

# Improving Trauma-Informed Education and Parenting for Resource Parents at a Foster Care Agency

Courtney Albers, DNP, APRN, PMHNP-BC

*University of Louisville*

Sarah Schirmer DNP, M Ed., APRN, PMHNP-BC

*University of Louisville*

Rudy Clark, EdD, RN

*University of Louisville*

## Abstract

675,000 children nationwide were involved with the foster care system in 2019, and nearly all children within the foster care system actively suffer from the effects of trauma. Resource parent trauma-informed trainings, such as Resource Parenting Curriculum (RPC) developed by The National Child Traumatic Stress Network, are associated with improved parental perceptions towards trauma-informed care, improved child outcomes, and placement stability. Foster care agencies have trauma-informed state-based curriculum, but it does not meet the needs of resource parents, specifically those caring for children with developmental delays or disorders. The project was implemented at a therapeutic foster care agency for resource parents to improve knowledge, beliefs, and attitudes surrounding trauma-informed parenting, tolerance of misbehavior and parenting efficacy. Resource parents participated in a two-hour workshop consisting of a condensed version of RPC, which was adapted to meet the needs of parents caring for a child with a developmental delay or disorder. Resource parents completed a pre- and post-workshop knowledge test and Resource Parent Knowledge and Beliefs Survey (RPKBS). Qualitative measures identified resource parent satisfaction with workshop. Resource parent knowledge ( $p=0.108$ ) and all three scales from the RPKBS: trauma-informed parenting ( $p=0.074$ ), tolerance of misbehavior ( $p=0.500$ ), and parenting efficacy ( $p=0.293$ ) improved from pre- to post-workshop but were not statistically significant. The project will have sustained outcomes as the project site has adopted a trauma-informed curriculum to implement into their program as a tool for resource parents. Future implementation of this intervention should focus on improving response rates, studying the relationship of collaborative trainings and the development of staff specific trauma-informed assessments and the impact of trauma-informed workshops on parenting behaviors and outcomes, specifically placement stability.

Keywords: Child Trauma, Child Welfare, Foster Care, Resource Parent Training, Placement Stability

## Introduction

The Department for Community Based Services (DCBS) maintains the Foster Adoptive Caregiver Exchange System (FACES) to relieve children and adolescents, ages 0 to 18 years-old, from unsafe circumstances (DCBS, 2017). DCBS and more specifically, the foster care system, has provided placements and safety during times of need. Unfortunately, of the children involved with the foster care system, nearly 70% have experienced three or more adverse childhood experiences (ACEs) (Freeman, 2014). The current literature indicates ACEs can have long-term effects that follow children into adulthood (Boparai et al., 2018; CDC, 2019; Chang et al., 2019; Crouch et al., 2018). ACEs have been associated with the development of physical and mental illnesses (Boparai et al., 2018; CDC, 2019; Chang et al., 2019; Crouch et al., 2018). The state of Kentucky ranks in the top ten states for ACEs and has ranked the number one state in rates of child abuse for the past three years (Health Resources and Services Administration, n.d; Yetter, 2021). Resource parents play an influential role in a child's trauma recovery and thus, resource parents require specific training to

adequately understand and manage trauma-related complexities (Bartlett & Smith, 2019; Brodzinsky, 2013; Hardwood et al., 2013; Henry et al., 2007; Sullivan et al., 2016; Wojciak et al., 2017).

## Background

Some children may experience only brief symptoms following a traumatic experience; however, many children experience lasting effects of trauma (Children's Bureau, 2020; Tlapek et al., 2017). Trauma causes toxic stress which dysregulates hormone production within the hypothalamic-pituitary-adrenal (HPA) and the sympathetic-adrenal-medullary (SAM) axes causing a physiological imbalance, which can alter a child's brain during sensitive periods of development (Boparai et al., 2018; Child Welfare Information Gateway, 2015). A child's presentation of trauma symptoms is dependent on the part of the brain affected (Child Welfare Information Gateway, 2015). Childhood trauma may hinder brain development, both structure and functioning, and disrupted neurodevelopment can lead to developmental delays or developmental disorders (Bartlett & Smith, 2019; Child Welfare Information Gateway, 2015; Hughes et al., 2017).

A needs assessment was conducted at the project site, a therapeutic foster care agency located in two different cities in a southeastern U.S. state, and a gap in knowledge among resource parents regarding trauma and its effects on child development was identified. The vice president of the foster care program requested the project focus on trauma-informed parenting with an emphasis on developmental delays or disorders. While there is a state required curriculum from DCBS for trauma-informed parenting training, the vice president expressed the need for more extensive training. Precise estimates of prevalence of developmental delays and disorders in foster care are often difficult to determine due to the ambiguous presentation (Bartlett & Smith, 2019; Boparai et al., 2018; Child Welfare Information Gateway, 2015; Hughes et al., 2017; Putnam, 2006). However, there's an estimated 40% to 60% of children in the foster care system with diagnosed with either a developmental delay or disorder (Leslie et al., 2005; Weiss, 2013). The project site reported they do not currently track the number of children with a diagnosed developmental delay or disorder. The clinical director stated, "it's hard to know exactly how many children, as not all children are psychologically tested; though, many children we serve show signs of a developmental delay or disorder."

Discussions with key stakeholders, including program supervisors and social workers, identified the need for improved relations between resource parents and their children, noting the continuous mission to improve placement stability. Without an understanding of the effects of trauma, resource parents can misinterpret behaviors, and their attempts to address behaviors can be unsuccessful. The National Child Traumatic Stress Network (2010) explains children may react to trauma reminders such as sights, smells, tastes, sounds, sensations, people, places, colors, textures, words, or emotions. Often, this is not a conscious process, and the child may be unaware of the connection leading to their inability to express the reasoning for their reaction. A trauma reminder may prompt a child to experience intrusions, physiological arousal, avoidance, or dissociation. When a response to trauma occurs, resource parents may not understand the cause and may not react with a therapeutic approach leading to strain on the parent-child relationship, which can potentially result in resource parents requesting for the child to be removed from their home (Child Welfare Information Gateway, 2014; Henry et al., 2007). Jones et al. (2016) found placement stability was able to be maintained when families felt feelings of closeness. When resource parents respond therapeutically to a child's response to a trauma reminder, it can prompt healing. Conversely, disruptions in a child's placement can further traumatize and potentiate their feelings of instability (Child Welfare Information Gateway, 2015).

According to the foster care agency, many resource parents reported children's behavioral needs as their most difficult challenge in the home. Brown et al. (2020) states development and behavior are intricately related. Development can inform behavior, and children with developmental delays and disorders are at an increased risk for disruptions in foster placement due to problem behavior (Fisher et al., 2011).

Further, "[m]aintaining and maximizing placement stability is one of the key desired outcomes for children and youth involved with the foster care system" (Child Welfare Information Gateway, n.d.). Jones et al. (2016) deemed the goal for children in foster care to be placed in two or fewer different placements throughout their time in care, and The Casey Family Programs, a foster care foundation, reiterated this goal. Yet, less than 40% of foster care agencies are meeting this goal (Jones et al., 2016). The national average is over three different foster home placements within a 15-month period (Children's Bureau, 2020; Children's Bureau, 2008). Parallel to the national level, children in Kentucky had on average three different placements within the year in 2018 (Cabinet for Health and Family Services, 2020). The project site was seeing disruptions in

placement every four months and, sometimes, more than once a month. The literature supports the correlation between trauma-informed parenting and improved placement stability (Bartlett & Rushovich, 2018; Strolin-Goltzman et al., 2018).

## **Population**

The target population for this project was resource parents at a therapeutic foster care agency located in two different cities in a southeastern U.S. state. Resource parents were invited to participate in the workshop whether they are currently caring for a child or not. Resource parents at the site care for youths from age newborn to 21 years old; however, most referrals are for children ages 6 and older.

## **Problem**

Caring for a child within the foster care system is challenging; however, caring for a child within the foster care system with a developmental delay or disorder adds an additional layer of complexity to an already demanding task. A problem was identified as resource parents' state-based curriculum training does not equip them to fully understand and manage complexities associated with trauma.

## **Purpose and Specific Aims**

The purpose of this project was to implement trauma-informed parenting training for those resource parents caring for a child who has a trauma related developmental delay or disorder. The specialized trauma-informed parenting training aimed to improve knowledge, beliefs, and attitudes towards trauma-informed parenting.

## **Definition of Terms**

**Adoption.** The action of legally accepting permanent guardianship of a non-biological child as a parent.

**Developmental delay.** Refers to a child who is gaining developmental skills later than expected. Delays can be present in various skills including cognitive, social, and emotional, speech and language, fine and gross motor, and daily living activities.

**Developmental disorder.** Refers to a child who has not gained the developmental skills expected of him or her to a level of impairment, which can last throughout a person's lifetime. Disorders can be present in various skills including cognitive, social, and emotional, speech and language, fine and gross motor, and daily living activities.

**Foster care.** State-funded program that provides temporary guardianship and care for a child.

**Kinship care.** The care of a child is provided by the child's relative(s).

**Placement.** A living arrangement for a child who is within the FACES program. Placements can include residential, foster home, adoptive home, or independent living.

**Placement stability.** A living arrangement for a child with limited disruptions.

**Resource parents.** Individual(s) who become trained and certified to serve as a foster parent or adoptive parent.

**Therapeutic foster care.** Foster care settings designed for children that need extra support, including greater structure and intensity of therapeutic services, due to trauma histories.

**Trauma-informed.** An approach based on knowledge of the impact of trauma that aims to ensure a secure environment.

**Trauma-informed parenting.** A parenting style approach based on knowledge of the impact of trauma that aims to ensure a secure environment.

## **Literature Review**

A review of the literature supports the provision of trauma-informed parenting education to adequately equip resource parents with necessary understanding and application of learned skills (Bartlett & Smith, 2019; Sullivan et al., 2016). While many states and foster care agencies have standard education requirements, current research supports the need for additional parenting education for individuals caring for a child who has experienced trauma (Bartlett & Smith, 2019; Brodzinsky, 2013; Hardwood et al., 2013; Henry et al., 2007; Sullivan et al., 2016; Wojciak et al., 2017). A needs assessment at the project site revealed a gap in resource

parent knowledge. The site requested more in-depth trauma-informed training with an emphasis on the ability of childhood trauma to imprint in the form of a developmental delay or disorder.

This project utilized the Resource Parenting Curriculum (RPC), developed by The National Child Traumatic Stress Network. The “RPC aims to increase resource parents’ knowledge of trauma exposure and its effects, parents’ willingness to tolerate difficult behaviors that stem from trauma exposure, and to ultimately empower resource parents to feel effective in their ability to parent a child with a trauma history” (Murray et al., 2019, p. 164). The research regarding RPC yielded favorable results indicating RPC increases trauma-informed parenting, tolerance of misbehavior and parenting self-efficacy. RPC best meets the needs of the project site, and while no curricula from the literature review explicitly addresses trauma-informed parenting for the resource parent caring for a child with a developmental delay or disability, RPC addresses how trauma impacts development. Additionally, RPC can be adapted to incorporate supplemental information to resource parents caring for a child with a developmental delay or disability. Four empirical published studies provide evidence of RPC’s effectiveness (Gigengack et al., 2017; Murray et al., 2019; Strolin-Goltzmann et al., 2018; Sullivan et al., 2016).

While all articles in the literature review focused on components to improve parental knowledge, a common barrier noted throughout the literature was the lack of assessment of application of trauma-informed parenting skills inside the foster care home (Bartlett and Rushovich, 2018; Murray et al. 2019). Sullivan et al. (2016) stated resource parents were more knowledgeable about essential elements of trauma-informed parenting; although Murray et al. (2019) asks if improved knowledge leads to parenting changes, and if those changes impact child outcomes. The literature supports the correlation between trauma-informed parenting and improved placement stability; however, specific causation is unknown (Bartlett & Rushovich, 2018; Strolin-Goltzman et al., 2018). A goal of this project was to bridge parental trauma-informed knowledge with application to an in-home setting. Dorsey et al. (2008) explains individualized support and guidance throughout parenting workshops can promote trauma-informed parenting skills. The RPC promotes individualization through “My Child” activities. The “My Child” activities allowed resource parents the opportunity to apply concepts learned throughout the workshop to an actual child in their care.

In-person and online trauma-informed parenting workshops showed promising results. Razuri et al. (2016) expressed the goal of online parent training was to overcome prohibitive barriers brought about by in-person delivery such as space limitations, expenses, and time restraints. Conversely, Forehand et al. (2019) expressed the most cited benefit of the intervention, beyond increased knowledge and parenting skills, was benefits of in-person training sessions. Participants identified benefits such as the class provided a “safe space on a weekly basis for resource parents to raise challenging caregiving issues, receive feedback, and identify with other resource parents who were facing similar issues” (p. 377). Sullivan et al. (2016) echoed the benefits for face-to-face training, declaring it promotes a support network for resource parents. While there are benefits of in-person training, for this project, in-person training was not feasible due to limitations brought about by the COVID-19 pandemic.

A gap noted within the literature was lack of follow-up results to determine lasting effects of the interventions (Murray et al., 2019; Razuri et al., 2016). Without post-intervention follow-ups to establish effects of the interventions, researchers are limited in understanding the overall impacts of the trainings. Knowing the long-term follow-up results will allow for researchers to alter aspects of curriculum to achieve maximum effects in the future. The principal investigator in this study worked to close the gap by sustaining outcomes of RPC through reinforcing learning post-intervention and evaluating those outcomes with follow up assessments.

Current research supports the need for additional parenting education for individuals caring for a child involved with the foster care system (Bartlett & Smith, 2019; Brodzinsky, 2013; Hardwood et al., 2013; Henry et al., 2007; Sullivan et al., 2016; Wojciak et al., 2017). By studying the relationship between trauma, placement stability, and developmental delays in children within the foster care system, it became clear: to break the cycle of trauma foster parents would benefit from intentional trauma-informed training. A previous resource parent who attended RPC discussed the benefits stating, “when we became familiar with the RPC and started parenting through a trauma lens, where we weren’t thinking about having punitive consequences but instead, how we can heal them and help them grow and develop... it changed [our home]... and our kids with challenging behaviors were able to stay in our home long-term instead of us needing to terminate placement” (National Child Traumatic Stress Network, 2017).

## Conceptual Framework

Rosswurm and Larabee's (1999) Theory for Change to Evidence-Based Practice Model guided this project. This model endorses the utilization of evidence-based practice. The project sought to change the current practice to one that is evidence-based. This model serves as a systematic process for health care professionals to implement evidence-based practice change to ultimately improve patient outcomes, and includes six steps: assessing need, linking the intervention and outcomes, synthesizing the best evidence, designing a practice change, implementing, and evaluating change, and integrating and maintaining change.

## Ethical Considerations

This project was submitted to the Institutional Review Board (IRB) and the IRB classified as non-human subject research. The project site's Quality Improvement and Corporate Compliance Chief Officer and Project Manager provided support and approval for the project implementation.

## Measures

This project measured two outcomes: resource parents' knowledge of trauma-informed parenting and resource parents' beliefs and attitudes toward trauma-informed parenting. The purpose of the workshop was to improve knowledge, beliefs, and attitudes surrounding trauma-informed parenting, increase resource parent's ability to tolerate challenging behaviors, and grow resource parent's confidence in caring for a child with a traumatic history. Involved stakeholders were hopeful that this project would yield similar results of improving parent-child relations and placement stability overtime; however, this aim is outside the timeframe and scope of the project and was not measured (Bartlett & Rushovich, 2018; Conn et al., 2018; Murray et al., 2019; Sullivan et al., 2016).

To measure knowledge, a 10-question multiple choice knowledge test was administered. The knowledge test was developed by the principal investigator and is aligned with the learning objectives of the educational workshop. No other instrument existed to measure knowledge specific to this intervention. The knowledge test was administered at three different time intervals: pre-, post-, and at one-month follow up.

To measure the resource parent's beliefs and attitudes to trauma-informed parenting, the Resource Parent Knowledge and Beliefs Survey (RPKBS), developed by Murray (2014), was utilized. The RPKBS is a 33-item questionnaire that assesses three domains: trauma-informed parenting knowledge, tolerance of misbehavior and parenting efficacy. The items were scored on a six-point Likert scale (strongly disagree, disagree, slightly disagree, slightly agree, agree, and strongly agree). The RPKBS was chosen as the survey for this project because it's widely used in the literature, and it measures the specific objectives for this project. Each item correlates to one of the three main objectives: trauma-informed knowledge, tolerance of misbehavior and parenting efficacy. Additionally, the RPKBS was deemed to have good psychometric properties: Cronbach's alpha coefficient yielded good to excellent reliability ( $\alpha = 0.84$  to  $0.90$ ) on each domain, and validity was reported as moderate to large association ( $r = 0.48$  to  $0.66$ ) by means of Pearson's correlations (Murray et al., 2019). The RPKBS was administered at three different time intervals: pre-, post-, and at one-month follow up. Previous studies measured follow up results at one-month post-intervention, therefore the project also measured at one-month to be comparative (Akin et al., 2018; Bartlett and Rushovich, 2018; Maaskant et al., 2016). Permission for use was granted by developer.

## Methods

For this quality improvement project, a trauma-informed parenting workshop was implemented. The trauma-informed workshop was held virtually on January 18, 2022, and January 20, 2022. Attendees were given the option to choose the date that worked best with their schedule. Resource parents at the foster care agency were sent an invitation to participate via email from the clinical director. The email included information pertaining to the educational workshop: date and time of workshop, zoom link, and materials and instructions for the workshop. Workshop materials included a preamble, workshop slides, and "My Child" worksheets. The one-day workshop was programed during a regularly scheduled resource parent support group and lasted approximately two hours. Participation was voluntary.

During the intervention, resource parents received a condensed and adapted version of the RPC delivered by the principal investigator. RPC was condensed and adapted to meet the site's needs, specifically related

to caring for a child who has experienced trauma with a developmental delay or disability. Permission to use and edit curriculum was granted by The National Child Traumatic Stress Network (NCTSN). The condensed version of RPC addressed six of the 21 learning objectives for the program. The learning objectives were identified by key stakeholders and deemed most beneficial for the site. The evidence-based educational workshop was delivered virtually via Zoom software due to COVID. To participate in this project, resource parents needed access to an electronic device such as a cell phone, tablet, laptop, or desktop computer with internet connection. The project site confirmed resource parents' access to these resources.

At the beginning of the workshop, resource parents were asked to complete a brief demographic survey. The demographic survey included age, gender, race/ethnicity, length of time spent as a resource parent, type of resource parent, number of children in home over the past year, number of children who could not be maintained in home due to behavior, and information on current birth and non-birth children in home such as age, gender, and placement status. Additionally, the resource parents completed the trauma-informed pre-knowledge test and the pre-workshop RPKBS.

Immediately following the workshop, resource parents completed the post-knowledge test and post-workshop RPKBS. Resource parents were asked to reflect over workshop participation. Resource parents were prompted with the question, "What went well during the workshop or what would you like to see improved?" The qualitative responses were recorded.

To promote lasting effects of the intervention, resource parents were sent booster education including a one-page summary of learned concepts via email by the vice president of the foster care program at two-weeks post-workshop. At one-month post-workshop, resource parents completed a follow-up knowledge test and follow-up RPKBS. Resource parents were incentivized with continuing education credit for their complete participation. Staff members from the project site attended the workshop and completed the pre-, post- and follow-up materials including the demographic survey, knowledge test, and RPKBS.

### **Data Collection and Privacy**

Data was collected from January 19, 2022, until February 17, 2022. It was a high priority for the site to maintain privacy of resource parents and children; therefore, throughout the project, the principal investigator was blinded from all participant information including name and email. The principal investigator signed a pledge of confidentiality form. Resource parents completed the demographic questionnaire, knowledge test and RPKBS via JotForm, an online database. All data was stored on a password protected laptop. Resource parents used a unique identifier code consisting of their favorite color and birth year (i.e., RED1989). Resource parents input their unique identifier code for each form completed. The unique identifier code also served as their name on Zoom to de-identify participants during the workshop. Participant confidentiality and anonymity was maintained throughout the project.

### **Data Analysis**

Data analysis was completed using Jamovi version 2.3.2. A pretest, posttest, and follow-up design with quantitative data analysis was performed to evaluate the effectiveness of the educational workshop on resource parents' knowledge, beliefs, and attitudes towards trauma-informed parenting. Descriptive statistics, including frequencies, central tendencies, and standard deviation, were used to describe characteristics of participants and pre-, post-, and follow up data.

The Shapiro-Wilk test determined normality within the knowledge test and RPKBS data sets. The knowledge test was normally distributed; therefore, a parametric test, a paired t-test, was performed to compare pretest, posttest, and follow-up results for significance. The RPKBS data set deviated from normal distribution; therefore, a non-parametric test, the Wilcoxon signed rank, was employed. The Cohens d statistic was calculated to determine the effect size, or extent of differences between pre- and post-workshop.

### **Results**

While the project was developed and intended for resource parents, staff within the organization were invited to attend. Key stakeholders identified staff who work closely with children who have experienced trauma and would likely benefit from the curriculum. Staff training on trauma-informed approaches can decrease potential traumatic reactions and distress and encourage emotional support and positive coping throughout

the recovery process (Marsac et al., 2016). The decision to include staff within the organization occurred approximately two weeks prior to the implementation date; therefore, no accommodation was made to the curriculum, knowledge test, or survey.

**Pre-Workshop Data**

Seventeen participants attended the workshop including resource parents (n=9) and staff members (n=8). Resource parent demographic data is listed in Table 1. Staff demographic data is listed in Table 2.

**Table 1**

*Resource Parent Demographic Data*

<b>Characteristic (n=4)</b>	<b>n (%)</b>
Age in years (mean)	52.75
Sex	
Male	1 (25%)
Female	3 (75%)
Race	
White/Caucasian	4 (100%)
Black/African American	0 (0%)
Asian	0 (0%)
Hispanic	0 (0%)
Native American	0 (0%)
Pacific Islander	0 (0%)
Length of time spent as a resource parent in years (mean)	6.47
Type of resource parents	
Therapeutic Foster Care Parent	4 (100%)
Adoptive Parent	0 (0%)
Kinship Caregiver	0 (0%)
Specialization with Medically Fragile Children	1 (25%)
Pre-licensed foster parent (no placements yet)	1 (25%)
# of children in home over the past year (mean)	2.5
# of children who could not be maintained in home due to behavior (mean)	1.25
# of current birth and non-birth children in the home (mean)	3

**Table 2**

*Staff Demographic Data*

<b>Characteristic (n=4)</b>	<b>n (%)</b>
Age in years (mean)	38.5
Sex	
Male	1 (25%)
Female	3 (75%)
Race	
White/Caucasian	4 (100%)
Black/African American	0 (0%)

Asian	0 (0%)
Hispanic	0 (0%)
Native American	0 (0%)
Pacific Islander	0 (0%)
Length of time spent as a resource parent in years (mean)	N/A
Type of resource parents	
Therapeutic Foster Care Parent	N/A
Adoptive Parent	N/A
Kinship Caregiver	N/A
Specialization with Medically Fragile Children	N/A
Pre-licensed foster parent (no placements yet)	N/A
# of children in home over the past year (mean)	N/A
# of children who could not be maintained in home due to behavior (mean)	N/A
# of current birth and non-birth children in the home (mean)	N/A

Four resource parents completed the post-workshop material; therefore, the knowledge test and RPKBS data reflects those responses (n=4). Resource parents scored a mean of 9.00 (SD=1.15) for the pre-workshop knowledge test. The RPKBS was scored on a six-point Likert scale in which certain items score three categories: trauma-informed parenting, tolerance of misbehavior, and parenting efficacy. Resource parents scored a mean of 5.00 (SD=0.00) for the RPKBS trauma-informed parenting items. Resource parents scored a mean of 4.75 (SD=0.50) for the RPKBS tolerance of misbehavior items. Resource parents scored a mean of 5.15 (SD=0.59) for the RPKBS parenting efficacy items.

Six of the foster care agency staff completed pre-workshop materials; however, only four completed the post-workshop material. Four staff member's data was analyzed (n=4). Staff scored a mean of 10.00 (SD=0.00) for the pre-workshop knowledge test. Staff scored a mean of 5.5 (SD=0.57) for the RPKBS trauma-informed parenting items. Resource parents scored a mean of 4.75 (SD=0.95) for the RPKBS tolerance of misbehavior items. Resource parents scored a mean of 4.5 (SD=1.11) for the RPKBS parenting efficacy items. The RPKBS was not intended for staff evaluation; however, there was no other measure available to measure staff's knowledge and beliefs toward trauma-informed practices specific to the RPC. This baseline data may be useful for the development of a staff-specific trauma-informed assessment.

### Post-Workshop Data

Resource parents scored a mean of 9.75 (SD=5.00) for the post-workshop knowledge test. Resource parents scored a mean of 5.75 (SD=0.50) for the RPKBS trauma-informed parenting items. Resource parents scored a mean of 5.25 (SD=0.50) for the RPKBS tolerance of misbehavior items. Resource parents scored a mean of 5.50 (SD=0.60) for the RPKBS parenting efficacy items.

Staff scored a mean of 10.00 (SD=0.00) for the pre-workshop knowledge test. Staff scored a mean of 5.75 (SD=0.50) for the RPKBS trauma-informed parenting items. Resource parents scored a mean of 5.25 (SD=0.50) for the RPKBS tolerance of misbehavior items. Resource parents scored a mean of 5.31 (SD=0.57) for the RPKBS parenting efficacy items.

### Follow-Up Workshop Data

Follow-up materials were sent out at four weeks post-workshop. No resource parents participated in the follow-up data collection. It is hypothesized that virtual instruction due to COVID-19 posed a barrier on engagement and data collection throughout the project. Two staff members completed follow-up materials; however, the unique identifier codes did not correlate to previous submissions. The follow-up data was voided.

### Pre-Post Workshop Data

Due to the small sample size, determining the distribution of the data sets was essential for choosing the



appropriate statistical method. Resource parent knowledge was normally distributed according to the Shapiro-Wilk test ( $W=0.863$ ,  $p=0.272$ ). A paired t-test compared resource parent knowledge pre- and post-workshop ( $p=0.108$ ). Resource parent trauma-informed parenting deviated from normal distribution according to the Shapiro-Wilk test ( $W=0.630$ ,  $p=0.001$ ). A Wilcoxon signed-rank test compared resource parent trauma-informed parenting pre- and post-workshop ( $p=0.074$ ). Resource parent tolerance of misbehavior deviated from normal distribution according to the Shapiro-Wilk test ( $W=0.630$ ,  $p=0.001$ ). A Wilcoxon signed-rank test compared resource parent tolerance of misbehavior pre- and post-workshop ( $p=0.500$ ). Resource parenting efficacy deviated from normal distribution according to the Shapiro-Wilk test ( $W=0.828$ ,  $p=0.163$ ). A Wilcoxon signed-rank test compared resource parenting efficacy pre- and post-workshop ( $p=0.293$ ). Resource parent statistical data is reported in table 3.

**Table 3**

*Resource Parent Statistical Data*

<b>Resource Parents (n=4)</b>	Pre-Workshop Mean (SD)	Post-Workshop Mean (SD)	<i>t</i>	Sig. (2-tailed)	Cohen's D
Knowledge	9.00 (1.15)	9.75 (.50)	1.57	0.108	0.78
Trauma-Informed Parenting	5.00 (0)	5.75 (.50)	0.00	0.074	1.50
Tolerance of Misbehavior	4.75 (.50)	5.00 (.81)	0.00	0.500	1.00
Parenting Efficacy	5.15 (.59)	5.50 (.60)	1.50	0.293	0.48

Staff knowledge did not contain enough observations for the Shapiro-Wilk test to be performed. The staff knowledge data set did not change from pre- to post-workshop. A Wilcoxon signed-rank test compared staff knowledge pre- and post-workshop ( $p=1.000$ ). Staff trauma-informed parenting deviated from normal distribution according to the Shapiro-Wilk test ( $W=0.630$ ,  $p=0.001$ ). A Wilcoxon signed-rank test compared staff trauma-informed parenting pre- and post-workshop ( $p=0.500$ ). Staff tolerance of misbehavior deviated from normal distribution according to the Shapiro-Wilk test ( $W=0.729$ ,  $p=0.024$ ). A Wilcoxon signed-rank test compared staff tolerance of misbehavior pre- and post-workshop ( $p=0.173$ ). Staff parenting efficacy deviated from normal distribution according to the Shapiro-Wilk test ( $W=0.939$ ,  $p=0.650$ ). A Wilcoxon signed-rank test compared staff parenting efficacy pre- and post-workshop ( $p=0.091$ ). Staff statistical data is reported in table 4.

**Table 4**

*Staff Statistical Data*

<b>Staff (n=4)</b>	Pre-Workshop Mean (SD)	Post-Workshop Mean (SD)	<i>t</i>	Sig. (2-tailed)	Cohen's D
Knowledge	10 (0)	10 (0)	0.00	1.00	NaN
Trauma-Informed Parenting	5.50 (.57)	5.75 (.50)	0.00	0.500	.50
Tolerance of Misbehavior	4.75 (.95)	5.25 (.50)	0.00	0.173	0.86
Parenting Efficacy	4.50 (1.11)	5.31 (.57)	0.00	0.091	1.29

## Discussion

The purpose of this project was to improve knowledge, beliefs, and attitudes towards trauma-informed parenting for resource parents. There were improved scores from pre- to post-workshop; however, the data was not statistically significant. Despite the results, the current project was meaningful, impacting resource parents, foster children, and staff. Resource parent knowledge ( $d=0.78$ ), trauma-informed parenting ( $d=1.50$ ), and tolerance of misbehavior ( $d=1.00$ ) had a large effect size indicating practical significance. Parenting efficacy ( $d=0.49$ ) had a medium effect size which also indicates some practical significance. At the conclusion of the workshop, resource parents were asked “What went well?” and “What would you like to see improved?” and one participant expressed, “this workshop was very helpful...it helps us...it reminds us of things to consider,” and another participant added, “thank you for this...the activities were very practical...this was one of the most useful sessions.” Feedback included themes of appreciation, stating the workshop was highly practical with tangible ways to implement trauma-informed parenting in the home.

The findings of this project are consistent with the overall findings of four previously published studies indicating RPC improves the trauma-informed perspective of resource parents (Gigengack et al., 2017; Strolin-Goltzman et al., 2018; Murray et al., 2019; Sullivan et al., 2016). Resource parent knowledge ( $p=0.108$ ), and all three scales from the RPKBS: trauma-informed parenting ( $p=0.074$ ), tolerance of misbehavior ( $p=0.500$ ), and parenting efficacy ( $p=0.293$ ) improved from pre- to post-workshop. No findings were statistically significant. The previously published studies adhered to high standards of fidelity including the delivery of all eight modules, in-person, with NCTSN-trained facilitators. The basis of the current project did not allow for the provision of eight in-person modules due to time restrictions and the COVID-19 pandemic.

The current project has limitations. First, resource parents had low engagement toward data collection, especially four weeks post-workshop. Future research should focus on interventions to improve response rates; however, it is hypothesized that lack of completion was accredited to online collection of data due to COVID-19. Other common causes for limited resource parent responses may include the non-mandatory nature of the workshop and the competing demands of resource parents including family and child-related obligations (Murray et al., 2019). Current research supports the provision of individualized and personal aspects of training programs to improve engagement and outcomes (Dorsey et al., 2008; Jackson et al., 2012;). At approximately two weeks post-workshop, resource parents, key stakeholders, and staff were given hand-written thank you notes and a small gift of appreciation for their time and participation. Additionally, throughout the workshop, the facilitator promoted individualization using the “My Child” worksheets and provided realistic and tangible trauma-informed strategies including identification and management of emotional “hot spots,” safety message planning, and the SOS coping skill. Unfortunately, even with the provision of these recommendations, responses to pre-, post-, and follow up knowledge tests and surveys was still low. The resource parent sample size remained small ( $n=4$ ). Previous research used the completion of the knowledge test and survey as exit tickets (Murray et al., 2019). Future workshops could implement the exit ticket strategy by dismissing resource parents from the virtual workshop once materials are received. This may require additional planning with workflow design, but this method could improve the amount of data collected. Fleming et al. (2016) evaluated predictors of engagement and found child attendance at workshops resulted in higher engagement. Future research and workshops should explore the impacts of child-parent workshops and focus on data collection, specifically follow-up data to determine lasting effects of RPC.

Next, it was outside of the scope for the current project to measure RPC’s impact on placement stability. The literature supports the correlation between trauma-informed parenting trainings and improved placement stability (Bartlett & Rushovich, 2018; Strolin-Goltzman et al., 2018). When a child is moved from placement to placement, it can further traumatize and potentiate a child’s feelings of instability, halting the recovery process (Child Welfare Information Gateway, 2015). Children with multiple placements experience more delinquency, aggression, depression, and trauma symptoms compared to those with fewer placements (Mishra et al., 2020). Additionally, when asked about the effects of placement instability, foster care alumni reported feeling unwanted by caregivers and subsequent difficulties with relationships (Chambers et al., 2018). Future research should focus on understanding the correlation between the RPC and placement stability.

Lastly, the RPKBS was not an appropriate assessment of staff perceptions of trauma-informed care. The RPKBS was developed with resource parents as the intended audience, and for example, one statement is “I know I am doing a good job as a resource parent,” which explicitly does not apply to staff. Conversely, another statement on the RPKBS is “I feel confident about my ability to handle challenging behaviors,” which could be

accurately answered by a staff member. Therefore, the staff results from this project are not conclusive, but serve as a starting point for the development of staff-specific assessments.

In 2020, a NCTSN-based training program, the Child Welfare Trauma Training Toolkit (CWTTT), was developed for staff members at various levels and roles to improve trauma-informed care delivery (NCTSN, 2020). There is limited research on this specific training, and no correlated tools have been established. The NCTSN has developed the Trauma-Informed Organizational Assessment (TIOA), which aims to measure trauma-informed care at the organizational level (NCTSN, 2021). However, currently, the NCTSN does not have a tool to measure staff perceptions, knowledge, beliefs, or attitudes towards trauma-informed care. The current literature evaluates staff perceptions, knowledge, beliefs, and attitudes towards trauma-informed care using qualitative assessments (i.e., interviews and focus groups; Galvin, 2021). Future research should consider the development of a tool to measure staff perceptions of trauma-informed care (i.e., staff interaction with child with trauma history) and staff perceptions of trauma-informed parenting (i.e., usefulness of resource parent education and training of trauma-informed practices).

Despite these limitations, the current project has several important implications for trauma-informed parenting for resource parents. First, each measure improved from pre- to post-workshop, indicating RPC can improve resource parent knowledge, beliefs, and attitudes toward trauma-informed parenting, tolerance of misbehavior, and parenting efficacy. These improvements, though not significant, have practical implications toward improving outcomes for the child. Resource parents have greater ability to care for children who have experienced trauma. Improved resource parent trauma-informed parenting has been correlated with improved trauma-informed strategies inside the home, parent-child relations, and placement stability, all of which can promote trauma recovery (Bartlett & Rushovich, 2018; Strolin-Goltzman et al., 2018). While further research is needed to determine if RPC and self-reported parental perceptions are related to changes in parenting styles, the results are encouraging.

Second, this project goes beyond previous research and implementation of RPC, incorporating staff. This project serves as a starting point for the development of staff-specific trauma-informed trainings and self-reported assessments. There is limited research for staff-specific trauma-informed trainings and assessments. Current research is using qualitative assessments such as interviews and focus groups to explore staff perceptions of trauma-informed care. While RPC is not an ideal curriculum to use with staff, it did offer a common language to use when discussing trauma. The use of a common language among resource parents, therapists, social workers, and other health care providers has been associated with better collaboration and outcomes (Bartlett and Rushovich, 2018). Future research should explore the impact of collaborative trainings, and the development of staff-specific trauma-informed assessments.

Third, this project was deemed highly valuable and effective by the organization. The organization has adopted a trauma-informed curriculum to sustain the results of this project. The site's new trauma-informed curriculum was evaluated for use for this project, however, was deemed not feasible due to the high price of the curriculum. The project site's allocation of money toward this trauma-informed curriculum reveals the reported benefits of trauma-informed trainings as a tool for resource parents.

## Conclusion

The high prevalence of trauma throughout the U.S. indicates the need for further attention for post-traumatic interventions, especially within the foster care system (Bartlett & Smith, 2019). The trauma-informed parenting workshop was well-received by resource parents and had reported benefits on resource parents' knowledge and beliefs of trauma-informed parenting, tolerance of misbehavior, and parenting efficacy. Future implementation of this intervention should focus on improving response rates by exploring additional options for individualized components, implementing the exit ticket strategy, and studying the relationship of collaborative trainings including the resource parents, staff, and children. Additionally, future implementation of this intervention should consider the development of staff specific trauma-informed assessments and the impact of trauma-informed workshops on parenting behaviors and outcomes, specifically placement stability.

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### About the Authors

**Courtney Albers, DNP, APRN, PMHNP-BC** is a board-certified psychiatric mental health nurse practitioner providing psychiatric mental health care at several practice locations across the Commonwealth of Kentucky, including Kentucky's leading Community Mental Health Center. She is an assistant professor at the University of Louisville, where she graduated from the Doctor of Nursing Practice Program in 2022. Her published article was based on her Doctor of Nursing Practice project. Dr. Albers has a deep passion for supporting children and adolescents in foster care and volunteers her time weekly. Due to her outstanding contributions in psychiatric mental health nursing, she received the President's Volunteer Service Award from the President of the United States and was recognized as an American Psychiatric Nurses Association Board of Director Scholar. Dr. Albers is an active member of the American Psychiatric Nurses Association and the Kentucky Association for Nurse Practitioners and Nurse Midwives, where is committed to advocating for improved access to patient care at the local, state, and national levels.

**Sarah Schirmer DNP, M Ed., APRN, PMHNP-BC** has over 20 years of experience working in mental health care. She began her career as a licensed professional clinical counselor providing individual and family therapy to children and families and went on to earn her Doctor of Nursing Practice degree in the psychiatric-mental health track at the University of Kentucky in 2015. Dr. Schirmer is board certified by the ANCC to provide psychiatric mental-health treatment across the lifespan. She is an assistant professor at The University of Louisville's School of Nursing where she teaches in the graduate school and co-coordinates the psychiatric-mental health track. Dr. Schirmer, DNP is also vice chair of Kentucky's Eating Disorder Council representing the Kentucky Association of Nurse Practitioners and Nurse Midwives.

**Rudy Clark, EdD, RN** completed her BA in Psychology and ADN from the Kentucky Wesleyan, MSN from Bellarmine University with a focus in Nursing Education, and her EdD from Spalding University in 2018, with a focus on educational leadership. She is an active member in the American Association of Psychiatric Mental Health Nursing and the Kentuckian chapter. Dr. Clark has 27 years of teaching experience with traditional undergraduate nursing students and graduate students. Dr. Clark teaches the psychiatric mental health course and clinical. Her research focus is the use of the arts to increase critical and creative thinking.