What Is Foster Parents' Role in Trauma-Informed Child Welfare Practice?

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Introduction

Although foster parents are the cornerstone of the foster care system, they often lie outside of formal structures: They are recruited, trained, certified, and paid by agencies but are not considered staff, and they are caretakers but are not considered family members. As a result, there can be ambiguity around their role that leaves them outside of decision-making processes at both the child and agency level. This can cause particular problems when agencies seek to implement trauma-informed practices, which are conceptually designed to support foster patents in their care of children but instead may feel like an additional requirement that is imposed without a clear rationale or needed support and reinforcement.

Based on the available literature, it appears that it is rare for the implementation of new foster care practices to actively involve foster parents at any stage of the process: planning, training, application or evaluation (Cohen & Canan, 2006; Mahoney & Wiggers, 2007; Smith & Donovan, 2003). Additionally, traditional program implementation can also overlook the fact that, like child welfare staff (Caringi & Hardiman, 2011; Sprang, Craig, & Clark, 2011), foster parents experience both primary and secondary trauma in the course of parenting traumatized children (Conrad, n.d.). Based on anecdotal evidence, unaddressed trauma can create and exacerbate conflict between foster parents and child welfare staff, and thereby contribute to children moving between homes and foster parents leaving the system.

Drawing from efforts to implement trauma-informed practices in Treatment Family Foster Care (TFFC) programs in New York City, and from the author's personal experience as a therapeutic foster and adoptive parent, this article reviews the challenges and benefits of actively involving foster parents in the implementation of trauma-focused efforts. It also discusses how doing so can result in improvements in managing children's behaviors, collaboration with agency staff, and outcomes at the child and agency level.

Trauma-Informed Child Welfare Practice

Over the last decade, child welfare has seen a movement toward trauma-informed practice (Bartlett et al., 2016; Ko et al., 2008). However, there is not complete consensus around what "trauma-informed child welfare practice" entails, and these concepts have been operationalized in different ways by entities such as the Administration for Children, Youth and Families (ACYF) and the National Child Traumatic Stress Network, public child welfare systems, and direct care providers. Some have focused more narrowly on identifying children who have trauma symptoms, referring them to appropriate services and tracking their treatment progress over time (e.g., Kerns et al., 2016), while others have taken a broader approach that includes training, support, and policy change related to trauma and secondary trauma experienced by children, caretakers. and staff (e.g., Lang, Campbell, Shanley, Crusto, & Connell, 2016).

To the point of this article, however, most available

definitions of trauma-informed child welfare practice do not implicitly or explicitly address the role of foster parents in delivering trauma-informed care, despite the fact that they are the primary service providers in the foster care system. This oversight can lead to efforts that, while well-intentioned, result in large gaps that affect the care children receive. I can speak to this from my personal experience as a foster parent when, for example, I learned from one of our caseworkers that our agency was now using a well-known trauma model. She told me about the multi-day trainings that staff attended and related changes that they were making to their internal processes—but nowhere on the list of implementation activities was anything related to foster parents. My response to her was, "How are these efforts supposed to make a difference for children if the people who care for them every day are left out of the loop?"

An Example of Foster Parent Involvement: The Atlas Project

The Atlas Project is an ACYF-funded demonstration effort focused on bringing trauma-informed care to New York City-based TFFC programs (Tullberg, Kerker, Muradwij, & Saxe, 2018). Atlas aims to infuse child welfare agencies and their mental health partners with trauma-informed care through systematic trauma screening and assessment of children, staff and foster parent training, treatment decision-making tools, and trauma-informed mental health treatment. Each Atlas site is a partnership with a TFFC program and a mental health provider; some of the mental health partners are part of the same agency (i.e., "in house") and others are community-based agencies with which the TFFC program has a close relationship.

Given foster parents' role as primary service providers to children in care, we sought to involve them in planning, implementation, and ongoing program activities as true partners, not just passive recipients of information or services. Drawing from the literature about engaging family members in program development and implementation (Shalowitz et al., 2009), we found several ways to involve foster parents in our work.

For example, during the project's planning period, we conducted focus groups with various child welfare stakeholders, such as administrators, staff, youth, biological parents, and foster parents. The purpose of these groups was to identify key concerns of each group related to existing foster care services and mental health treatment, including the coordination (or lack thereof) between service providers. In talking with foster parents, we were particularly interested in their understanding of child trauma and the degree to which they felt existing services were addressing the trauma children in their care had experienced. The primary concerns raised by foster parents focused on not receiving critical information about their children's trauma exposure and related symptoms and their lack of involvement in decision making regarding their children's care and treatment. We addressed these concerns by actively including them in the following mental health screening and treatment activities:

- As part of the Atlas Project evaluation, we completed an implementation study that included (additional) focus groups with foster parents both at the beginning of our work with each TFFC program and a year into the implementation process. The purpose of these groups was to ensure that Atlas was addressing needs expressed by foster parents, and to assess any change in practice that resulted from the implementation of the Atlas model. When foster parents expressed concerns about the functioning of their foster care programs, or their inclusion in Atlas activities, we relayed that information back to program leadership to be addressed.

  For all foster parent focus groups (both during the planning period and those that were part of our implementation study), we sought to have different perspectives represented, but because of the limitations of our project staffing, we included only English-speaking foster parents. To recruit participants, our partner sites were provided with fliers advertising the groups, and in some cases we followed up with outreach to individual parents to remind them of when the groups would be meeting. Focus group participants were provided with refreshments

and a $25 gift card for their participation.

- We also included foster parents in our training efforts and, whenever possible, trained foster parents, TFFC staff, and mental health clinicians together. In addition to ensuring that all participants were receiving the same information and learning the same concepts, we included foster parents and staff together in training to reinforce Atlas's team-focused approach and (at least temporarily) level the hierarchy between foster parents and staff. This approach was particularly powerful in trainings focused on secondary trauma, where staff and foster parents discussed the difficulties of their work in a safe space and were able to see each other not as sources of their stress, but rather as partners who were facing the same struggles.

- Following ACYF's wellbeing framework (U.S. Department of Health and Human Services, Administration on Children Youth and Families, 2012), an important component of the Atlas Project was mental health and trauma screening of all children in our partner TFFC sites. Whenever possible, TFFC or clinical staff would collect information (about children's trauma exposures and any current behaviors or symptoms) directly from foster parents as well as the child and other informants. In some cases, this process revealed important disconnects. For example, through their responses on screening forms, we learned that some foster parents did not consider being removed from one's parents or experiencing multiple moves between foster homes to be traumatic experiences for children. Although on its face, such information might be more alarming than helpful, this information created a valuable teaching opportunity that could make a vital difference in a foster parent's parenting, and in turn, a foster care agency's ability to understand and address a child's trauma.

- The Atlas Project used a team-based clinical model, trauma systems therapy (TST), that involves all of the child's caretakers and service providers in developing and implementing the child's treatment plan (Saxe, Ellis, & Brown, 2015). A main component of TST is identifying trauma triggers in the child's social environment that are contributing to the child's emotional or behavioral dysregulation, or both. For children in foster care, the foster home is a central part of the child's social environment, making it necessary to closely involve the foster parent in the assessment, treatment planning, and treatment delivery processes. To this end, in addition to eliciting information from the foster parent during home and agency visits, we encouraged our TFFC partners to actively involve foster parents in treatment team meetings whenever possible as equal members of the treatment team.

Challenges and Benefits

In our experience, several factors made involving foster parents in the Atlas screening and evaluation activities challenging. The first was logistical; many foster parents work or have childcare responsibilities and are therefore not available during the hours when meetings and trainings typically occur. Additionally, staff and foster parents typically have different levels of preparation and knowledge. Using clinical or technical language in meetings and trainings risked "losing" some of the foster parents; however, framing the concepts in a way that was more accessible to foster parents sometimes resulted in complaints from staff that the language was "dumbed down" and their experience and expertise were not being respected.

A more important factor, however, was less concrete but often more difficult to overcome: shifting the culture from one where staff members are the professionals and foster parents are service recipients, to one where information and influence are shared among equals. In some cases, foster care agency leadership was so uncomfortable having foster parents attend "their" meetings and trainings that they either asked for the idea to be revisited once their staff had more competence with the material, or rejected it altogether. However, when foster parents were at the table, whether it was during trainings or team

meetings, the depth of the conversation, and the progress that could be made, was notably different. In several instances, in fact, TFFC program leadership attributed the "saving" of a placement or improvement in a child's functioning to the foster parent's increased understanding of trauma, engagement with staff, and effectiveness in intervening with the child.

Increased understanding of trauma also influenced the *nature* of foster parent–agency partnerships. In some instances, it was clear that a foster parent's reactions to a child's behavior was contributing to the child's emotional instability, at times threatening the viability of the child's placement. Although these reactions were often unintentional, they were sometimes viewed as parental personality traits or attempts at discipline that, while not ideal, needed to be accommodated. In these situations, we encouraged our foster care agency partners to instead understand these reactions through a "trauma lens," and doing so often learned information about foster parents' own experiences of primary or secondary trauma. This led to a different kind of engagement, one focused on helping the foster parent to better understand her own reactions so that she could both get the support she needed and step back from the vicious cycle she was in with her kids. As a result, foster parents felt more respected and heard, staff felt less frustrated and helpless, and both were in a better position to effectively partner around children's care.

Taking Foster Parent Involvement to the Next Level

While we made strides in incorporating foster parents into the various components of the Atlas Project's planning and implementation, we certainly could have integrated them more fully. We might have, for example, have foster parents be involved in the initial project design and agency-specific implementation planning, had them co-deliver trainings with staff, and more actively participate in program evaluation efforts. Such efforts would have further elevated these parents' status as equal members of the project team and likely motivated other foster parents to be more actively involved in planning and caring for the children in their homes.

Although I would assert that including foster parents in every step of program implementation is good practice in general, it is particularly relevant to trauma-informed care. On an individual level, effectively addressing a child's trauma is not just about engaging him or her personally but also making adjustments in a child's environment that promotes both physical and psychological safety—and doing so is not possible without foster parents' active involvement in this process.

More broadly, at the core of trauma are the concepts of power and control, specifically the loss of power and control in the face of danger. Foster parents are on the frontline of child welfare practice and, as a result, are regularly exposed to trauma both directly and indirectly. In this context, treating foster parents solely as passive service recipients can increase their feelings of helplessness, decrease their feelings of efficacy, and make it more likely that they will ask a child to be removed from their home or choose to stop fostering altogether. Alternatively, genuine partnerships with foster parents in the development, implementation, and evaluation of agency practice can help to restore them with a sense of agency and make them more effective in both collaborating with staff and parenting children.

About the Author

Erika Tullberg, MPA, MPH, is on the faculty of NYU's Department of Child and Adolescent Psychiatry, where her work focuses on children who have experienced maltreatment, the impact of trauma on parenting and child safety, and secondary trauma experienced by child welfare staff. Prior to coming to NYU, she worked in various leadership roles at New York City's Administration for Children's Services. She earned her MPH at the Columbia University Mailman School of Public Health, her MPA at the Columbia University School of International and Public Affairs. She is currently a doctoral student at the CUNY School of Public Health and a parent to a 28-year-old foster care alumna.

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