Children and Youth Services Review 91 (2018) 30–38

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Implementation of Trauma Systems Therapy-Foster Care in child welfare

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A B S T R A C T

Trauma exposure is pervasive among children living in foster care, and yet most resource parents (foster parents and kinship caregivers), child welfare staff, and others in the child welfare system are not adequately prepared to recognize and respond effectively when children exhibit trauma symptoms. Trauma-systems Therapy-Foster Care (TST-FC) is a systemwide model of trauma-informed care focused on meeting the emotional needs of children in foster care who have experienced traumatic events. This study evaluated the implementation of TST-FC in two state child welfare agencies that included training for staff (n = 123) and resource parents (n = 111). Study findings show training participants had positive perceptions of TST-FC and found it useful. TST-FC also was associated with significant increases in trauma-informed parenting and tolerance of children's misbehavior by resource parents, as well as more trauma-informed policies and practices in the child welfare agencies. Training participants reported that TST-FC provided useful tools and a common language about trauma that enhanced their capacity to collaborate with one another and manage children's difficult behavior. An exploratory study of resource home retention and children's placement stability revealed fewer foster home closures and placement disruptions when resource parents were trained in TST-FC compared to homes not trained in the model. The results of this study suggest that TST-FC is a promising model for increasing the capacity of child welfare agencies to provide trauma-informed care to children and families in the foster care system.

1. Introduction

Child abuse and neglect is a serious and pervasive public health problem, with approximately 3.4 million children in the United States reported to child protective services (CPS) in 2015 alone (U.S. Department of Health and Human Services, 2017). Child victims often suffer severe and long-lasting adverse effects of maltreatment, including impairments in brain functioning (Bruce, Fisher, Pears, & Levine, 2009; Gunnar & Vazquez, 2001; Shonkoff et al., 2012), alterations to gene expression (Mehta et al., 2013; Yang et al., 2013), problems with physical growth and development (Johnson & Gunnar, 2011; Roeber, Tober, Bolt, & Pollak, 2012), difficulty forming attachments (Cyr, Euser, Bakermans-Kranenburg, & van Ijzendoorn, 2010), chronic health problems (Brown et al., 2010; Gooding, Milliren, Austin, Sheridan, & McLaughlin, 2016; Widom, Czaja, Bentley, & Johnson, 2012; Widom, Horan, & Brzustowicz, 2015), and mental health conditions, such as posttraumatic stress disorder (PTSD) (Kearney, Wechsler, Kaur, & Lemos-Miller, 2010; Kolko, 2010; McLaughlin et al., 2013). However, child welfare staff and resource parents (foster parents and kinship caregivers) often receive little professional preparation to help them understand and address the impact of trauma when caring for these children.

For children in foster care, the negative effects of maltreatment are often exacerbated by family disruption and placement in multiple resource parent homes, leading to additional traumatic experiences of separation and loss that further jeopardize children's mental health and well-being (Goldsmith, Oppenheim, & Wanlass, 2004; Kisiel, Fehrenbach, Small, & Lyons, 2009). For example, children who experience unstable placements in addition to abuse and neglect are twice as likely to develop behavior problems compared to children who achieve stability in foster care soon after placement (Rubin, O'Reilly, Luan, & Localio, 2007). They also have high rates of PTSD. Kolko (2010) found that 19% of maltreated children placed in foster care had symptoms of PTSD compared to 11% of children who remained at home. Another study by Pecora et al. (2005) determined that 30% of foster care alumni met the clinical criteria for PTSD compared to < 8% of the general population.

Posttraumatic stress and associated behavior problems among children in foster care often lead to placement instability in the first placement, as foster and kinship caregivers struggle to care for these children (Chamberlain et al., 2003). Research suggests that approximately 20% of placement changes in foster care are related to children's behavior problems (Kolko, 2010), and the longer traumatic stress reactions remain unaddressed, the more likely children are to exhibit

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https://doi.org/10.1016/j.childyouth.2018.05.021
Received 8 February 2018; Received in revised form 17 May 2018; Accepted 17 May 2018
Available online 19 May 2018
0190-7409/

psychological distress and continue to experience placement disruptions (Cook et al., 2005; Rubin et al., 2007). Thus, it is essential that resource parents (foster parents and kinship caregivers), child welfare staff, and others in the child welfare system who are responsible for the well-being of maltreated children are knowledgeable about child trauma and prepared to offer trauma-informed care (TIC; Child Welfare Information Gateway, 2015).

2. Trauma-informed child welfare systems

Given that children involved in the child welfare system are at higher risk for exposure to traumatic events than are children in any other service system (Ko et al., 2008), it is not surprising that there is increasing consensus in the field that, to meet the needs of abused and neglected children, child welfare systems must develop and maintain a cadre of professionals and resource parents who have the skills and knowledge to work together to identify and respond to child trauma. This requires the adults in children's lives to help children learn to self-regulate their emotions and behaviors, to provide stable placements in which children can recover from traumatic events, and to find permanent homes for children as soon as possible (Chadwick Trauma-Informed Systems Project, 2013; Child Welfare Information Gateway, 2015; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). According to the National Child Traumatic Stress Network (n.d.):

> A trauma-informed child and family service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive.

Unfortunately, to date the training and professional development efforts needed to support a trauma-informed system have not yet been widely disseminated or evaluated (Annie E. Casey Foundation, 2016).

2.1. Trauma training in child welfare

Providing trauma training for resource parents, child welfare staff, and other system stakeholders is a key strategy for developing and implementing a trauma-informed child welfare system (Chadwick Trauma-Informed Systems Project, 2013). Children's difficulties with self-regulation and forming healthy relationships, coupled with extensive psychological needs, can be challenging for even the most experienced resource parents and professionals. A shift in beliefs about the causes of problem behaviors in children who experience maltreatment is an important first step. When adults view children or themselves as culpable for these negative behaviors, children's stress reactions may worsen, increasing the risk for placement disruption (Barth et al., 2007; Rubin et al., 2007). On the other hand, when adults understand the effects of trauma on children, learn to manage difficult behaviors, and gain skills for responding effectively, the quality of care can improve and out-of-home placements are more likely to remain intact (Agosti, Conradi, Halladay Goldman, & Langan, 2013; Hartnett, Falconnier, Leathers, & Testa, 1999; Henry, Sloane, & Black-Pond, 2007). Keeping resource parents engaged and supported throughout training also has been shown to contribute to placement stability and the retention of resource homes. Given the critical shortage of resource homes and high rates of resource parent turnover in the U.S. (Casey Family Programs, 2014)— attrition rates have been estimated to range from 30% to 50%, with most resource homes closing within a year of a first placement (Gibbs & Wildfire, 2007)—promoting resource parents' capacity to care for children who have been exposed to trauma is also essential to supporting a viable foster care system.

Several promising training initiatives for resource parents and child welfare staff have emerged in recent years, derived from evidence-based and evidence-informed trauma treatment models (Agosti et al., 2013; Bartlett et al., 2016; Bartlett et al., 2018; Lang, Campbell, Shanley, Crusto, & Connell, 2016; Murphy, Moore, Redd, & Malm, 2017; Redd, Malm, Moore, Murphy, & Beltz, 2017; Sullivan, Murray, & Ake III, 2016). Still, additional research is needed to understand effective implementation (Fraser et al., 2014) and to identify the particular attributes of trauma training models that support successful child welfare outcomes and are primary drivers of positive change (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). The current study evaluates the implementation of Trauma Systems Therapy-Foster Care (TST-FC), a promising trauma-informed training initiative based on Trauma Systems Therapy (Saxe, Ellis, & Brown, 2016) and piloted in child welfare agencies in two states.

2.2. Trauma Systems Therapy-Foster Care (TST-FC)

Trauma Systems Therapy (TST; Saxe et al., 2016) was developed by Glenn Saxe, M.D. and colleagues as a clinical model to improve emotional, social, and behavioral functioning among children and youth, ages 6 to 18, who have experienced trauma. TST uses a research-based, integrative treatment approach that attends to both the child's individual emotional needs and his or her social environment, including parents and other caregivers, social service workers, and clinicians. The model has roots in Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006), acknowledging the interplay between individual development and the social ecology. TST is both a clinical and an organizational model that emphasizes breaking down barriers between services, understanding the child's trauma symptoms in his or her developmental context, and building on family strengths. TST has been tested in a number of child and youth service settings, including residential care (Brown, McCauley, Navalta, & Saxe, 2013) and a private child welfare agency (Murphy et al., 2017; Redd et al., 2017). In the current study, we focus on Trauma Systems Therapy-Foster Care (TST-FC), an organizational model developed with the aim of creating a trauma-informed system in child welfare agency settings. Typically, TST trainers and/or developers offer training and technical assistance to organizations for a period of one to two years to embed the model in the organizational system.

TST was first adapted for child welfare as a systemwide training with an emphasis on training for resource parents—both foster parents and kinship caregivers (Trauma Systems Therapy-Foster Care; TST-FC). TST-FC was developed by Kelly McCauley with support from Drs. Glenn Saxe and Adam Brown and incorporates the same principles of TST, as well as many of its tools and measures. TST-FC can be implemented in a child welfare setting with or without the TST clinical model. It was first implemented in child welfare in a private agency in Kansas, KVC Health Systems (KVC) in combination with the original clinical TST model. Findings from an evaluation of the model implemented in KVC revealed it could be successfully implemented across all levels of the system, although the process was complex and somewhat challenging, with marked progress in fidelity to the model over time (Redd et al., 2017). A second study on KVC focusing on child outcomes found increases in child exposure to the combined model was associated with significant improvements in functioning and behavioral regulation, but not emotional regulation. However, higher levels of model fidelity were associated with improvements in children's emotional regulation skills, and increased fidelity over time was related to greater placement stability (Murphy et al., 2017).

Following implementation in a private child welfare agency, the developers made adaptations to make the model responsive to the particular nature of public child welfare settings. For example, public child welfare staff do not typically provide mental health counseling,