Nochajski, 2015). There are five main principles to trauma-informed care: ensuring safety, establishing trustworthiness, maximizing choice, maximizing collaboration, and prioritizing empowerment (Carello & Butler, 2015). The first principle is arguably the most important, because without ensured safety, no learning can truly occur, and without learning, there will be little to no healing.

When using trauma-informed care, providers identify youth's negative behaviors as a product of past traumatic experiences, and they provide support instead of judgement (Murphy, 2014). Understanding that the behaviors youth present may be correlated with their traumatic histories should help providers see youth through a different lens. One in which they no longer

see a diagnosis that needs to be fixed with medication, but with evidenced-based therapeutic treatments. The National Child Traumatic Stress Network (NCTSN) has been around since 2000 with the purpose of improving services in America that work with children who have experienced trauma (SAMHSA, 2011). The trauma that youth experience is so impactful that the Child and Family Services Improvement and Innovation Act of 2011 was passed, and it requires state child welfare agencies to report how they address trauma youth experience in the foster care system (Hanson & Lang, 2016). However, the youth's trauma can also impact those around them.

This type of care considers parent or caregiver trauma and its impact on the family system (Beyerlien & Bloch, 2014). It is important to address the issue of secondary trauma, which can be described as the re-experiencing a client's trauma and an increased arousal or a rapid avoidance of symptoms after an indirect exposure to traumatic event (Sprang, Craig, & Clark, 2011). Secondary trauma is often correlated or interchanged in text with compassion fatigue (Sprang, Craig, & Clark, 2011). This type of trauma is common in those that work with traumatized victims, such as child welfare workers. Therapist tend to have vicarious trauma from the empathetic engagement to their client's trauma material which in turn changes their internal schemas (Jenkins & Baird, 2002). Secondary traumatic stress (STS) also impacts those closest to the victim. Family members may experience emotional duress when learning about and hearing in further detail what the victims experienced (Jenkins & Baird, 2002). Those with STS present with symptoms similar to PTSD, such as arousal, avoidance of reminders to a traumatic event, and re-experiencing the victim's trauma (Figley, 1995).

Social Worker's Education of Trauma-Informed Care

It has been established that utilizing trauma-informed care is important when working with youth in the foster care system. As a result, understanding social workers training in this area is a key element as well. The requirements to become a social worker in the foster care systems of different counties within the state of Minnesota vary. To become a Child Protection Social Worker in Hennepin County, the application states that “the best qualified candidates” will have a bachelor’s degree in either social work or other areas that are closely related to social work (Hennepin County, 2017). The language of the job requirements leaves room for interpretation on whether a degree in social work is required. To qualify as a Child Protection Worker in Ramsey County, an applicant must have at minimum a bachelor’s degree in social/behavioral science field (Ramsey County, 2017). The wording for Ramsey County is clearer on its educational requirements. The requirements to become a foster care social worker in a private agency in MN are less ambiguous. Volunteers of America requires their foster care social workers to have a master’s degree in social work and as well as a LGSW license (Volunteers of America, 2017). Unfortunately, these requirements are not generalizable for all of the private agencies in Minnesota that have foster care services. That being said, studies have shown that caseworkers in both the public and private sectors have similar educational backgrounds, most with bachelor’s degrees (Hollingsworth, Bybee, Johnson, & Swick, 2010).

The information on trauma-informed care education in the curriculum for a bachelor’s degree in social work is non-existent. There is a basic knowledge of TIC for first year MSW students, which may correlate with their knowledge of social work best practices (Wilson & Nochajski, 2016). Research has also shown that after a curriculum was put into place there was a higher sense of self-efficacy surrounding the application of TIC in their work with clients

(Wilson & Nochajski, 2016). Though prior education of TIC may not be necessary for those applying to become a Child Protection worker, Minnesota does require all new hires in every county to participate in a child welfare foundation training within the first six months of their employment (Minnesota Department of Human Services, 2017). Part of this training is a three-day course called, Introduction to Foundation Training. The description for this class does specify that trauma-informed practices will be included in the course content (Minnesota Department of Human Services, 2017). Unfortunately, the extent to which this topic is covered is unclear. Even after an extensive training on TIC and attachment styles, both foster parents and social workers reported they would like further support (Allen & Vostanis, 2005). According to N. Vogel, the head of the Minnesota Department of Human Services- Extended Foster Care unit, all licensed social workers required 40 continuing education units (CEU's) and all non-licensed social workers need 20 CEU's every two years (personal communication, April 6, 2017). The topics of the CEUs that the social workers choose are up to them, so the levels of education surrounding TIC vary from person to person. Due to the lack of existing information, the researcher chose to focus research on the extent that social workers in the foster care system are taught trauma-informed care and how they implement it in their work with clients.

Conceptual Framework

The conceptual framework or lens utilized throughout this research was competency. Competency was chosen due to the nature of the research objective. As stated previously, the objective of this research was to gain a better understanding of the education social workers receive on trauma-informed care and how they implement it in their work. It was important to understand the level of competency because if the subject matter was misunderstood or not comprehended, then it would have been implemented incorrectly. The research should ascertain if the social workers feel competent in applying trauma-informed care (TIC) with their clients, as well.

Further understanding of competency, can lead to “evaluations of the learning settings needed for sustainable development” and the learning approaches that are the most successful (Barth, p. 3, 2009). Gaining a better understanding of the competency of those trained in TIC will help the social work field and those that create the curriculums to adapt or modify their approaches. As for social workers, the NASW Code of Ethics states in 1.04.b that they should use intervention techniques and approaches only after they have received adequate training (National Association of Social Workers, 2017). Without adequate education and training, the social workers may do their clients a disservice when applying TIC. As discussed above in the literature review, TIC has been shown to be very beneficial to youth and their families in the foster care system, so it is important that the professionals who work with them feel competent and confident when applying it in their work.

Methods

Design/Methodology

The research question for this qualitative study was: To what extent are social workers in the foster care system taught trauma-informed care and how do they implement it in their work with clients? In order to answer this question and get a better understanding on this topic the researcher utilized a qualitative approach to interview eight social workers from the foster care system on their experience of education of trauma-informed care as well as how they apply it in their practice with clients.

Sampling

The sample consisted of eight social workers from the foster care system. Inclusion criteria for participation was the ability to speak and understand English, at least two years' experience working directly with clients in the foster care system, and to be at least 25 years of age so they have matured enough to be more "articulate and introspective" to produce more in depth and rich data (Pagdett, 2008).

Convenience and snowball sampling. The participants were recruited using convenience and snowball sampling. Convenience sampling is a form of recruiting participants in which any individuals who are available, willing, and meet the inclusion criteria may be included (Pagdett, 2008). The researcher's network of professionals was used to find the first participant that met the inclusion criteria. In order to recruit more participants, snowball sampling was used as well. The researcher asked the participants interviewed to recommend other social workers that met the inclusion criteria.

Protection of Human Subjects

In order to protect the privacy and confidentiality of the participants, the researcher used a private email and phone number for contacting purposes. The email was accessed on a personal computer, and only the researcher had the password. During the interviewing phase, the researcher removed any identifying information about the participants to ensure further privacy and confidentiality. The researcher used pseudonyms in the results/findings sections of the paper. The audio recordings were destroyed after the research project was completed.

In order to protect the participant's emotional well-being, the research questions were focused on the education the social workers had received as well as how they implemented it in their work. Though the questions were designed in a positive format, discussing trauma could evoke negative memories or past secondary traumas. To respond to this and to prevent more emotional harm, the researcher debriefed with the participants after the interviews, and offered resources of support for Walk-in Counseling Center and Crisis Connection hotline, if necessary.

The researcher applied for approval to the St. Catherine University's Institutional Review Board (IRB). This ensured that the study followed the appropriate guidelines to protect the participants. If the IRB had found that the methodology did not meet their standards, the researcher would have changed the method as necessary. The letter of informed consent the researcher used for the study was based on the template that St. Catherine University provided. The purpose of the letter of informed consent was to explain to the participants the purpose of the study, what they were asked to do, what would happen if they chose not to participate, the risks and benefits of the study, if they would be compensated, and how their privacy would be upheld.

Data Collection Instrument and Process

The researcher began the data collection process by recruiting participants with convenience and snowball sampling. Once the participants had been recruited, the researcher sent them the list of research questions. After the participants received the questions, the interviews were set up in private and quiet locations. At the interviews, the researcher provided a brief explanation of the purpose of the study, reviewed the informed consent form, and reminded the participants that the interview was going to be audio recorded. Once the information had been reviewed, they signed the informed consent form (see Appendix A). The researcher asked the participants the research questions shown in Appendix B. Due to the semi-structured nature of the interview, there were questions that arose pertaining to the research topic that were not on the list of official research questions. The interview was recorded with a digital voice recorder and then transcribed. The researcher transcribed the interviews.

The research questions were designed with a competence conceptual framework surrounding key areas from the literature review that needed further investigation. These areas included: level of education, education received on trauma-informed care (TIC), education about TIC they would have liked to receive, and how they implemented TIC in their work with clients. There were 2 questions for general information pertaining to the professional experience and education levels. The remaining questions were open-ended with the purpose of gaining as much data from the participants as possible. Using the existing research literature, the researcher created the interview questions to answer this study's question. The questions were adapted or modified after they were reviewed by a research committee.

Data Analysis Plan

In order to begin data analysis, the interviews were transcribed. Once the interviews were transcribed, the researcher completed a content analysis on each interview by coding themes that emerge from the data. The content analysis was performed by reading the transcripts a minimum of two times, and coding occurred by identifying similar themes throughout all the interviews in response to the questions. The themes were further analyzed and put into categories.

Strengths and Limitations

For all types of research there are strengths and limitations. One of the strengths of qualitative research is the ability to learn more in depth and personal information from the subjects that are interviewed. The participants have real life experiences that helped provide information on the level of education they had received surrounding TIC and if they felt it had been sufficient enough to guide them in their work with clients. The data collected highlighted if there was a difference in the competence of TIC among different educational backgrounds. Lastly, the participants were able to voice if they had a need for more education about TIC and its application in their work with their clients.

The limitations of this study included a lack of generalizability to the whole population due to a small sample size. The participants were from the twin cities area, which leaves a lack of information from rural social workers. The information provided from interviewing rural social workers could have shown a difference in levels of satisfaction of education and competence when applying TIC in their work with clients. The use of recall/reflection may have been a limitation because opinions are subjective, and memories can shift overtime. However, it was

important for this topic to understand the competence that the social workers felt they had surrounding TIC.

Results

The purpose of this study was to gain a better understanding of how much education social workers in the foster care system receive related to Trauma-Informed Care (TIC) and how they implement TIC in their work with clients. The researcher conducted eight semi-structured interviews in order to delve into the social workers perspectives on this topic. The eight participants all met the study's inclusion requirements of speaking and understanding English, having at least two years of experience in the foster care system, and being 25 years or older.

Description of the Participants

A total of eight participants were interviewed for this study. All but one of the participants had an educational background in social work. The remaining participant had a Bachelor of Arts in Psychology and a Master of Arts in Human Services Administration. Of the seven participants who had an educational background in social work, six of them either had their master's degree, had master level credits to fulfill the requirements to be a supervisor, or they were currently working toward obtaining a master's degree. The remaining participant had a Bachelor of Social Work Degree.

In terms of employment, three of the participants worked for private agencies in Minneapolis, MN, and the other five worked for a county in Minnesota. Two of the participants were Executive Directors in private agencies, two were Supervisors for Extended Foster Care for a county, one was a Mental Health Case Manager that worked with families and youth in the foster care system for a private agency, and the last three were Child Protection workers for a county. There was a significant range of experience among the participants (two to forty plus years).

Findings

Within the data, I found several common codes which were categorized into five themes. In each theme I identified several sub-themes. The identified themes and sub-themes attempted to answer this study's research question. The themes included: Trauma-Informed Care as a Lens, Trauma Impacts All Facets of the Foster Care System, Educating and Relationship Building is Critical to Trauma-Informed Care, Mixed Access to Trauma-Informed Care Training, and Trauma-Informed Care Existed Before It Was Given Its Name.

Trauma-informed care as a lens. When asked what their definition of TIC was, half of the participants thought it meant looking through a lens of "It's not what is wrong with you, but it is what has happened to you". One participant defined TIC as "how one's organization and staff recognize and respond to trauma and being able to recognize the affects it has on our clients and what we can do to work with that to help alleviate that" (Participant 5). A few key aspects that were described were "recognizing trauma on a basic and overall level" (Participant 6) and "Understanding how I present myself when I am with clients in order to plan for interventions or services that would best fit them given their history" (Participant 6). By focusing on the trauma that the clients and their families had faced, and not "blaming" or "shaming" the clients for their behaviors, one participant felt they had a better understanding of their client's needs.

Trauma impacts all facets of the foster care system. A clear theme that was identified during the analysis was understanding the impact of trauma. Within this theme there were three sub-themes, which were: The Impact of Trauma on the Brain and Development, Trauma from Foster Care, and The Social Worker's Trauma.

The impact of trauma on the brain and development. In order to be trauma-informed, it is important to see how trauma “shows up in bodies, in our kid’s bodies, and how it shows up in their actions and their daily lives” (Participant 1). When participant three discussed trauma-informed parenting, she stated:

Looking at what our own triggers are and what is it that gets us going. And then looking in a meaningful way at our own ways of responding to our own triggers and what might trigger us to inflict harm on other people.

While discussing the impact trauma has on people, Participant one brought up the Adverse Childhood Experiences (ACES) study from the 90’s. The participant spoke to the studies research on “what adverse experiences are and what kind of impact it has on people”.

Digging in further she elaborated on the ways:

It can show up in dependency, or it could show up in poverty, it can show up in health challenges and for us mostly with our kids in care it shows up in the decisions they make and how they express themselves (Participant 1)

Along with discussing how trauma can impact our client’s futures, participant one also talked about how early trauma, specifically while the mother is pregnant, impacts development. The environment surrounding the mother while the baby was in utero can not only change the development of the brain, but also the rest of the client’s life.

Trauma from foster care. Not only was the trauma the client experienced prior to their involvement in the foster care system a common focus among the participants, but some also felt that “entering the child welfare system is traumatic in and of itself” (Participant 1). Participant five and seven both stated that “going into a stranger’s home can be traumatic”. Participant seven

elaborated on how not knowing “the people”, “how they are going to treat you”, and “how long you are going to be there” made it traumatic for their clients in terms of foster placements. To minimize the trauma while in the foster care system, some participants said that they “try to prevent [placement] disruptions” and create times to bring the children together because it can be an isolating experience for them (Participant 1). Examples of those times were “teen camps” and “annual overnights at hotels”.

The social worker’s trauma. A handful of participants touched on the ways in which their trauma and experiences played a role in their work with clients. Participant two discussed how in their past work experience they had a “fairly traumatic experience when I met and learned about the abuse my clients had endured”, which resulted in them stating “child protection was always something I avoided”. Similarly, one participant stated:

Us individuals working in the field also experience trauma, because you’re going into a situation that you are not used to, and it can come to you as a total shock. So, when you’re seeing these pictures of kids with bruises and scars it is traumatizing. (Participant 7)

“Understanding that workers feel trauma” was identified as an important part of the work, but “learning how to deal with my trauma while this kid is dealing with their trauma” was an obstacle that participant seven discussed. One participant thought that “Once the worker starts crumbling then the client system starts crumbling as well” (Participant 7), so they felt the social workers trauma should be a focus in the mandatory training that child protection workers receive.

Educating and relationship building is critical to trauma-informed care. Throughout the interviews all the participants acknowledged the role of the social worker in relation to TIC. This theme can be broken down into two sub-themes: Educating the Clients and Foster Families and Focusing on the Relationship.

Educating the clients and foster families. An important responsibility that some of the participants discussed as essential to the social workers role was that of providing education about TIC to their clients and the foster families. One participant from a private agency stated:

We have made a concentrated effort in the agency to provide trauma informed trainings for our applicants in our foster parents as well as our kids in care that are often forgotten about when explaining about what trauma informed care means, about how trauma has impacted them, and how it shows up in their lives today. (Participant 1)

A common thread throughout the interviews with the participants from private agencies was educating foster parents. Participant three discussed how “We [the agency] made it mandatory for all of our parents to get trauma-informed education”. In relation to what they taught the foster parents, participant five said, “really helping them understand what’s behind the behaviors they are seeing in the children and helping them recognize that it is coming from a place of trauma.”

Focusing on the relationship. Building a relationship with the client was discussed by many participants. Participant one described what a client had reported they needed from the social workers, they said, “to just ask me how I am that day, to ask me what my interests are...not solely leading with their [youth in the foster care system] experiences and their history”. Participant six felt it was important to “allow them to be very upset that I’m there and

sometimes they're very angry and I let them know that that is perfectly okay and perfectly normal to be upset" when interviewing the youth and their parents for the first time.

While focusing on the relationship, some participants felt that "giving the client space" was vital. Participant five stated:

I've had situations where youth have gotten upset during a meeting or become agitated by people talking about things... And in that moment, I always offer them and allow them to take a break, we talk, ask people to stop talking and give them some space.

By focusing on the relationship with the client, social workers are able to create a space where their clients can feel "comfortable" and "safe". As stated by participant five, "we don't make them retell their stories, we wait until they're ready and are comfortable and discussing that with who they choose to discuss it with". This helps the social worker "give them [the client] the control back to say what they are wanting and needing for them to feel comfortable in that space" (participant 6).

The participants believed that by "being mindful" and "listening to what the client needs", a social worker could build a better relationship with the client. Participant one found it important to "listen to what our kids want and what they benefit from". Being mindful of "body language" and being aware of that a social worker can be "a very threatening presence" were also mentioned. Relationships are an essential part of a social workers job and by "always being empathetic and compassionate" participant eight felt they could have stronger relationships with their clients.

Mixed access to trauma-informed care training. There were three questions that pertained to TIC training. The first, asked about the training that they had already received. The second, looked into how often a professional in the foster care system should be given a refresher course on TIC. The purpose of the third question was to explore what information the participants did not receive but they felt would have been helpful. After analysis, four sub-themes were found: Education Received in School, Education Received after Graduation, The Frequency of Trainings, and The Needs from Trainings.

Education received in school. When asked about the level of education they had received on TIC, six of the participants said that they had not received any formal training while in school. Four of the participants had graduated ten or more years ago, and one of those participants attributed the absence of TIC training to TIC not being “as prevalent as it is today, so there were no classes that I can recall that were specific to trauma-informed care” (Participant 1). The other two participants had either graduated five years ago or were currently working on obtaining their master’s degree in social work. Both had admitted that they had discussed trauma in some classes, but that “it wasn’t a major discussion”. One participant felt that her lack of education on TIC while in her graduate program was surprising because the participant was a title IV-E student. They felt “it would be a major conversation we would be having. Specifically, as title IV-E I would think would be a great candidate of students who would be discussing that” (participant 5). Participant five thought that there should be discussion into “why aren’t graduate programs discussing it more”.

On the opposite end of the spectrum, two of the participants felt that TIC was “touched” on in “most” or “all” of their classes. Participant six felt that, “it was and continues to be a huge topic”. They also said that no matter the topic, “in every single class we would have discussions

about trauma-informed care and units on specifically that [trauma-informed care]”. Although, later on after inquiring about the training that the researcher had received, the same participant stated:

You know I’ve never done a training specifically on trauma-informed care or class specifically on it. When I said that, I meant that we would talk about it in discussions and in all of our trainings one of the slides they put up is about trauma-informed care. So, it is never specific to trauma-informed care by itself but implementing that no matter what the topic is. (Participant 6)

Education received after graduation. Though six participants felt they had not received any formal training when attending school, five of the participants stated that they had received TIC training from their agencies or from the “CEU’s” they had obtained. The other three participants specified that they had never received any formal training. Two of those participants said that the trainings were offered to them through the county, but it was not required so they had not chosen to pursue it. Participant four stated that, “Unless I seek that [TIC training] out on my own, I could spend the rest of my career at [name of county] not doing anything about it”. Later they expressed that they thought the county should “formalize some type of training and make it mandatory” Both participant two and four also claimed that they thought child protection workers were required to take trainings on TIC. However, when asked if they had received any TIC training when they first started working in child protection, participant seven said they had not. All of the participants that worked in private agencies felt that TIC was “central” to the trainings they had received. One participant explained that in their first year at their agency there was “big push around trauma-informed care”. They did that by “bringing trainers in and discussed it as an agency and practices we could do within our organization to be more trauma-

informed” (Participant 5). Participant three was the executive director of a private agency when it was first introduced. At that time, they believed it was important for the board of directors to “enthusiastically support” TIC trainings, in order for their staff to be trained in it.

The frequency of trainings. When asked how often a professional in the foster care system should be given a refresher course on TIC, participants answered “once a year”, “once or twice a year”, or “once every two years”. Even the participants who had not received any formal TIC training thought “yearly” trainings were important. However, most of the participants expressed that, “it should be an on-going discussion” either “with colleagues”, “in team meetings”, or “in supervision”. At one private agency there was “a woman that’s really been extensively trained in trauma-informed, that does all of our clinical support supervision, that happens almost on a weekly basis” (Participant 3). Outside of work, one participant had personally studied TIC by “reading books and studies”. As participant eight explained, “I think it’s something that as a social worker you continually need to learn about. There is always something new you can learn in regard to trauma-informed care”.

Needs from training. All the participants were asked if there was any information about TIC that would have been helpful to them that they had not received. The participant’s answers included application ideas like “more day to day kind of examples and ideas for ways in which to respond or react to situations” (participant 3), “tangible or little things that I can be doing... that I can say to help or give comfort, or things that I can do for clients when I’m meeting with them to help make the experience easier for them” (participant 6), and “case examples”. Many participants commented on how “the field is constantly evolving and the science behind it” (Participant 1). Due to the fact that “research changes all the time” it is important to “get a reminder of those practices and the reasoning behind them” (Participant 5). Participant seven

expressed that, “there is always new research out there or is being presented that you would never know if you did not receive it once throughout your career in the foster system”.

Trauma-informed care existed before it was given its name. Throughout almost all of the interviews the predominant theme of TIC existing prior to a name being given to it was highlighted. Participant one stated that the private agency they work for “has always done trauma-informed care, there's just now a name to it”. Along the same frame, participant six stated, “you see that it does drive a lot of what the community of social workers are doing, but it doesn't mean they necessarily call it that”. Participant three worked in the field of social work for more than forty years, and when prompted about if they used a similar lens prior to their education of TIC, they explained that it was a, “strengths-based lens” because it was “helping the kid identify ways in which he can take care of himself and do well”. Participant two had also worked for many years in the social work field and felt that “some of what we used to do was on that same therapy continuum”. They also explained that, “things kind of recycle. The pendulum swings back and forth and things kind of get named a different name”. One participant claimed that “social work practice is based off of trauma-informed care”. Participant four was one of the participants who had not received any formal training on TIC, but they stated:

I think in an informal way we are doing trauma-informed care but like I said I don't think it is intentional I think it's just a skill that we have picked up the more we have done this work, is to find out what did the client experience, and does this make sense with the way the client might be behaving, the choices they're making (Participant 4).

Moreover, many of the participants expressed that trauma-informed was a “buzzword”. Due to the frequency that participant eight encountered the trauma-informed lens, they knew that

“had been around it in practice and trainings”. Similarly, participant 6 had heard and talked about it while in graduate school but posed the question of “what does that actually mean?” A participant that worked in a county explained how that particular county “kind of jumps on board” with “whatever the new buzzword is in child protection”. With this in mind, participant one asserted that, “even though it has become a real popular buzzword these days... my hope is that people understand the root of it first and foremost”.

Discussion

The data gathered in this study allowed for a comprehensive answer to the research question: to what extent are social workers in the foster care system taught trauma-informed care (TIC) and how do they implement it in their work with clients? The themes discovered within the findings uncover the ways this research question was answered, as well as support many findings within the literature that already exists. This discussion will consider how the findings relate to the literature around trauma-informed care in the foster care system. It will then consider the implications of these findings upon social practice, policy, and future research as well as identify limitations and strengths of the study.

Summary of Research

The findings from the interviews revealed connections with the existing literature, as well as new information pertaining to social workers experience with TIC training and use in their practice. A main correlation was the level of trauma that the youth face before and during their time in the foster care system. This presented as a theme throughout all of the interviews, which exposes the vast role that trauma plays in all areas of foster care. Not only does trauma impact the youth in the foster care system, but as seen from the findings, it also impacts the families, foster parents, and professionals. The findings aligned with the literature regarding how isolating the foster care system is and how having to adjust to new families and homes is traumatic for the youth (Marinkovic & Backovic, 2007). Disruptive placements were also seen as traumatic in the findings which aligned with the literature.

As for the definition of TIC, both the literature and the findings aligned. Both touched on the importance of viewing the clients' behaviors as a result of the trauma that they had

experienced. The focus for TIC was on education about trauma and its impact on people, rather than symptom management (Wilson & Nochajski, 2015). Educating the clients, their foster families, and their biological families was seen as a clear aspect of the social workers role when applying a trauma-informed lens. Helping the clients and their families understand why they reacted to things the way they did, was a way to remove the blame and shame that generally impacted them. It also allowed their families and their foster parents a different way to view and understand the youth. The belief that the social workers and their agencies should focus on providing a safe space, while being empathetic, mindful, and compassionate was highlighted in the literature and findings. In the literature there were five main principles for TIC, though they were not specifically referenced by the participants, there were similarities in their answers. For example, focusing on the relationship with the client was a prominent responsibility for the worker in the findings, which encompassed four of the principles of establishing trustworthiness, maximizing choice, maximizing collaboration, and prioritizing empowerment (Carello & Butler, 2015). Though the trauma that social workers experience was not sought out by the researcher, it was a sub-theme that arose in the findings and was present in the literature as well. This was an area of education that the participants felt needed more attention.

The education that social workers received was central for the research question. Literature pertaining to a social worker's education in TIC was non-existent, so the results were valuable. Most of the participants felt that they did not receive any education on TIC while in school. Some of the participant's felt that TIC was named after they graduated, so it is logical that they would not have learned about it unless it was mandated by their workplace. In this study, only private agencies had mandated their staff to be trained in TIC. The participants that worked in the counties did not feel that training specific to TIC was mandatory for them, but they

did have the opportunity to attend trainings on TIC. Some felt that other trainings, which were not specific to TIC, highlighted it in relation to the topic of the trainings. An example of this was the Indian Child Welfare Act (ICWA) trainings that two of the county workers attend regularly. They both felt that those trainings focused on how the historical trauma was impacting their clients and it was important to be mindful of when meeting with a client. Making TIC trainings mandatory for all social workers in Minnesota was suggested by multiple participants. However, without any mandated formal training on TIC, most of the participants had a basic understanding of it and felt it was already part of the work that they did. TIC was seen as something that was innate to the work that social workers do and was present prior to a name being given to it.

Implications for Policy, Practice and Research

Along with the literature, the findings highlighted the significance of using a trauma-informed lens while working in the foster care system. The trauma that the clients had faced prior to entering the foster care system as well as the trauma that impacts them while they are in it, is critical to how they interact and react to their environments. Knowing this, it should be mandatory for all professionals that work in the foster care system to be educated about TIC even if they do not work directly with clients. Many of the participants thought that TIC should be an ongoing discussion in supervision and team meetings. If a supervisor is not trained in TIC, then they may not be able to discuss how trauma is impacting the worker and their clients. With a significant amount of research that displays the benefits of using a trauma-informed lens, there should be a discussion about changing the educational requirements for social workers, so it can be implemented into social work curriculums.

Additionally, a few of the participants talked about the Title IV-E stipend program. The purpose of this program is to support the delivery of public child welfare services to children in foster care and special needs children waiting for adoption (Minnesota Department of Human Services, 2010). If a person is a public employee or seeking future employment for a public child welfare agency they have the possibility of being given a stipend to help pay for their education. This program is for students seeking their bachelor's or master's in social work. One participant of this study was in the Title IV-E program at the University of Minnesota and they felt that they did not receive any education on TIC. If this federal program's main focus is to educate child welfare workers so they can provide quality services to those in the foster care system, then it would be important for these programs to also educate their students on TIC. There is a significant amount of literature that supports the necessity of TIC in the foster care system and how it benefits the youth and their families who are involved in it, so programs like the Title IV-E should consider changing its policy to make it mandatory to add it into their curriculums.

Moreover, as part of those mandatory trainings, a discussion about the responsibilities of a social worker when using a trauma-informed approach in their practice should take place. As seen from the findings, the participants thought that social workers should focus on the relationship with their clients. Social workers can do this by being mindful and compassionate, creating and providing a comfortable and safe space, and listening to their client's needs. The social worker should also focus on educating clients and families. It would be beneficial for trainings to include what information is useful for clients and their families and ways to discuss it with them. Another piece that should be covered in the trainings and refresher courses are examples of cases and day-to-day situations where TIC has been used. The participants thought

that these would be helpful for them in order to better understand how to apply a trauma-informed lens in their work with clients.

Lastly, there should be a continuation of research on how TIC is taught to social workers and how agencies that work in the foster care system implement it into their practice. Further research can be done on TIC in the curriculums of both bachelor and master social work programs in Minnesota. This research could provide further information about whether curriculums need to change to add TIC along with the new research that is being discovered on the topic. Research can also be done on TIC in training programs for all state, county, and private agency social workers who work in the foster care system. Information that can be gathered is how often they receive these trainings and the material that is being taught. This research could lead to areas in which policy and practice may need to be changed in order to best serve the youth, their families, and foster parents in the foster care system.

Limitations

There were some important limitations to this study that must be considered. One limitation to this study was the small number of participants. Because this study only had eight participants, it did not allow for a full picture or saturation of the data collected. And so, it is important to note that regardless of the data found from this study, more will need to be done in future research around this topic to gain a fuller understanding of the education social workers receive on TIC and how they implement it into their work.

Another limitation of the study is that it only sheds light on one county in Minnesota and two private agencies in Minneapolis. The data cannot be generalized to all of Minnesota counties and private agencies. A more comprehensive study should be done for social workers that work

in the foster care system in Minnesota to gain a more accurate representation of the education that they receive on this topic. Going forward, it will be valuable for social workers to seek out trainings about TIC in order for them to be competent in best practices.

References

- Allen, J., & Vostanis, P. (2005). The impact of abuse and trauma on the developing child: An evaluation of a training programme for foster careers and supervising social workers. *Adoption & Fostering*, 29. doi: 10.1177/030857590502900308
- American Psychological Association. (2013). *Desk reference to the diagnostic criteria from DSM-5(TM)*. Arlington, VA: American Psychiatric Publishing Inc.
- Bellamy, J.L., Gopalan, G., & Traube, D.E. (2010). A national study of the impact of outpatient mental health services for children in longterm foster care. *Clinical Child Psychology and Psychiatry* 15(4), 467–479. DOI: 10.1177/1359104510377720
- Beyerlein, B. A., & Bloch, E. (2014). Need for trauma-informed care within the foster care system: A policy issue. *Child Welfare*, 93(3), 7-21.
- Briere, J. N., & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, CA: SAGE.
- Byers, K.D. (2016). Buffering the effects of toxic stress in early childhood: Screening for the prevention of childhood social-emotional disorders and family system disruption. Retrieved from: ProQuest Digital Dissertations (10100971)
- Carello, J., & Butler, L.D. (2015). Practicing what we teach: Trauma-informed educational practice. *Journal of Teaching in Social Work*, 35. Retrieved from: <http://dx.doi.10.1080/08841233.2015.1030059>

- Chow, W.Y., Mettrick, J.E., Stephan, S.H., & Von Waldner, C.A. (2014). Youth in group home care: Youth characteristics and predictors of later functioning. *Journal of Behavioral Health Services & Research, 41*(4). doi: 10.1007/s11414-012-9282-2
- Copeland, W.E., Keeler, G., Angold, A., & Costello, J. (2007). Traumatic events and posttraumatic stress in childhood. *Arch Gen Psychiatry, 64*, 577-584.
doi:10.1001/archpsyc.64.5.577
- Costello, E.J., Erkanli, A., Fairbank, J. A., & Angold, A. (2002). The prevalence of potentially traumatic events in childhood and adolescence. *Journal of Traumatic Stress, 15*(2), 99-112. DOI 10.1023/A:1014851823163
- dosReis S., Tai, M.H., Goffman, D., Lynch, S.E., Reeves, G., & Shaw, T. (2014). Age-related trends in psychotropic medication use among very young children in foster care. *Psychiatric Services, 65*(12). doi: 10.1176/appi.ps.201300353
- Dorsey, S., Kerns, S.E., Trupin, E.W., Conover, K. L., & Berliner, L. (2012). Child welfare caseworkers as service brokers for youth in foster care: Findings from project focus. *Child Maltreatment, 17*(1), 22-31. DOI: 10.1177/1077559511429593
- Figley, C.R. (1995). *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel.
- Fontanella, C.A., Hiance, D.L., Phillips, G.S., Bridge, J.A., & Campo, J.V. (2014). Trends in psychotropic medication use for medicaid-enrolled preschool children. *Journal of Children and Family Studies, 23*. DOI: 10.1007/s10826-013-9761-y

- Garcia, A.R., Gupta, M., Greerson, J.K.P., Thompson, A., & DeNard, C. (2017). Adverse childhood experiences among youth reported to child welfare: Results from the national survey of child & adolescent wellbeing. *Child Abuse & Neglect, 70*, 292-302. Retrieved from: <https://doi.org/10.1016/j.chiabu.2017.06.019>
- Geenen, S., & Powers, L.E. (2007). "Tomorrow is another problem": The experiences of youth in foster care during their transition into adulthood. *Children and Youth Services Review, 29*(8). Retrieved from: <https://doi.org/10.1016/j.childyouth.2007.04.008>
- Giaconia, R.M., Reinherz, H.Z., Silverman, A.B., Pakiz, B., Frost, A.K., & Cohen, E. (1995). Traumas and posttraumatic stress disorder in a community population of older adolescents. *Journal of American Academic Child & Adolescent Psychiatry, 34*(10). 1369-1380. <https://doi.org/10.1097/00004583-199510000-00023>
- Green, D. L., Hawkins, W., & Hawkins, M. (2005). Medication of children and youth in foster care. *Journal of Social Work in Disability & Rehabilitation, 4*. Retrieved from: http://dx.doi.org/10.1300/J198v04n01_03
- Hanson, R.F., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child Maltreatment, 21*(2). doi: 10.1177/1077559516635274
- Hennepin County. (2017). *Social Worker, Child Protection*. Retrieved from: <https://www.governmentjobs.com/careers/hennepin/jobs/1467884/social-worker-child-protection>

- Hollingsworth, L.D., Bybee, D., Johnson, E.I., & Swick D.C. (2010). A Comparison of caseworker characteristics in public and private foster care agencies. *Children & Youth Services Review, 32*. 578-584. DOI: 10.1016/j.childyouth.2009.12.004
- Hyde, J., & Krammerer, N. (2009). Adolescents' perspectives on placement moves and congregate settings: Complex and cumulative instabilities in out-of-home care. *Children and Youth Services Review, 31*(2). Retrieved from: <https://doi.org/10.1016/j.childyouth.2008.07.019>
- Jenkins, S.R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress, 15*(5). 423-432. DOI: 10.1023/A:1020193526843.
- Kenny, M.C., Vazquez, A., Long, H., & Thompson, D. (2016). Implementation and program evaluation of trauma-informed care training across state child advocacy centers: An exploratory study. *Children and Youth Services Review, 73*. doi: 10.1016/j.childyouth.2016.11.030
- Keeshin, B. R., & Strawn, J. R. (2012). Treatment of children and adolescents with posttraumatic stress disorder (PTSD): A review of current evidence. *Child and Adolescent Psychopharmacology News, 17*(2), 5–10. doi: 10.1521/capn.2012.17.2.5
- Marinkoivc, J.A., & Backovic D. (2007). Relationship between type of placement and competencies and problem behavior of adolescents in long-term foster care. *Children and Youth Services Review, 29*(2). Retrieved from: <https://doi.org/10.1016/j.childyouth.2006.08.004>

- McLaughlin, K.A., Koenen, K.C., Hill, E.D., Petukhova, M., Sampson, N.A., Zaslavsky, A.M., & Kessler, R.C. (2013). Trauma exposure and posttraumatic stress disorder in a national sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 52*(8), 815-830. Retrieved from: <https://doi.org/10.1016/j.jaac.2013.05.011>
- Mersky, J. P., Topitzes, J., & Reynolds, A. J. (2013). Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: A cohort study of an urban, minority sample in the U.S. *Child Abuse & Neglect, 37*(11), 917–925. doi: 10.1016/j.chiabu.2013.07.011
- Minnesota Department of Human Services. (May 2016). Foster care: Temporary out-of-home care for children. Retrieved from: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4760-ENG>
- Minnesota Department of Human Services. (October 2017). Child protection, foster care, adoption: Training. Retrieved from: <https://mn.gov/dhs/partners-and-providers/training-conferences/child-protection-foster-care-adoption/>
- Murphy, N. (2014). *Nine evidence-based, guiding principles to help youth overcome homelessness*. Developed by the Homeless Youth Collaborative on Developmental Evaluation.
- Narendorf, S.C., Bertram, J., & McMillen, J.C. (2011). Diagnosis and medication overload? A nurse review of the psychiatric histories of older youth in treatment foster care. *Child Welfare, 90*(3), 27-43.

Padgett, D.K. (2008). *Qualitative methods in social work research*. Thousand Oaks, CA: Sage Publications.

Racco, A., & Vis, J. (2015). Evidence based trauma treatment for children and youth. *Child and Adolescent Social Work Journal*, 32, 121-129. doi:10.1007/s10560-014-0347-3

Ramsey County. (2017). *Child Protection Worker*. Retrieved from:

<https://www.governmentjobs.com/careers/Ramsey/jobs/1859534/child-protection-worker>

Rebbe, R., Nurius, P.S., Ahrens, K.R., & Courtney, M.E. (2017). Adverse childhood experiences among youth aging out of foster care: A latent class analysis. *Children and Youth Services Review*, 74, 108-116. Retrieved from:

<https://doi.org/10.1016/j.chilyouth.2017.02.004>

Reibschleger, J., Day, A., Damashek, A. (2015). Foster care youth share stories of trauma before, during, and after placement: Youth voices for building trauma-informed systems of care. *Journal of Aggression, Maltreatment, & Trauma*, 24(4). Retrieved from:

<http://dx.doi.org/10.1080/10926771.2015.1009603>

Rubin, D., Matone, M., Huang, Y.S., dosReis, S., Feudtner, C., & Localio, R. (2012). Interstate variation in trends of psychotropic medication use among Medicaid-enrolled children in foster care. *Children and Youth Services Review*, 34(8). Retrieved from:

<https://doi.org/10.1016/j.chilyouth.2012.04.006>

Shearin, S.A. (2007) Kinship care placement and children's academic performance. *Journal of Health & Social Policy*, 22(3/4). Retrieved from:

http://dx.doi.org/10.1300/J045v22n03_03

Sprang, G., Craig, C., Clark, J. (2011). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare, 90*(6), 149-168.

Substance Abuse and Mental Health Services Administration. (2011). Leading change: A plan for SAMHSA's roles and actions 2011-2014. HHS publication No. (SMA) 11-4629. Rockville, MD: Author.

Tufts Clinical and Transitional Science Institute. (2010, September). *Multi-state study on psychotropic medication oversight in foster care*. Retrieved from:
https://www.tuftsmedicalcenter.org/-/media/Brochures/TuftsMC/Research%20Clinical%20Trials/Institute%20for%20Clinical%20Research%20and%20Health%20Policy%20Studies/Executive%20Summary%20090710_138.ashx

US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2016). The AFCARS report (No. 23). Retrieved from:
<https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport23.pdf>

Wilson, B., & Nochajski, T.H. (2016). Evaluating the impact of trauma-informed care (TIC) perspective in social work curriculum. *Social Work Education, 35*(5). Retrieved from:
<http://dx.doi.org/10.1080/02615479.2016.1164840>

Van Der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY: Penguin Books.

Volunteers of America. (2017). *Foster Care Social Worker*. Retrieved from:

https://rew21.ultipro.com/VOL1008/JobBoard/JobDetails.aspx?__ID=*88F301F4B00D0

FEB

Appendix A

ST CATHERINE UNIVERSITY Informed Consent for a Research Study

Study Title: Trauma-informed care: Training and Implementation in the Foster Care System

Researcher(s): Danielle Norgren, MSW Clinical Social Work student at St Catherine University and the University of St. Thomas.

You are invited to participate in a research study. This study is called trauma-informed care: training and implementation in the foster care system. The study is being done by Danielle Norgren, a Master's Student at St. Catherine University in St. Paul, MN. The faculty advisor for this study is Rajean P. Moone, PHD, Graduate School of Social Work at St. Catherine University.

The purpose of this study is to better understand how trauma-informed care is being taught to social workers and child welfare workers in Minnesota and how they implement it in their work. This study is important because Studies have shown that youth in the foster care system are vulnerable to trauma, which has impacted their physical and mental health. You in the foster care system are on average prescribed more psychotropic medications than their counterparts in the community. When using a trauma-informed care lens, the behaviors children present can be understood in different ways, as to prevent them from being misdiagnosed. It is important for social workers and child welfare workers to understand how a youth's environment and the professionals they interact with impacts them while they are in the foster care system. Approximately eight to ten people are expected to participate in this research. Below, you will find answers to the most commonly asked questions about participating in a research study. Please read this entire document and ask questions you have before you agree to be in the study.

Why have I been asked to be in this study?

You were selected as a possible participant because of your experience as a foster care social worker or child welfare worker. You are eligible to participate in this study because you have more than two years' experience in this field, you have the ability to speak and understand English, and you are over the age of 25.

If I decide to participate, what will I be asked to do?

If you meet the criteria and agree to be in this study, you will be asked to do these things:

- Schedule an interview with the research on a date and time of your choosing.
- Review the interview questions prior to the scheduled interview.
- Participate in a 45 to 60-minute audio recorded interview, in a location of your choosing.

In total, this study will take approximately 75 minutes over one session.

What if I decide I don't want to be in this study?

Participation in this study is completely voluntary. If you decide you do not want to participate in this study, please feel free to say so, and do not sign this form. If you decide to participate in this study, but later change your mind and want to withdraw, simply notify me and you will be removed immediately. You may withdraw until April 1st, 2018, after which time withdrawal will no longer be possible. Your decision of whether or not to participate will have no negative or positive impact on your relationship with St. Catherine University, nor with any of the students or faculty involved in the research.

What are the risks (dangers or harms) to me if I am in this study?

There are no foreseeable risks from participating in this study.

What are the benefits (good things) that may happen if I am in this study?

The social workers who participate in this study will have an opportunity to learn more about the field that they work in and gain more insight on how they use trauma-informed care in their work with clients.

Will I receive any compensation for participating in this study?

You will not be compensated for participating in this study.

What will you do with the information you get from me and how will you protect my privacy?

The information that you provide in this study will be kept confidential. I will not include information that will make it possible to identify you. The types of records I will create include a signed consent form, an audio tape of the interview, and a transcription of the interview. I will transcribe the interview. All of the participants identifying information will be removed during transcription. I will keep the research results on the researcher's private computer and only I and the research advisor will have access to the records while I work on this project. I will finish analyzing the data by June 30th, 2018. I will then destroy all original reports and identifying information that can be linked back to you.

Any information that you provide will be kept confidential, which means that you will not be identified or identifiable in the any written reports or publications. If it becomes useful to disclose any of your information, I will seek your permission and tell you the persons or agencies to whom the information will be furnished, the nature of the information to be furnished, and the purpose of the disclosure; you will have the right to grant or deny permission for this to happen. If you do not grant permission, the information will remain confidential and will not be released.

Are there possible changes to the study once it gets started?

If during the course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings

How can I get more information?

If you have any questions, you can ask them before you sign this form. You can also feel free to contact me at foot9492@stthomas.edu. If you have any additional questions later and would like to talk to the faculty advisor, please contact Dr. Rajean P. Moone at rpmoone@stkates.edu. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:

I consent to participate in the study and agree to be audiotaped.

My signature indicates that I have read this information and my questions have been answered. I also know that even after signing this form, I may withdraw from the study by informing the researcher(s).

Signature of Participant

Date

Signature of Parent, Legal Guardian, or Witness

Date

(if applicable, otherwise delete this line)

Signature of Researcher

Date

Appendix B

Interview Questions

1. What is your educational background?
2. Describe your current and previous practice environments?
3. Describe the education you have received surrounding trauma-informed care?
4. How do you define “trauma informed care”?
5. To what extent do you implement trauma-informed care into your work with clients?
6. Can you give me examples of times when you used trauma-informed care in your work with clients?
7. How has your education of trauma informed care and its application been useful to your work?
8. What information about trauma-informed care would have been helpful to you that you didn't receive during your trainings?
9. In your opinion, how often should a professional working in the foster care system be given a refresher course on trauma-informed care and its application with youth in the foster care system?
10. What are other things that you think would be necessary to my research?
11. Do you have any questions?