Assessing and Addressing the Parenting Needs of Resource Parents

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Abstract

In the 2021-2022 fiscal year, the monthly average number of children and youth in care in Ontario was 8,700 (OACAS, 2022$_e$). Most of these young people have histories of developmental trauma and require safety, consistency, and predictability in order to heal. As such, placement stability is a key goal within child welfare. However, placement disruptions are common and often result in widespread negative outcomes for young people in care. Within the context of the many supports that must be offered to youths and resource parents, one area of intervention includes parenting support for resource parents. The overall objective of this two-study dissertation was to *assess* youth and caregiver associations with the number of youth placement changes and to *address* some of these factors by evaluating an in-service trauma-informed parenting program. For Study 1, hierarchical regression analyses examined youth and resource parent variables associated with the number of placement changes among 1,624 Ontario youths aged 10-17 years. Study 1 utilized data from 2017 previously collected as part of the Ontario Looking After Children project, which is an initiative designed to improve developmental outcomes for young people in care in Ontario. For demographic variables, parent-model placements (i.e., foster, adoptive, kinship homes) were associated with fewer changes than residential placements. Also, younger age when first placed in care, older current youth age, and a higher number of maltreatment types experienced by the youth were associated with a greater number of placement changes. For youth variables, greater conduct problems, peer problems, and prosocial behaviour, as well as fewer internal developmental assets, were associated with greater placement changes. For caregiver variables, lower placement satisfaction was associated with a greater number of placement changes. These findings highlight the importance of considering both youth and caregiver factors that are associated with placement changes and as

such, provides insight into possible areas of intervention to increase placement stability for youths in out-of-home care. Building on these results, Study 2 involved conducting a preliminary evaluation of the Resource Parent Curriculum (RPC), which is an in-service, group-based parenting program developed by the National Child Traumatic Stress Network. This 8-module program was delivered virtually to resource parents in Ontario on six occasions during 2020-2021, with a total of 43 research participants. Youth and caregiver outcomes were examined by way of a quasi-experimental design that included 22 resource parents in the experimental group and 21 in the waitlist control and involved baseline, post-program, and 2-month follow-up assessments. In terms of resource parents' reactions, quantitative and qualitative results suggested that resource parents were highly satisfied with the program's content and delivery. For learning outcomes, RPC resulted in improvements in resource parents' knowledge and beliefs in trauma-informed parenting. While not statistically significant, post-hoc exploratory analyses revealed some potential small effects for improvements in resource parents' tolerance of challenging youth behaviours and in parenting self-efficacy. For behavioural outcomes among resource parents, several potential effects (not statistically significant) were noted with small to medium effect sizes regarding possible improvements in resource parents' attachment relationship with their youth, increased social supports, improved family functioning, and reduced parenting distress. Study 2 was novel in being the first to evaluate RPC using a quasi-experimental design within a Canadian context and through virtual delivery. Findings highlighted both the benefits of the program as well as resource parents' ongoing training needs and required supports to improve youth well-being and placement stability.

Keywords: child welfare; placement stability; resource parent training; trauma

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Content of Thesis and Contribution of Authors

This article-based dissertation consists of two studies that are entitled: (1) Number of Placement Changes Among Young People In Care: Youth and Caregiver Associations; (2) Evaluation of a Trauma-Informed Parenting Program for Resource Parents. Study 1 has been published in a peer-reviewed journal in which I appear as the first author[1]. The majority of Study 2 findings have also been published in peer-reviewed journals. In particular, findings related to resource parents' reactions to RPC have been published in a peer-reviewed journal in which I appear as the second author[2]. I took the lead in developing and writing all of the content related to the dissertation in this particular publication. Primary outcomes on resource parents' learning and behaviour have been published in a peer-reviewed journal in which I appear as the first author[3]. I took the lead on all aspects of this dissertation, including the literature review, project formulation, development and implementation of the procedures and methodology, applications to the Ethics Review Board, participant recruitment, data collection, scoring and analysis, and writing. Dr. Romano served as an advisor throughout the dissertation process in the above-mentioned activities.

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[1] Stenason, L., & Romano, E. (2023). Number of placement changes among young people in care: Youth and caregiver associations. *Children and Youth Services Review*, 144. https://doi.org/10.1016/j.childyouth.2022.106737

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Assessing and Addressing the Parenting Needs of Resource Parents

General Introduction

In the 2021-2022 fiscal year, the monthly average number of children and youth in care in Ontario was 8,700 (Ontario Association of Children's Aid Societies (OACAS), 2022e). Placement disruptions often occur once a youth enters the home of a kin or non-kinship resource family (i.e., a relative, nonrelated extended family member, or nonrelated foster parent; Brown & Bednar, 2006; California Evidence Based Clearinghouse (CEBC), 2022c). It is critical to focus on the issue of placement disruptions because they can have widespread negative psychological, social, and educational consequences for youth (Rock et al., 2015). In fact, data from 852 youth aged newborn to 17 years in the province of Ontario (Canada) revealed that, after two years, almost one third of placements ended with transfer to another family or to a group home placement (Perry et al., 2012).

The number of placements that a youth experiences may be related to their age, health status, and emotional and behavioural difficulties, as well as resource parent responsibilities and inadequate caregiving support (Hanson & Lang, 2016). Many emotional and behavioural difficulties exhibited by youth are the result of their histories of developmental trauma and child welfare involvement, which often includes a number of transitions (Hanson & Lang, 2016). One method of better avoiding placement breakdowns is to ensure that caregivers are well-equipped and supported so they may meet the many needs of child welfare-involved youth.

Although resource parents in Ontario are required to complete the Parent Resources for Information, Development, and Education (PRIDE) program prior to the start of fostering, there is little in the way of in-service support that focuses on trauma-informed parenting and that has been evaluated for effectiveness. As such, the objectives of this dissertation were to: 1) Gain a

better understanding of Ontario resource parent demographics, youth characteristics, and parenting concerns that are associated with placement changes and 2) Evaluate by way of an experimental design, an in-service parenting program for resource parents in Ontario.

Child Welfare in Ontario

The Canadian child welfare system is governed by provincial legislation run independently throughout each of the provinces and territories so there is no national or federal office of child welfare (Courtney et al., 2013). In Ontario, child welfare services are governed by the Child, Youth, and Family Services Act. Although the policies and practices specific to each province and territory may differ, they share a number of common themes such as considering the best interests of the child, paying close attention to the child and family's culture and heritage, promoting healthy child development, and preserving the family unit (Child Welfare League of Canada, 2021). The services of Ontario child welfare are triggered once a member of the community (professional or citizen) makes a report of suspected child maltreatment or risk thereof, which may include physical abuse, neglect, emotional abuse, sexual abuse, concerns regarding caregiver capacity, and/or exposure to intimate partner violence involving a child under the age of 16 (OACAS, 2022a). Although it is mandatory to report suspected maltreatment for youth under 16 years of age, legislation implemented in January 2018 also allows the option for youth between the ages of 16-17 years to be signaled to child protection (Child, Youth, and Family Services Act, 2022).

Following a report to an Ontario Children's Aid Society (CAS), an investigation may be conducted with the family, and caseworkers may reach one of three potential conclusions. First, there may be no evidence of maltreatment or future risk of harm so contact with the family is terminated. Second, there may be no imminent risk of harm to the youth, but the family may be

offered supports if they are experiencing difficulties (e.g., counselling, parenting support; Den Dunnen, 2017). In this case, the youth may also informally reside temporarily with a relative until any safety concerns are resolved. In this arrangement, known as *kinship service*, CAS does not have legal custody of the child. Third, if the youth is in imminent risk of harm, they may be removed from their home and placed in out-of-home care. Placement in out-of-home care is not the norm, as data show that the vast majority of youth remain with their families (OACAS, 2022$_c$).

There are a number of options to consider when placing a youth in out-of-home care, based on available supports and needs. *Kin-based care* involves an extended family member or another adult in the youth's community who has a strong relationship with the young person (OACAS, 2022$_c$). This is the preferred method of out-of-home care because kin-based care promotes family preservation and is thought to be less distressing for the youth, as they are entering an environment with which they are familiar and in which they may already have an established relationship with the caregiver (e.g., grandparent, aunt/uncle, godparent, family friend; Hélie et al., 2017; OACAS, 2022$_c$). There are several forms of kin-based care including kinship service (described above), kinship care, and customary care. *Kinship care* occurs when the youth enters the home of a kin caregiver but has "in care" status so caregivers undergo the same procedures for approval as foster caregivers (i.e., pre-service training and assessment; see below; OACAS, 2022$_c$). If the youth is of Indigenous heritage, they may participate in a *customary care* arrangement, which preserves cultural and family ties and respects Indigenous values regarding child-rearing including shared collective responsibility (Ministry of Children, Youth, and Family Services, 2013; OACAS, 2022$_d$). Previous research has reported that youth in kin-based care tend to experience more positive outcomes overall than youth in non-kin based

foster care. Two meta-analytic reviews by Winokur et al. (2009, 2014) compared kin and non-kin care on various outcomes, including safety, permanency, mental health, placement stability, and educational attainment. Findings across 102 experimental studies showed that youth in kin-based care had more favourable behavioural outcomes, better placement stability, and fewer cases of substantiated abuse while in care compared to youth in foster homes. However, youth in kin-based care were less likely to be adopted and to access mental health services. There were no significant differences between the groups on reunification with their family of origin, length of stay in care, family relationships, graduation rates, or developmental/physician services. Bell and Romano (2017) added to these findings by providing a scoping review of the literature across 54 studies on outcomes associated with foster and kin-based care. In addition to the aforementioned findings, results indicated that longitudinal research demonstrated weakening differences between foster and kin-based care over time. Findings regarding safety outcomes were mixed, with some research suggesting no differences between foster and kin-based care for placement quality and another study suggesting youth in foster homes were more likely to make allegations of maltreatment compared to kin-based care (Bell & Romano, 2017; Winokur et al., 2008).

While there are several positive outcomes related to kin-based care, research has also shown that kin caregivers are more likely to be older (e.g., grandparents), have had fewer opportunities to access education on average, and have poorer physical health than non-kin caregivers (Christenson & McMurtry, 2007; Cuddeback, 2004; Geen, 2003). Depending on the type of kin-based care, they may also receive little preparation prior to caring for the youth as well as fewer supports and services compared to other resource parents (e.g., foster caregivers), in part due to existing child welfare policies (Christenson & McMurtry, 2007; Geen, 2003; Winokur et al., 2014). As such, kin caregivers often experience greater parenting challenges

(Christenson & McMurtry, 2007; Geen, 2004). Kin caregivers may also face additional stressors as they navigate complex relationships with birth parents, role confusion, and the impact of intergenerational trauma (Rose et al., 2022). If adoption is part of permanency planning, kin caregivers may express reluctance if they do not wish to disrupt family relations through talk of adoption (Farris-Manning & Zandstra, 2003). Nonetheless, kin-based care provides youth with a sense of continuity through on-going connections with family members and community (Geen, 2003).

If CAS does not deem kin-based care to be appropriate, youth may alternatively be placed in *foster care*. Foster care refers to a temporary placement with previously-unknown adult(s) who provide the youth with a stable and nurturing home environment (OACAS, 2022b). Foster homes in Ontario first need to be approved by child protective services, and they may provide care for up to four youths at a time (Rodger et al., 2006). As part of the application process to become a resource parent, a Structured Analysis Family Evaluation (SAFE) assessment is completed to examine such issues as the resource parent's home safety, medical reports, police clearances, and references (OACAS, 2022b). Resource parents must also participate in pre-service Parent Resources for Information, Development, and Education (PRIDE) training. As of July 2020, to provide a more culturally appropriate approach to engaging caregivers of Indigenous young people, caregivers may alternatively complete both the Helping Establish Able Resource-Homes Together (HEART) and Strong Parent Indigenous Relationships Information Training (SPIRIT; Association of Native Child and Family Services Agencies of Ontario, 2022). Resource parents receive some compensation for their work, and they may foster for as little as a few days to several years. The legal responsibility for the youth, however, still remains with CAS (OACAS, 2022b). If the youth has special needs (e.g., medical,

mental health, or developmental), they may enter a specialized placement that includes group homes, residential facilities, or hospitalization. Some foster caregivers are also considered therapeutic or treatment foster caregivers and have specialized training to care for young people with complex mental health or medical needs (Kenora-Rainy River Child and Family Services, 2022). Regardless of a youth's out-of-home placement type, the end goal is always reunification with the family of origin if at all possible. If parental rights are removed, the provincial government assumes legal responsibility for the youth (*Extended Society Care*) until adulthood or until the youth is adopted (OACAS, 2022b).

Child Maltreatment

Types and Rates of Maltreatment

Child maltreatment is considered a form of complex, developmental trauma (National Child Traumatic Stress Network (NCTSN), 2022b). While multiple definitions exist, OACAS defines child maltreatment as a "pattern of abuse and risks of harm" including physical abuse, neglect, emotional abuse, and sexual abuse (Fallon et al., 2021; OACAS, 2022e). It typically includes a youth's exposure to multiple traumatic events that are frequently invasive and interpersonal (NCTSN, 2022b). These events often occur early in life and have significant and long-lasting consequences that interfere with critical developmental processes including attachment relationships, physical health, and cognitive, emotional, and psychological development (NCTSN, 2022b). More often than not, maltreatment occurs in multiple forms and in combination with other forms of trauma (e.g., bullying; Finkelhor et al., 2005; Lau et al., 2005; Turner et al., 2010).

The Ontario Incidence Study of Reported Child Abuse and Neglect (OIS) is a provincial study that provides incidence estimates of child maltreatment. Its most recent wave of data

collection occurred in 2018 across a three-month period in a representative sample of 18 child welfare agencies across Ontario (Fallon et al., 2021). Based on these data, provincial estimates were generated showing that 25% of maltreatment-related investigations were substantiated in Ontario in 2018 (a rate of 62.89 per 1,000 children). Of the substantiated cases, the primary maltreatment category consisted of exposure to intimate partner violence (45%), followed by neglect (21%), physical abuse (19%), emotional maltreatment (12%), and sexual abuse (3%). In terms of placement decisions, 97% of youth with substantiated maltreatment remained in the home, 2% entered informal kinship care (1.05 investigations per 1,000 children), 1% entered foster care (0.64 investigations per 1,000 children), and fewer than 1% entered residential placements (e.g., group homes; .07 investigations per 1,000 children).

Maltreatment estimates from OIS are likely an underestimation, as the findings are limited to reports investigated by child welfare. Many youths experiencing maltreatment do not come to the attention of child welfare, and OIS does not include reports that were screened out, investigated solely by law enforcement, or not reported at all (Fallon et al., 2021). For example, MacMillan et al. (2013) examined the prevalence of physical and sexual abuse using retrospective reports of a representative sample of 1,928 young adults aged 21-35 years as part of the Ontario Child Health Study. Findings indicated that 31% of participants reported physical abuse, 15% reported experiences of sexual abuse, and 8% reported both physical and sexual abuse before the age of 16. Similarly, Afifi and colleagues (2015) examined a representative general population sample of 23,395 individuals ages 18 and older from the 2012 Canadian Community Health Survey and found that 68% of participants reported no child maltreatment experiences, followed by physical abuse (16.8%), sexual abuse (4.2%), and exposure to intimate partner violence (1.4%). Specific combinations of two or more types of abuse ranged from 0.4%

to 3.7%. Among all the individuals who reported a maltreatment experience, only 7.6% indicated having had contact with child welfare (Afifi et al., 2015). Thus, young people entering the child welfare system, particularly those who are placed in out-of-home care, experience high levels of developmental trauma.

Consequences of Maltreatment on Youth Wellbeing

A youth's response to maltreatment varies based on complex interactions between risk and protective factors that include, but are certainly not limited to, the following: maltreatment type; timing, severity, and frequency of the experience(s); the youth's age and developmental stage; individual factors including the youth's temperament; their reactions and responses during the event (e.g., repeated, prolonged, and unpredictable activation of their stress response system); past experiences of trauma; and the aftermath (e.g., whether the youth returned to a period of safety; availability of supportive adults; Cicchetti & Toth, 1995; Claessens et al., 2010; Perry & Hambrick, 2008). Thus, a combination of these factors can either exacerbate or buffer against negative outcomes (Afifi & MacMillan, 2011). Afifi and McMillan (2011) provided a review of protective factors and reported that certain family-level factors have been consistently linked to more adaptive responses to maltreatment, including a stable family environment and supportive relationships. Individual-level factors include positive self-esteem, adaptive skills, and possibly intelligence (though this finding is inconsistent; Afifi & MacMillan, 2011). Despite these protective factors, many youth continue to struggle with the impact of trauma and are at increased risk for physical health problems, poor educational outcomes, mental health difficulties, externalizing behaviour, involvement in the justice system, suicidal behaviour, and decreased wellbeing overall (Angelakis et al., 2019; Casiano et al., 2009; Enns et al., 2006; Gilbert et al., 2009; MacMillan et al., 2001). In addition, these responses to maltreatment are

often exacerbated through entry into the child welfare system due to instability, grief, loss, and separation from family members. While it is beyond the scope of this dissertation to provide a comprehensive literature review of the impact of maltreatment (e.g., physical health, neuropsychological development) below is an overview of the factors relevant to this dissertation regarding the impact on youth wellbeing and functioning.

The prevalence rates of mental health challenges among young people in care tend to be much higher than young people in the general population. Exposure to multiple forms of trauma impact emotional and interpersonal domains (e.g., sensitivity to rejection and abandonment, unstable relationships; Briere & Jordan, 2009), impulse control, self-image, and overall mental health symptoms (Spinazzola et al., 2005). Previous estimates of mental health disorders for youth in care range from 32 to 87% (American Academy of Child and Adolescent Psychiatry, 2001; Burge, 2007; Leslie et al., 2000; Nixon et al., 2008). Youth in care with mental health challenges are less likely to be adopted, experience more restrictive placement settings and placement instability, and have a higher likelihood of juvenile justice involvement (Burge, 2007; Kutcher & McDougall, 2009; Ungar, 2005).

The OIS (Fallon et al., 2021) identified child functioning concerns reported by the child welfare practitioner following initial maltreatment investigations. In 37% of substantiated maltreatment investigations, child welfare practitioners identified at least one child functioning issue. The most common challenge included internalizing difficulties (i.e., depression, anxiety, withdrawal) in 16% of substantiated cases, followed by academic or learning difficulties (15%), Attention Deficit Hyperactivity Disorder (ADHD; 10%), behavioural difficulties (e.g., aggression; 10%), intellectual/developmental disability (9%), and attachment issues (8%). It should be noted that these ratings were based on what was available to the child welfare

practitioner during the initial investigation. Various studies have further demonstrated the increased mental health needs of youth in care, including, but not limited to, behavioural/emotional challenges (e.g., aggression, rule-breaking behaviours, and withdrawn behaviours), ADHD, and post-traumatic stress disorder (PTSD; Ackerman et al., 1998; Burge, 2007; Heflinger et al., 2000; Leslie et al., 2005; Sullivan & Van Zyl, 2008). A systematic review conducted by Bronsard et al. (2016) reported that almost half of youth in care were identified as meeting criteria for a mental disorder, with the most common being disruptive behaviour disorders (27%). The authors estimated that 11% of youth had ADHD, 18% had depressive and/or anxiety disorders, and 4% had PTSD.

Unfortunately, youth in care are also more likely to experience educational difficulties. Maltreatment influences the developing brain, resulting in poorer emotion regulation and impaired executive functioning (Grayson et al., 2006). These challenges impact youth at home, school, and with their peers. Studies have found that maltreated youth score significantly lower on standardized tests of cognitive functioning and academic achievement, experience delays in reading and math, have lower IQ scores and reading ability, are more likely to repeat grades, and are more likely to be suspended or expelled, compared to non-maltreated peers (Romano et al., 2015; Stone, 2007; Zima et al., 2000). Academic difficulties also continue into high school, with Ontario data suggesting that adolescents involved in the child welfare system graduate high school at a rate of 45% in comparison with 80% in the general population (OACAS, 2012).

Despite the high prevalence of mental health challenges and impacts on youth functioning (e.g., poor educational outcomes), our current diagnostic classification systems have limitations around fully capturing the far-reaching impact of developmental trauma. Many youth continue to struggle with the impact of trauma without meeting criteria for a diagnosis or

alternatively, receive a large number of diagnoses (Hambrick et al., 2019). Indeed, reliance on diagnostic categories may prevent identification of the varied ways in which trauma influences development and does not provide insight regarding the underlying mechanisms that youth use to cope with their experiences (Hambrick et al., 2019). For example, VanMeter et al., (2020) described pathways between maltreatment and internalizing and externalizing behaviours in youth. In particular, youth who experience maltreatment develop particular coping strategies to protect themselves from overwhelming stressors (Ullman & Peter-Hagene, 2014; VanMeter et al., 2020). As such, a youth's stress response system develops in particular ways that help them adapt to a stressful and overwhelming environment, which puts them at greater risk for poor physical and mental health outcomes.

The Role of Kin and Non-Kinship Caregivers

When considering areas of intervention to support youth in care, the role of resource parents (i.e., kinship, foster, adoptive, caregivers) is critical. Not only are they important by virtue of their proximity to the youth, but it is very difficult to attract and retain resource parents within the child welfare system (Rodger et al., 2006). Currently, the rate of youth in out-of-home care is growing faster than the number of available resource parents (Administration of Children, Youth and Families, 2012; Leake et al., 2019; Rodger et al., 2006). A limited number of resource parents means that youth in need of out-of-home care may be required to reside in group homes or residential facilities, and these living arrangements have been shown to be more detrimental to youth well-being relative to kin-based or foster care placements (Conger & Rebeck, 2001; Rodger et al., 2006).

The role of positive, supportive adult relationships is important for any young person, but particularly for those who have experienced trauma of an interpersonal nature. In fact, stable

family environments and supportive relationships have been found to be a protective factor against the negative effects of maltreatment (Afifi & MacMillan, 2011). The relationship between youth and caregiver(s) can serve a protective function and is related to more positive outcomes (Cooley et al., 2014; Griffin et al., 2011). For example, more positive communication and stronger youth-caregiver attachments were associated with fewer behavioural challenges (Leathers, 2006; Vuchinich et al., 2002). Leathers (2006) found that youths who had positive relationships with their caregivers were less likely to experience a placement disruption despite the presence of challenging behaviours. Alternatively, youths with fewer positive relationships tend to have greater difficulty decreasing the arousal of their stress response system, making it much harder to heal from trauma's effects (Ludy-Dobson & Perry, 2010).

The benefits of a positive youth-caregiver relationship are bi-directional. Resource parents are more likely to continue providing care to their youth if they feel competent to handle their needs, if they observe improvements in their youth's functioning throughout their placement, and if they are supported by their child welfare agency (Denby et al., 1999; Leschied et al., 2014). Resource parents also benefit when they experience a sense of self-efficacy in their parenting role (Whenan et al., 2009). Conversely, resource parents tend to be dissatisfied and more likely to withdraw from fostering when there is conflict with the child welfare practitioner, insufficient compensation, and/or allegations of abuse within the home (Leschied et al., 2014). Additionally, a highly reported and significant concern for the retention of resource parents is the inability to manage a youth's behavioural challenges (Barber et al., 2001; Koh et al., 2014; Leschied et al., 2014; Newton et al., 2000).

When resource parents struggle in their parenting role, there is a greater likelihood of placement breakdowns, which have a negative impact on both the resource parent and the youth.

Placement breakdowns result in young people moving to and from foster homes without achieving stability either in their home life or at school (should a placement result in a school change as well). Consequently, there is a strong association between placement instability and internalizing and externalizing problems, even after considering the young person's baseline level of behavioural functioning (Newton et al, 2000; Rubin et al., 2007). There seems to be a harmful cycle between youth emotional/behavioural problems and out-of-home placement instability, such that problems contribute to placement breakdowns, which then contribute to a worsening of emotional and behavioural issues, contributing to a further likelihood of additional placement breakdowns.

Theoretical Framework

The results of this dissertation can be situated within Bronfenbrenner's Ecological Systems Theory (1979). Ecological Systems Theory considers how a young person is influenced by nested systems and individuals within these systems (Hitchcock & Chestnut, 2020). Systems and individuals most proximal to the young person are considered to have a direct impact (e.g., family, resource parents, teachers), while systems and individuals further away from the young person have an indirect influence (e.g., neighbourhoods, schools). Ecological Systems Theory posits that these influences are bi-directional, suggesting that the various systems and individuals within these systems influence the young person, and are influenced by the young person. Although this dissertation did not directly address many of the components of the Ecological Systems Theory (e.g., child welfare systemic factors, educational context, etc.), the results may be interpreted within this wider context. Thus, this dissertation emphasized individual youth factors (e.g., behavioural and emotional functioning) and resource parents given their close proximity to the young person and influential role.

Dissertation Objectives

The combination of maltreatment experiences and the impacts on youth mental health challenges, along with the often limited supports for resource parents, contribute to a greater likelihood of placement disruptions that only increase the burden of trauma and loss on youth in care. Despite permanency being a key goal within child welfare, many youth in care experience multiple placements which have been associated with poor outcomes (Brown & Bednar, 2006; Rock et al., 2015). Within the context of the many supports that must be offered to resource parents and youth in care, one area of intervention includes parenting support for resource parents. Currently, there is no mandated in-service trauma-informed parenting program for resource parents in Ontario. Thus, the overall objective of my dissertation was to *assess* youth and caregiver associations with the number of placements youth experience (Study 1), and *address* some of these factors by evaluating an in-service trauma-informed parenting program for resource parents (Study 2).

While numerous studies have examined the predictors of placement disruptions, few have done so within a Canadian context using data from multiple sources, including the youth, caregiver, and child welfare practitioner. Thus, Study 1 of the dissertation focused on better understanding the strengths and needs of both youth in care and their caregivers. I also examined the factors associated with the number of placements a youth experiences with a focus on proximal youth and caregiver variables. Despite the importance of strong connections for youth in care, much of previous research has focused on individual youth risk factors and not on the caregiving relationship despite this being a key opportunity for intervention (Storer et al., 2014). Thus, I conducted a hierarchical regression analysis to examine youth and caregiver associations with the number of placement changes among 1,624 Ontario youth aged 10-17 years based on

data collected from youth, caregivers, and child welfare practitioners. These results further serve to inform Study 2, as some of these same characteristics were targeted through the evaluation of a trauma-informed parenting program.

While the objective of Study 1 was to further our *understanding* of youth characteristics and caregiver concerns related to the number of placements a youth experiences, Study 2 focused on *addressing* some of these factors in order to better support resource parents and youth in care, with the overall intention of reducing the likelihood of placement disruptions. Although there are programs worldwide designed to support resource parents, a number are only pre-service training programs delivered to resource parents before they welcome a youth into their care. However, resource parents benefit from both pre-service and in-service training and support (Rork & McNeil, 2011). It appears that programs that include an in-service component demonstrate more positive outcomes (e.g., awareness, competency, skill acquisition) than programs with only a pre-service training program, although such evaluation research is limited (Rork & McNeil, 2011). In Ontario, only the pre-service PRIDE or HEART and SPIRIT training is mandated, with in-service components varying among child welfare agencies. Given the complex needs of youth in care, the delivery of in-service support for resource parents seems critical to better ensure placement stability, youth well-being, and caregiver satisfaction (which in turn promote continued fostering). Thus, Study 2 focused on evaluating an in-service trauma-informed parenting program for resource parents, namely *The Resource Curriculum* (RPC; see Appendix A for RPC's Logic Model developed for the purposes of this dissertation), developed by experts at the National Child Traumatic Stress Network. This preliminary evaluation used a repeated-measures quasi-experimental design that included a wait-list control group. The program evaluation was organized according to Kirkpatrick and Kirkpatrick's (2016) four levels of

training evaluation to evaluate the first three levels of outcomes: 1) reactions, 2) learning, and 3) behaviour. Due to time constraints and the preliminary nature of the evaluation, it was beyond the scope of this dissertation to include the fourth level (results), which is the degree to which more global outcomes occur as a result of the program (e.g., a reduced likelihood of placement disruptions).

Both studies have important practical implications for improving youth and caregiver wellbeing. Given that previous research on placement disruptions has been conducted largely in the United States, Study 1 provides a Canadian context as well as an updated picture of placement disruptions within the context of caregiver and placement characteristics and youth mental health functioning. Study 1 also provides important insights into possible areas of intervention for youth (e.g., addressing emotional and behavioural needs) and caregivers (e.g., opportunities to further expand knowledge and skills in parenting a youth with a history of trauma).

Study 2 provides important information regarding resource parent satisfaction with the RPC program and program effectiveness targeting youth and caregiver outcomes. To my knowledge, this is the first virtual delivery of RPC that has been formally evaluated. This format may help to improve accessibility and remove barriers in attendance, ensuring resource parents may have better access to effective in-service programs. Study 2 is also the first to use a quasi-experimental design to evaluate RPC (regardless of virtual or in-person delivery) across multiple time-points, including a 2-month follow-up. This study speaks to the importance of continued efforts to engage resource parents and provide them with trauma-informed in-service training.

Study 1: Number of Placement Changes Among Young People In Care: Youth and Caregiver Associations

Although a central goal of child welfare is to create placement stability for young people in care, disruptions often occur once a youth joins the home of a resource parent (i.e., foster, adoptive, and kinship caregivers). Placement disruptions have a number of negative psychological, social, and educational consequences for youth (Brown & Bednar, 2006; Goyette et al., 2021; Rock et al., 2015). To understand placement instability (operationalized in this study as the number of placement changes a young person has experienced), one must first consider permanency within the child welfare system. Achieving permanency for a youth in care is one of several central goals within child welfare (Schofield et al., 2012; Stott, 2012). Permanency is multifaceted and encompasses psychological (unconditional emotional connections), physical (safe and stable living environment), and legal (reunification, legal custody, adoption) considerations (Osmond & Tilbury, 2012).

Placement stability is related to permanency planning for young people in care (Schofield et al., 2012; Stott, 2012), because a youth in a stable placement is more likely to be adopted or to experience reunification with their biological family (Akin, 2011; Practice and Research Together, 2016). Permanency can be a complicated task when considering the young person's lived experience, the availability and quality of placement options, and child welfare organizational principles and policies. Research from the U.S. indicates that placement disruptions are common. In 2007, 39% of youths (ages 1 to 20 years) in care for longer than 12 months, and 68.3% in care for 24 months or longer, lived in more than two placements (U.S. Department of Health and Human Services, 2010). Other U.S. estimates have indicated that between 20-50% of youth placements end prematurely (Minty, 1999). Data from 852 youths

aged newborn to 17 years in the province of Ontario (Canada) revealed that, after two years, 31.2% of the placements were still intact, 34.2% ended with biological family reunification, 29.6% ended by transfer to another family or group home placement, and 5% ended in other ways (e.g., transitioning out of care, running away, incarceration; Perry et al., 2012). Other Canadian data from Quebec indicate that over a third of adolescents in care until 18 years old were moved from one home to another (Hélie et al., 2017).

Young people who do not experience permanency and "age out" of the child welfare system are at greater risk for incarceration, income insecurity, unemployment, educational difficulties, and mental health problems (Goyette et al., 2021; Lockwood et al., 2015). With limited availability of out-of-home placements, high staff turnover, and difficulties with resource parent retention, the challenge lies not only in finding physical permanence for young people but also in ensuring a good match with a resource parent who can provide the youth with a positive relationship and support (Schofield et al., 2012).

Barriers to Achieving Placement Stability

Youth Factors

Risk factors for placement disruptions at the individual level include youth age, gender, reason for child welfare involvement, emotional and behavioural needs, and access to services. Although there are multiple individual risk factors, I have reviewed those that have been found to be most strongly associated with placement breakdown and that are most relevant to my focus on proximal youth and caregiver variables (Konijn et al., 2019; Oosterman et al., 2007). Regarding youth age, two meta-analyses (Konijn et al., 2019; Oosterman et al., 2007) found that youths placed in care at an older age (i.e., older than 3 years old) were more likely to experience placement disruptions. Canadian data from 29,040 youth in care in Quebec also found that older

youth, particular those aged 10 to 13 years at initial placement, were at highest risk of placement changes (Esposito et al., 2014). It is important to consider other relevant factors that are likely to co-occur with youth age (McDonald et al., 2007). For example, circumstances that existed within the home prior to entering foster care (e.g., poverty, maltreatment characteristics, parental substance use) may contribute to older youth engaging in greater high-risk behaviours (e.g., substance use; Stott, 2012). Understandably, these behaviours are often challenging for resource parents to manage without the appropriate supports, which may result in resource parents feeling overwhelmed, less engaged, and more likely to prematurely terminate the placement (Tonheim & Iversen, 2019). For gender, although several studies have reported a correlation between male gender and greater placement instability, results are mixed so additional research is required (Farmer et al., 2008; Webster et al., 2000).

Turning to child welfare involvement, research has found that youths who entered care for reasons related to abuse were more likely to experience placement disruptions than those in care for neglect (Oosterman et al., 2007). Youths with histories of neglect are more likely to be younger and have fewer behavioural difficulties, both of which are factors linked to fewer placement disruptions (Oosterman et al., 2007). Stone and Stone (1983) found that young people who experienced chronic maltreatment were more likely to experience placement disruptions. Unfortunately, this tends to be the reality among many young people in care. For example, Turner et al. (2010) found that two in three youths who experience victimization experience multiple forms. Similar findings have been reported by Babchishin and Romano (2014) in a Canadian sample of school-aged children (N = 213), where the majority of children who experienced victimization had multiple forms (e.g., child maltreatment, peer/sibling victimization). Multiple experiences and chronicity of victimization are strong predictors of

future negative outcomes, with a dose-response relationship between maltreatment and future mental health challenges which can subsequently place young people at greater risk for placement disruptions (Jonson-Reid et al., 2012).

In terms of youth behavioural and emotional difficulties, Oosterman et al. (2007) found that mental health difficulties were a robust predictor of placement disruptions. Courtney and Prophet (2011) noted that youths diagnosed with an emotional disorder were significantly more likely to have lived in three or more placements. Koh et al. (2014) examined the factors that contribute to placement disruptions using matched U.S. samples of newborn to 18 year olds experiencing stable versus unstable placements. The stable group included young people who had two or fewer placements during an 18-month period (N = 3,223), whereas the unstable placement group included those who had experienced three or more placements during the same period (N = 184). Results showed that the following factors contributed most to placement stability: 1) caregiver commitment to establishing legal permanence (e.g., adoption); 2) absence of a youth mental health diagnosis; and 3) kinship placement. Thus, any mental health impairments may pose some risk for placement disruptions, with externalizing problems being even more predictive of placement disruptions than internalizing challenges (Akin, 2011; Benedict & White, 1991; Oosterman et al., 2007; Vreeland et al., 2020). Indeed, Esposito et al. (2015) found that youths placed in residential placements were at greater risk of placement breakdown due to behavioural challenges. This latter finding may be partially due to disruptive or hyperactive behaviours being more difficult for resource parents to manage (Rock et al., 2015; Taylor & McQuillan, 2014). Nonetheless, these findings are concerning given the greater frequency of emotional and behavioural difficulties among young people in care as a function of their adverse and traumatic life experiences (Ackerman et al., 1998; Burge, 2007; Heflinger et

al., 2000; Leslie et al., 2005; Sullivan & van Zyl, 2008; Trocmé et al., 2010). In a meta-analysis by Konijn et al. (2019), the overall effect of behavioural challenges was smaller for internalizing than for externalizing problems.

Placement Factors

In terms of placement history, youths in residential care (i.e., group homes or institutions) appear to be at greater risk for placement disruptions, compared to those in parent-model placements (e.g., foster, adoptive, or kinship homes; Oosterman et al., 2007). Esposito et al. (2015) examined the factors related to out-of-home placements in a sample of 15,518 youths ages 10 to 17 from Quebec's child welfare agencies and the 2006 Canadian Census. Findings showed that residential care was associated with a higher level of placement instability than foster care, and that youths placed in residential care were considered at greater risk of placement breakdown due to behavioural challenges. Previous research has found that the first 6 to 12 months pose the greatest risk for placement disruptions (Esposito et al., 2014; Oosterman et al., 2007). Consequently, when it comes to placement history, prior moves predict future moves and point to a need to provide supports to resource parents during these critical first few months (Stott, 2012). Turning to placement characteristics, living with kinship caregivers and siblings was protective against placement disruptions (Koh et al. 2014; Konijn et al., 2019; Murphy et al., 2012; Oosterman et al., 2007). Placing siblings together reinforces existing social and emotional supports, preserves family attachments, and prevents multiple separations from family members (Ainsworth & Maluccio, 2002). Additionally, Leathers (2005) found that young people placed with siblings for the duration of their time in care were described by their caregiver and child welfare worker as experiencing an easier integration and having a greater sense of belonging in their foster homes than youths who were separated from siblings.

Resource Parent Factors

Resource parent characteristics also impact the likelihood of placement disruptions. Due to the challenges of supporting young people with high needs, many resource parents feel unprepared in their caregiving role (Barber et al., 2001; Koh et al. 2014; Leschied et al., 2014; Newton et al., 2000). Resource parent unpreparedness was deemed a potential reason for ending placements (Rock et al., 2015). In contrast, youths whose resource parent participated in training (e.g., parenting skills) were more likely to experience stable placements (Kalland & Sinkkonen, 2001). Additionally, setting effective boundaries, showing tolerance, and being emotionally involved and child-centered in one's caregiving approach seems to help protect against placement disruptions (Rock et al., 2015). In fact, a meta-analysis by Konijn et al. (2019) found that low-quality parenting practices were predictive of placement disruptions. When resource parents struggle in their parenting role, the risk of placement disruptions increases and the toll on young people is significant, as it further challenges their well-being and increases their likelihood for future placement disruptions (Rork & McNeil, 2011).

These risk factors do not work in isolation, and it is important to examine how specific factors are inter-related (Konijn et al., 2019; MacKinnon et al., 2013; Oosterman et al., 2007). Indeed, Konijn et al. (2019) indicated that to date, there is limited and inconsistent research outlining the complexity of factors that moderate the risk of placement disruption. Given the current study's focus on proximal youth and caregiver factors, I will review how these particular variables interact. In terms of youth-related factors, previous research has found that the relationship between behavioural challenges and placement disruption was strongest for older youth (Aarons et al., 2010). There also seems to be a relationship between a young person's trauma history, behavioural challenges, and risk of placement disruption. For instance, Esposito

et al. (2016) found that behavioural problems drive the risk of placement disruption for all youth, but was especially strong for those with histories of sexual abuse. Oosterman et al. (2007) described that child abuse and neglect might influence the existence of youth behavioural problems, and that more chronic as opposed to acute family problems play a role.

Previous research has also found that the relationship between challenging youth behaviours and placement disruption is impacted by factors related to the resource parent-youth relationship. For instance, more positive communication between adolescents and caregivers was related to a lower frequency of problem behaviours (Vuchinich et al., 2002). Leathers (2006) found that the youths who reported a greater sense of belonging were less likely to experience placement disruptions even in the presence of challenging behaviours. Wojciak et al. (2016) found that a warm relationship with a caregiver moderated the relationship between the youth's trauma history and youth-reported internalizing behaviours. Thus, the relationships among factors related to the youth's trauma history, mental health and/or behavioural challenges, and the youth-resource parent relationship is dynamic. Factors that facilitate a positive attachment relationship between the youth and caregiver can serve as a potential protective factor that may mitigate the negative effects of a young person's trauma history, behavioural challenges, and risk of placement disruption. Thus, investigating potential moderating variables can provide insight into areas of intervention. In fact, one evaluation of a resource parent intervention found that caregiver engagement in the program moderated the relationship between the number of prior placements and increases in youth behaviour difficulties (DeGarmo et al., 2009). This may be explained by the impact of developmental trauma on a young person's capacity for emotion regulation, which in turn leads to more internalizing and externalizing difficulties (Konijn et al., 2019).

Study Objectives and Hypotheses

The objectives of the current study were to examine: 1) youth characteristics and 2) caregiver and youth associations with the number of youth placement changes. While several studies have examined the factors associated with placement disruptions, few have done so within a Canadian context using data from multiple sources (i.e., child welfare practitioner, caregiver, and youth). Most previous research has been conducted in the U.S. and, although informative, two important differences exist between Canadian and U.S. child welfare systems (Courtney et al., 2013). First, child welfare systems operate independently within the provinces and territories of Canada. In the U.S, state child welfare agencies operate independently, but are influenced by federal policies and funding. Second, unlike the U.S., several Canadian provinces have adopted England's Looking After Children, which is an assessment approach that impacts service planning for young people in care (e.g., services centered within a developmental approach; Courtney et al., 2013). Thus, it is important to demonstrate whether previous research findings replicate within a Canadian context, particularly within Ontario for the purposes of this dissertation.

Since the majority of placement disruptions are attributed to family- and/or youth-related factors (Koh et al., 2014), I focused on these variables in the current study using provincial data from 2017 across Ontario (Canada). For demographic and placement variables, I hypothesized that older current youth age and older age when first placed in care, residential placement, higher number of maltreatment types endorsed, and experiences of physical/sexual abuse would be associated with a greater number of placement changes. For youth variables, I hypothesized that greater caregiver-reported youth mental health difficulties (i.e., emotional symptoms, conduct problems, hyperactivity/inattention) and greater caregiver-reported peer problems would be

associated with a greater number of placement changes. I also hypothesized that fewer practitioner-reported internal and external assets, caregiver-reported prosocial behaviours, and youth-reported positive mental health indicators would be associated with greater placement changes. For caregiver variables, it was hypothesized that less youth-reported positive parenting, less placement satisfaction, and a less positive youth-caregiver relationship would be associated with greater placement changes. It was also hypothesized that poorer youth-reported supervision and more inconsistent discipline would be associated with a greater number of placement changes.

Interaction terms were also selected to better understand how a young person's age at first placement, maltreatment history, behavioural difficulties, and the resource parent-youth relationship (i.e., positive parenting, relationship with caregiver, and placement satisfaction) interact. Given the established relationships among a youth's age at first placement, maltreatment history, and behavioural difficulties, the current study included these variables as interaction terms to better understand this potential dynamic. It was hypothesized that the relationship between conduct problems and the number of placement changes would be strongest for youth with a higher number of maltreatment types (as reported by the child welfare practitioner), and older age at first placement. Interaction terms illustrating the resource parent-youth relationship were also included to better understand the potential role of these protective factors given the possible clinical implications, which is the focus of Study 2. It was hypothesized that the relationship between conduct problems and the number of placement changes would be mitigated for youth with higher placement satisfaction. It was hypothesized that the relationship between placement satisfaction and number of placement changes would be impacted by the use of positive parenting approaches and the youth's relationship with their caregiver.

Methods

Participants and Procedure

This study relied on secondary Ontario Looking After Children (OnLAC) data from 2017 (Flynn et al., 2004). Developed in 2000, Dr. Robert Flynn and colleagues initiated OnLAC as a developmentally sensitive outcome monitoring initiative for young people in care (Flynn et al., 2006). OnLAC is designed to improve youth developmental outcomes and the quality of substitute parenting (Flynn et al., 2006). OnLAC data are collected from provincial child welfare agencies, as they are required by the Ontario Ministry of Children, Community, and Social Services to monitor and collect data on young people who have been in care for at least one year for purposes of service planning.

Within OnLAC's framework is the Second Canadian Adaptation of the Assessment and Action Record (AAR-C2; Flynn et al., 2006), which is the primary instrument used to assess the following eight areas of functioning: health; education; identity; family and social relationships; social presentation; emotional and behavioural development; developmental assets; and self-care skills (Flynn et al., 2006). The instrument is completed annually with the goal of tracking the development of young people in care over time. The data generated from the AAR-C2 are used both at an agency and provincial level to assess service needs, inform plans of care, monitor service outcomes, and guide service delivery and policies (Flynn et al., 2006). The AAR-C2 is intended to be completed in the form of a conversational interview involving the resource parent, child welfare practitioner, and young person aged 10 years or older. In the AAR-C2, a caregiver is defined as the person considered to be the most knowledgeable about the young person, usually because they are most actively involved in the youth's care. For example, the caregiver may include a resource parent if the youth is in kinship, customary, or foster care. The AAR-C2

includes nine age-appropriate forms that fit into four major age groupings (i.e., 0-5 years, 6-9 years, 10-15 years, and 16+ years). I utilized data collected from youths aged 10-17 years in 2017, as this was the most recent data cycle available at the time of the study. The 10-17 age grouping was used due to the availability of self-report data from youths. Ethics approval for the study was obtained from the University of Ottawa's Office of Research Ethics and Integrity (H-02-18-338; Appendix B).

Measures

Outcome Variable

In the current study, the number of placement changes was operationalized as the number of changes in main caregiver that a youth experienced since birth. Child welfare practitioners responded to the following open-ended question:

> How many changes in main caregivers has [the young person in care] experienced since birth? A main caregiver is a person who has acted in that capacity for one month or more. If care was shared by two or more people, select only one of these people as main caregiver for that period. Try to give an estimate of the number, even if you are not certain.

Including main caregiver changes across the youth's life is relevant for understanding attachment and developmental disruptions, which place a child at greater risk for future placement breakdown while in care (Oosterman et al., 2007; Stott, 2012). Nonetheless, there are several limitations with this item. First, measuring main caregiver changes since birth could possibly include moves prior to the youth's entry into the child welfare system, which may inflate the number of out-of-home changes. Second, this measure does not provide contextual information

about the reason or timing for the moves. Thus, it is not possible to determine the temporal ordering of variables thereby limiting the ability to "predict" the number of placement changes. Third, not every placement change that a young person experiences represents a disruption. For example, if a young person moves from a foster to adoptive home or is reunified with their biological caregiver(s), this is considered a placement change but it may not be best categorized as a placement disruption because it is resulting in greater permanency. However, even though such changes may result in greater long term permanency, they still have important impacts on the young person. For instance, the young person may have to adapt to a new living situation, may need to change schools, and may experience loss and disruptions in their relationships (e.g., with their previous caregiver and/or other children in the home). Finally, child welfare practitioners are asked to estimate the number of changes in main caregiver if they are uncertain, so they may rely on memory as opposed to checking factual records. While acknowledging the limitations of this variable, it is the only one available in the AAR-C2 for assessing placement changes.

Youth Variables

Youth Characteristics. Child welfare practitioners responded to several AAR-C2 items on youth characteristics: current youth age in years; biological sex; ethnicity; length of time (in years) with their current caregiver; and youth age when first placed in care. Note that biological sex is reported as binary because intersex was not endorsed in the current sample. Child welfare practitioners identified the reasons for child welfare involvement from 11 possible response options and selected all that applied (e.g., physical/sexual harm, neglect, emotional harm, caregiver capacity). In addition to considering the specific impact of particular maltreatment types, I tallied the number of selected response options to calculate a total number of

maltreatment types endorsed by the child welfare practitioner and labelled this variable *maltreatment total*. Child welfare practitioners also identified the youth's current placement from 20 different response options (e.g., foster home operated by child welfare organization, kinship care, customary care, hospital). Of these response options, the following categories were developed: foster home (i.e., operated by child welfare organization or outside paid resource); group home; residential placement (e.g., hospital, psychiatric facility, detention facility); kinship care; customary care (i.e., care and supervision of a young person of Indigenous background by an individual within the young person's community); or other (e.g., independent living). Child welfare practitioners also identified the permanency plan for the young person from 10 possible response options.

Developmental Assets. Child welfare practitioners responded to an instrument assessing a young person's developmental assets (Miller et al., 2017). This measure was originally adapted from Scales (1999) for the purposes of the AAR-C2 (Miller et al., 2017). While internal consistency reliability from the current study is in line with what is reported in the OnLAC User Manual (Miller et al., 2017), the manual does not include other psychometric properties. Twenty dichotomous items measured internal developmental assets (Cronbach's $\alpha = .78$), and 20 dichotomous items measured external developmental assets (Cronbach's $\alpha = .88$). For internal assets, five items measured commitment to learning (e.g., young person is motivated to do well in school), six items measured positive values (e.g., young person places high value on helping other people), five items measured social competencies (e.g., young person knows how to plan ahead and make choices), and four items measured positive identity (e.g., young person feels they have control over "things that happen to me"). For external assets, six items measured support (e.g., caregivers provide high levels of love and support), four items measured

empowerment (e.g., young person perceives that adults in the community value youth), six items measured boundaries and expectations (e.g., caregivers have clear rules and consequences and monitor the young person's whereabouts), and four items measured constructive use of time (e.g., young person spends time regularly in lessons or practice in music, theatre, or other arts). Yes responses were scored as 1 and summed, with total scores ranging from 0 to 20 for each of the internal and external developmental assets. Higher scores indicated a greater number of internal and/or external developmental assets.

Strengths and Difficulties. Resource parents responded to the Strengths and Difficulties Questionnaire (SDQ; Goodman et al., 2003). Goodman et al. (2001) reported that this measure was judged to have satisfactory validity, cross-informant correlation, and retest stability. This measure included five items on emotional symptoms (e.g., many worries or often seems worried), five items on conduct problems (e.g., often loses temper), five items on hyperactivity/inattention (e.g., restless, overactive, cannot stay still for long), five items on peer problems (e.g., would rather be alone than with other youth), and five items on prosocial behaviour (e.g., considerate of other people's feelings). Responses were measured on a 3-point Likert scale ranging from 0 (*not true*) to 2 (*true*). Scores from each subscale were summed and ranged from 0-10, with higher scores indicating greater frequency of the behaviour. Each subscale demonstrated acceptable to very good reliability for the current sample, with Cronbach's α = .83 (hyperactivity/inattention), .78 (prosocial behaviour), .77 (conduct problems), .73 (emotional symptoms), and .65 (peer problems).

Youth Positive Mental Health. Youths responded to the Positive Mental Health Scale (Keyes, 2006), which consisted of 14 items measuring positive mental health (e.g., during the past month, how often did you feel interested in life?). This measure was reported to have good

construct validity and internal consistency reliability (Keyes, 2006; Miller et al., 2017). Responses were rated on a 6-point Likert scale ranging from 0 (*never*) to 5 (*every day*). Total scores were computed by summing all items, with higher scores indicating a greater level of positive mental health. The internal consistency reliability estimate for the current sample was excellent (Cronbach α = .93).

Caregiver Variables

Caregiver Characteristics. I utilized the following demographic data available for caregivers: age in years; gender; number of years providing foster care; education; number of young people currently in the home (both in care and not in care); and completed trainings.

Parenting Practices. Youths responded to the Parenting Practices Scale (Elgar et al., 2007). This measure included three items on positive parenting (e.g., your caregiver tells you that you are doing a good job), three items on inconsistent discipline (e.g., your caregiver lets you out of a discipline consequence early), and three items on poor supervision (e.g., your caregiver does not know the friends you are out with). Responses were measured on a 5-point Likert scale ranging from 0 (*never*) to 4 (*always*), with higher scores indicating a greater frequency of the behaviour. Total scores for each subscale were computed by summing the three items per subscale. Internal consistency reliability estimates for the current sample ranged from acceptable to very good, with Cronbach α = .87 (positive parenting), .66 (inconsistent discipline), and .63 (poor supervision), which is in line with the internal consistency reliability reported in the OnLAC User Manual (Miller et al., 2017). No other psychometric properties are reported in the OnLAC User Manual.

Quality of Relationship with Caregiver. Youths responded to the Quality of Relationship with Caregiver Scale (Statistics Canada & Human Resources Development Canada,

1999). This scale consisted of four items measuring the quality of the youth-caregiver relationship (e.g., how well do you feel they understand you?). Responses were rated on a 3-point Likert scale ranging from 0 (*very little*) to 2 (*a great deal*). Higher scores indicated a higher quality relationship, as perceived by the youth. The internal consistency reliability for the current sample was very good (Cronbach $\alpha = .86$), which is in line with the internal consistency reliability reported in the OnLAC User Manual (Miller et al., 2017). No other psychometric properties were available to review.

Placement Satisfaction. Youths responded to the Placement Satisfaction Scale (Flynn et al., 2006), which consisted of six items measuring the level of youth satisfaction with their current placement (e.g., you have a good relationship with other people with whom you are living). Responses were measured on a 3-point Likert scale ranging from 0 (*very little*) to 2 (*a great deal*). Total scores were computed by summing all six items, with higher scores indicating a higher level of placement satisfaction. The internal consistency reliability estimate for the current sample was very good (Cronbach $\alpha = .89$), which is consistent with the internal consistency estimate reported by Flynn et al. (2006). No additional psychometric properties were available to review.

Statistical Analyses

I first conducted a missing values analysis to determine the proportion and nature of missing data across all variables. There were a number of young people with incomplete item-level data across multiple measures, with 98% of independent variables having some form of missing data. Youths with more than 25% missing data across measures were eliminated from the analysis to avoid having to impute a large amount of data, which could contribute to inaccurate results (Tabachnick & Fidell, 2007). After removing 1,101 youth (37% of the total

sample), the sample was reduced to 1,882 with a remaining small amount of missing data (0.1-3% across variables).

There are valid reasons for some of the missing data. In particular, youths in residential (e.g., group homes) or other placement types (e.g., independent living) may not have had an available caregiver to complete some of the measures (e.g., Strengths and Difficulties Questionnaire). However, not all of these participants were eliminated from the analysis, as there may have been circumstances where a young person did have a primary caregiver despite living in a residential placement or living independently (e.g., a young person may be living independently but have contact with a previous caregiver who knows the young person well). Of those youths who were eliminated from the analyses, 49.2% were living in foster homes, 21.6% were living in group homes, 12% were living independently, 6.5% were living in kinship care, 2.1% were in customary care, and the remaining 8.6% were in other placement types. Single imputation using Expectation Maximization was used to account for the remaining missing data (Hancock & Mueller, 2010). This method of handling missing data is the current standard practice in the OnLAC project (M. Miller and R. Flynn, personal communication, 2021) and has been used in previous OnLAC studies (Barnsley, 2011; Den Dunnen, 2017; Romano et al., 2019).

Table 1 presents findings from Pearson chi-square and *t*-test analyses that were conducted to determine whether there were significant differences between youths retained (N = 1,882) and those removed from analyses because of missing data (N = 1,101). I included the following socio-demographic and child welfare variables: youth current age; youth gender; age when first placed in care; reason for child welfare involvement; and the number of placement changes. No statistically significant differences were found in terms of gender or age when first placed in

care. Youths excluded from the analyses were significantly more likely to live in a residential setting (as opposed to a parent-model placement) than those retained in the sample, which was a small effect. This finding logically relates to the way in which the AAR-C2 is completed (i.e., involves input from three informants that include caregivers) and the variables selected for the current study. Specifically, some youths in residential placements may not have access to a primary caregiver to complete particular measures and as a result, these data naturally would be missing.

Statistically significant differences also were found for youth age, with the included sample of youths being younger than the excluded youths (small effect size). Significant differences were found for child welfare involvement, in that included youths were more likely to be involved in child welfare due to physical or sexual abuse and emotional harm than excluded young people. Both differences represented small effect sizes. Included youths were less likely to be involved in child welfare for reasons related to abandonment/separation, compared to youths eliminated from the analysis (small effect size). No significant differences were found for other reasons related to child welfare involvement. Finally, significant differences were found for the number of placement changes, with included youths having fewer changes than excluded young people. This difference represented a small effect size.

Prior to running the analyses, data were screened and cleaned to ensure there were no violations of assumptions, including normality and homogeneity of variance. Several continuous independent variables were outside acceptable skewness and kurtosis limits so appropriate transformations were conducted (Tabachnick & Fidell, 2013). Specifically, internal assets, emotional problems, and peer problems were transformed using the log transformation. Relationship with caregiver, prosocial behaviour, and placement satisfaction were reflected and

log transformed. Positive mental health, conduct problems, inconsistent discipline, and poor supervision were transformed using the square root transformation. Positive parenting was transformed using reflect and square root transformations. All analyses were conducted with untransformed and transformed independent and dependent variables. Differences in the results were found between the transformed and untransformed independent variables and thus, results from the transformed independent variables were reported. For the dependent variable, there was a positive skew and kurtosis. Transformations were conducted (e.g., log), but it did not meaningfully change the shape of the data distribution or the results. Thus, for ease of interpretation, I reported findings using the untransformed dependent variable.

Categorical independent variables were dummy coded (i.e., youth sex, ethnicity, placement type, and reasons for child welfare involvement). A hierarchical multiple regression analysis using the enter method was conducted to examine associations with the number of placement changes. A multiple regression analysis was deemed the most appropriate statistical technique, as it allowed for an assessment of the relationship between one dependent variable and several independent variables (Tabachnick & Fidell, 2013). Although an Analysis of Variance (ANOVA) is a form of regression that can examine main effects and interactions in a series of dichotomous independent variables, multiple regression was considered most appropriate due to the correlations among independent variables (Tabachnick & Fidell, 2013). While continuous variables can be made discrete in ANOVA, dichotomizing or categorizing data could result in a loss of information and unequal cell sizes (Tabachnick & Fidell, 2013).

Block One consisted of demographic and placement variables, including youth ethnicity, placement type, youth age, youth sex, age when first placed in care, reason for admission to child welfare, and maltreatment total. Block Two consisted of youth mental health variables that

included internal and external developmental assets, positive mental health, emotional problems, conduct problems, hyperactivity/inattention, peer problems, and prosocial behaviour. Block Three included caregiver variables consisting of caregiver relationship, positive parenting, poor supervision, inconsistent discipline, and placement satisfaction. Interaction terms were also included in the regression analysis and were developed based on previous literature (Chamberlain et al., 2008; Clark et al., 2020; Crum, 2010; Leathers et al., 2019; Oosterman et al., 2007; Vreeland et al., 2020). Specifically, Block Four consisted of the six following interaction terms: 1) relationship with caregiver x placement satisfaction; 2) age when first placed in care x conduct problems; 3) positive parenting x relationship with caregiver; 4) positive parenting x placement satisfaction; 5) conduct problems x relationship with caregiver; and 6) maltreatment total x conduct problems. Variables used to construct interaction terms were centered to avoid problems with multicollinearity (Aiken & West, 1991; Tabachnick & Fidell, 2013). The large sample size permitted the examination of many predictors that were selected based on previous research. A post-hoc power analysis was conducted using G*Power for a small effect (f^2 = .02), alpha level of .05, and sample size of 1,624, which resulted in 91% power. However, the large sample also increased the chances of statistically significant findings. Thus, effect sizes (using Cohen's f^2) were examined, where small effects represent values less than .02, medium effects represent values between .02 and .15, and large effects represent values greater than .35 (Cohen, 1988). All statistical analyses were conducted using IBM SPSS Statistics, version 28.

Results

Youth Characteristics

Table 2 shows that the average youth age was 14.22 years (*SD* = 2.14, range 10-17 years), with a fairly even distribution of males (55%) and females (45%). The most common

placement type was a foster home (68%), followed by group home (15%), kinship care (11%), independent living (1%), customary care (1%), and other (4%; hospital, children's mental health facility). Note that AAR-C2 data are not collected for young people residing in informal kinship care, as the OnLAC project is reserved for youths in out-of-home care specifically. The majority of young people had Extended Society Care status (previously referred to as crown ward status; 78%) and were first placed in care at 7.43 years of age (*SD* = 4.59, range 0-17 years).

In terms of reasons for child welfare involvement, child welfare practitioners indicated that 49% of youths were in care because of difficulties with caregiver capacity, followed by emotional harm (36%), neglect (29%), abandonment (24%), and physical or sexual harm (22%). Other reasons included request for services or assistance (8%). Young people experienced an average of 4.33 (*SD* = 2.79) changes in main caregiver since birth, which ranged from 0 to 28. Youths were living with their current caregiver for an average of 3.55 years (*SD* = 3.83; range 0 - 17). For 39% of young people, the permanency plan was to remain in their current placement, followed by independent living (18%), adoption (11%), and an unspecified permanency plan (11%). The remaining youths were planning for adult services (7%), returning home (7%), returning to kinship care (3%), were in the process of changing the permanency plan (2%), returning to customary care (1%), or other (2%).

Among the two mental health disorders listed in the AAR-C2, 34% of youths were reported by child welfare practitioners to have Attention Deficit Hyperactivity Disorder, and 32% were reported to have emotional or psychological difficulties. Child welfare practitioners indicated that, in the past year, 21% of young people participated in services from a psychologist or counselor, and 21% participated in services from a psychiatrist. Just under half (47%) of the youths were prescribed psychotropic medication.

Table 3 presents findings on the mental health functioning of young people in the current sample. Scores for positive mental health and developmental assets fell within the normative ranges, as outlined in the 2017 OnLAC User Manual, which provides norms from 2016 OnLAC data (Miller et al., 2017) as there are no Canadian norms for general population youth. Young people's strengths and difficulties were compared to British norms outlined by Goodman et al. (2003), which are separated by gender. Each subscale is sorted into three categories: normative range; borderline difficulties; and high difficulties. Both males and females in the current sample fell within the normative range on all subscales.

Caregiver Characteristics

Table 4 indicates that caregivers in the current sample were predominately female (88%) and had been providing care for an average of 10.64 years (*SD* = 8.51, range from 0-62 years). Regarding level of education, 4 in 10 (41%) indicated having received a community college certificate, followed by a high school diploma (23%), bachelor degree (14%), a non-university certificate below the bachelor level (7%), trades certificate (5%), and university certificate above the bachelor level (3%). Several caregivers did not have a high school diploma (4%), and 3% had either a masters or doctoral degree.

Just over half of the caregivers reported having completed the Parent Resources for Information, Development, and Education (PRIDE) pre-service training (53%), which is a mandated training for resource parents in Ontario prior to undertaking any parenting work with young people in care. There are two possible reasons why 47% of caregivers did not endorse completing PRIDE pre-service training. First, PRIDE pre-service training is a requirement for foster, kinship, adoptive, and formal customary caregivers within the child welfare agency. However, some caregivers are not required to complete this training, such as group home

providers or caregivers from an outside paid resource. Second, it is possible that caregivers mistakenly interpreted this item as having completed this training in the past year, as the AAR-C2 is completed on a yearly basis and so this may be an underestimation. In terms of additional training, caregivers also indicated having completed agency-specific training (e.g., PRIDE in-service; 46%), a foster caregiver training program on parenting techniques (15%), or another form of foster caregiver training (42%). However, data on the specific types of completed trainings were not available. On average, caregivers reported having an average of two additional youth in care (besides the youth in the placement; *SD* = 1.88) and an average of one youth not in care (*SD* = 1.38).

Bivariate correlations between continuous independent and dependent variables are presented in Table 5. For the correlations between independent variables and the number of placement changes, findings showed that older youth age, higher maltreatment total, greater emotional problems, greater conduct problems, greater hyperactivity/inattention, greater peer problems, and poor supervision were related to greater placement changes. Younger age when first placed in care was related to a greater number of placement changes. Less prosocial behaviour, lower positive mental health, fewer internal and external assets, and lower positive parenting were related to greater placement changes. Finally, poorer quality relationship with caregiver and lower placement satisfaction were associated with greater placement changes.

Associations with the Number of Placement Changes

Results in Table 6 revealed that the overall model was significant, $F(32, 1623) = 10.70$, $p < .001$ and accounted for 17.7% of the variance ($R^2 = .17$, SE = 2.50). Demographic and placement variables accounted for 12% of the variance in the number of placement changes, $F(13, 1610) = 17.07$, $p < .001$. Compared to youths in residential placements (e.g., group

homes), those in parent-model placements (i.e., foster, adoptive, or kinship homes) experienced fewer placement changes, which was a small effect. Younger age when first placed in care and older current youth age were associated with greater placement changes, which were small effects. A higher number of maltreatment types experienced by the youth (as reported by the child welfare practitioner) was associated with a greater number of placement changes, which was a small effect.

Adding youth mental health variables accounted for an additional 4.3% of the variance in the number of placement changes, which was a small but statistically significant effect, $F(8, 1602) = 10.17$, $p < .001$. Fewer internal assets was associated with greater placement changes, which was a small effect. Greater conduct problems, peer problems, and more prosocial behaviour were associated with greater placement changes, which were small effects.

The addition of caregiver variables into the regression model accounted for an additional 0.6% of the variance, which was statistically significant, $F(5, 1597) = 2.33$, $p < .05$. Findings indicated that lower youth-reported placement satisfaction was associated with a greater number of placement changes, which was a small effect. Interactions accounted for an additional 0.7% of the variance and as a whole, were statistically significant, $F(6, 1591) = 2.40$, $p = .03$. However, no interactions were found to be associated with the number of placements changes.

Discussion

Placement stability is a key goal for young people in the child welfare system. Unfortunately, placement disruptions are not an uncommon experience and often result in widespread negative impacts on youth well-being (Brown & Bednar, 2006; Rock et al., 2015). Using OnLAC data from 2017, I examined: 1) youth characteristics; and 2) various associations with the number of youth placement changes, with a focus on proximal caregiver and youth

variables. Data were drawn from provincial data gathered for young people in care in Ontario, rather than a convenience sample of youth. The data also relied on multiple informants that included child welfare practitioners, caregivers, and young people.

One of the objectives of Study 1 was to gather an updated picture of youth demographics and current functioning. In terms of youth characteristics, findings are partially in line with previous literature documenting the mental health needs and psychotropic medication usage of youth in care (Practice and Research Together, 2016). This latter finding raises concerns about whether these prescriptions are clinically necessary and/or therapeutically beneficial, even after considering the higher frequency of mental health disorders among youth in care (Practice and Research Together, 2016). Youth internal and external developmental assets fell within the normative ranges, compared to previous data from the 2016 OnLAC sample of 10-17 year olds. Although the scores from the current study on positive mental health and developmental assets are comparable to previous years of OnLAC data, it was not possible to compare the current sample to general population youth due to the absence of such norms. In terms of the Strengths and Difficulties Questionnaire, youths in the current sample fell within the normative ranges for all subscales, compared to young people from a community-based British sample (Goodman et al., 2003).

These findings on the mental health functioning of youths in the current sample are inconsistent with previous literature on the mental health needs of youth in care. Indeed, Marquis and Flynn (2009) reported on SDQ findings from an Ontario sample of 11-15 year olds in care and found that a higher proportion of young people had SDQ scores in the at-risk range, compared to the normative sample of British youths. Previous research has consistently found higher rates of both internalizing and externalizing challenges among youth in care, compared to

the general population (American Academy of Child and Adolescent Psychiatry, 2001; Burge, 2007, Burns et al., 2004; Leslie et al., 2005; Steele & Buchi, 2008). These estimates are between two and six times higher than the normative population (Practice and Research Together, 2016). As several measures in the current study were completed by caregivers (e.g., Strengths and Difficulties Questionnaire), it may have been useful to have measures on youth mental health functioning completed by multiple informants (e.g., caregiver-report, youth self-report, mental health providers). In addition, youths in the current sample had been living in their most recent placement for approximately three years on average. Perhaps youths in more stable or lengthy placements experience greater consistency and support, which may in turn promote well-being. It is also possible that youths removed from the analyses because of missing data were struggling to a greater extent (e.g., due to mental health difficulties, conflict with their child welfare practitioner or caregiver, etc.) and therefore less likely to complete the AAR-C2. In the current sample, excluded youths had significantly higher socio-emotional difficulties than youths retained in the sample. As a result, the current sample may not capture the full extent of youth mental health difficulties, as reported in previous research. However, both youths excluded from and those included in the analysis had total difficulties scores within the *Normal* range, as outlined by Goodman et al. (2000).

The second objective of Study 1 was to examine the associations with the number of placement changes. In terms of the variables associated with the number of placement changes, several demographic and placement variables were statistically significant and accounted for most of the variance. Several of these demographic and placement variables were consistent with my hypotheses. Youths in parent-model placements, compared to youths in residential placements, experienced fewer placement changes. This finding is in line with previous research,

as youths with a history of residential care had higher levels of placement disruptions (Esposito et al., 2015; Oosterman et al., 2007). This result may be explained by the greater frequency of externalizing difficulties among young people in residential care, likely due to their more extensive trauma histories and child welfare involvement (Collin-Vézina et al., 2011; Landsverk et al., 2009). Caregivers may have difficulty responding effectively to these externalizing behaviours and high mental health needs, which may result in greater difficulty securing a parent-model placement for these youths (Practice and Research Together, 2017). However, Esposito et al. (2015) found that youths in residential placements had less stability than youths in family-based care regardless of pre-placement differences. Younger age when first placed in care and older current youth age were both associated with a greater number of placement changes. These findings are generally consistent with previous research (Fernandez, 1999; Kalland & Sinkkonen, 2001; Konijn et al., 2019; Oosterman et al., 2007; Parker, 2021; Stone & Stone, 1983; Walsh & Walsh, 1990). Oosterman et al. (2007) reported that the effect size for the relationship between youth age and placement breakdown was small. Specifically, the longer the youth is in care, the more likely they are to experience multiple placement moves (Oosterman, 2007). However, one recent meta-analytic review found that older age at initial placement was linked to greater placement disruptions (Konijn et al., 2019), which the authors indicated may be explained by the higher frequency of behavioural difficulties among older youths. Additionally, a higher number of maltreatment types was also associated with greater placement changes. This finding is in line with previous research demonstrating a dose-response relationship between a higher number of maltreatment experiences and negative outcomes, which in turn place youths at greater risk for placement disruptions (Jonson-Reid et al., 2012). Youth ethnicity, maltreatment type, and sex were not significantly associated with the number of placement changes. Overall,

these results point to important demographic and placement factors that play a role in the number of placement changes a young person in care experiences.

In terms of youth variables, a lower level of mental health functioning was associated with the number of placement changes. Specifically, fewer child welfare practitioner-reported internal assets, and greater caregiver-reported peer and conduct problems, were associated with greater placement changes. Surprisingly, more caregiver-reported youth prosocial behaviour was also associated with a greater number of placement changes. Prosocial behaviour had a negative correlation with the number of placement changes, which was in the expected direction. However, the addition of variables in the regression model changed the nature of the relationship between prosocial behaviour and the number of placement changes. This finding is difficult to interpret and contradicts previous literature on the factors associated with placement disruptions. When considering this variable in isolation, one would expect that high levels of prosocial behaviour (e.g., getting along well with peers, offering help to others) would actually serve a protective function and contribute to placement stability (Oosterman et al., 2007). Given that I do not have information regarding the reasons or context for each placement change, it is difficult to speculate on the reasons for the association between greater prosocial behaviour and greater placement changes. One possible explanation could be that perhaps a youth with high prosocial behaviour is more likely to be moved for reasons unrelated to individual youth factors because they are seen as better able to adjust to a placement move. Another possible statistical explanation for this finding is related to a suppressor effect, which refers to the regression and correlation coefficients differing in direction. Perhaps other variables or a particular combination of variables in the regression equation changed the nature of the relationship between prosocial behaviour and the number of placements (Falk & Miller, 1992).

External assets, emotional problems, hyperactivity/inattention, and positive mental health were unrelated to the number of placement changes. The current findings are consistent with previous literature showing that behavioural problems (specifically of an externalizing nature) are a robust factor related to placement disruptions, with generally small to medium effects (Akin, 2011; Benedict & White, 1991; Courtney & Prophet, 2011; Koh et al., 2014; Konijn et al., 2019; Oosterman et al., 2007). The current findings are also consistent with two meta-analyses conducted by Oosterman et al. (2007) and Konijn et al. (2019) on emotional problems and placement disruptions, such that behavioural problems were more strongly associated with placement disruptions than emotional difficulties. This finding may be because externalizing behaviours (i.e., aggressive and impulsive behaviours) are more difficult for resource parents to manage. As a result, resource parents may feel ill-equipped to respond effectively to these behaviours and, as a result, may be more likely to prematurely terminate the placement (Rock et al., 2015; Taylor & McQuillan, 2014).

Turning to variables related to the caregiving environment, lower youth-reported placement satisfaction was associated with greater placement changes. In terms of the factors related to placement satisfaction, the current study found that placement satisfaction had strong positive correlations with youth-reported positive parenting practices and youth-reported quality of the relationship with their caregiver. It is possible that the resource parent-youth connection is fostered when young people are parented in a way that helps them feel understood, valued, and respected, which may contribute to a youth feeling more satisfied and safe in their placement. On the other hand, placement satisfaction was negatively associated with caregiver-reported poor youth socio-emotional functioning. Previous literature on youth-reported placement satisfaction is limited, with few studies examining placement satisfaction directly from youth perspectives.

Findings from the current study are fairly consistent with the few studies that do exist. Flynn et al. (2006) examined youth-reported placement satisfaction in an Ontario sample of 414 young people in care aged 10 to 17 years. Findings indicated that youths in foster care placements reported high levels of satisfaction in their placements. Additionally, youths in foster care placements reported higher levels of satisfaction than youths in group homes. Delfabbro et al. (2002) also examined youths' satisfaction with their current placement experiences in South Australia. Findings showed that youth placement happiness was not related to satisfaction with social workers or general placement quality (i.e., security, interest shown by the caregiver) but was associated with higher youth-reported parenting quality. Similarly, a dated U.S. study by Festinger (1983) found that youths who felt close to their foster family were more satisfied with their experience in the child welfare system. These findings emphasize the importance of including youth perspectives when making decisions related to their care, especially given the current findings linking greater placement satisfaction with fewer placement changes.

The current results are inconsistent with previous literature on the relationship between parenting qualities and placement disruptions, as parenting variables (i.e., positive parenting, inconsistent discipline, and poor supervision) were not found to be associated with the number of placement changes. However, previous research has identified important factors related to the caregiving environment. For instance, low-quality parenting practices were predictive of placement disruptions (Konijn et al., 2019), while a "warm" foster home, parenting support, and limit setting were predictive of placement stability (Crum, 2010; Sinclair & Wilson, 2003; Tonheim & Iversen, 2019).

Implications for Practice

This study has several implications for practice. First, much of the previous research on placement disruptions has occurred in the U.S, where the child welfare system differs from the Canadian system (Courtney et al., 2013). The current study adds a Canadian context to previous literature on variables associated with the number of placements experienced by young people in care. Our study also provides an updated picture of caregiver and placement characteristics and youth mental health functioning.

Findings from the current study provide some insight into possible areas of intervention. For example, areas of intervention may include providing appropriate youth-level supports (i.e., matching the youth to a parent-model placement whenever possible, providing mental health services, making recreational programs accessible to foster developmental assets) and caregiver-level resources (i.e., counselling, respite care, opportunities for in-service training on trauma-informed parenting). While these proximal areas of intervention are critical, support at more distal levels is also necessary. For example, resources must exist at the level of the child welfare practitioner and supervisor (e.g., good communication among the caregiver, youth, and practitioner) and at the organizational-level (e.g., funding for appropriate training opportunities and services, trauma-informed child welfare system).

Some of our findings may have practical significance despite having small effect sizes. Ellis (2010) noted that small effects can be important if they accumulate into larger effects. Young people may be at greater risk of placement disruptions when they experience several risk factors that accumulate over time. The factors associated with placement disruptions do not work in isolation, and it is important to consider how all relevant factors interact. For example, placement satisfaction was significantly associated with the number of placement changes, which

also had large correlations with both positive parenting and the youth's relationship with their caregiver. When caregivers remain mindful of their youth's trauma history and subsequently respond to the youth's needs in sensitive and attuned ways, the caregiver-youth relationship may be strengthened. This positive relationship benefits both the caregiver and the youth by reducing ongoing conflict, thereby making placement disruptions less likely to occur. While these risk factors may have small effects, the benefits of implementing preventative supports can result in many potential positive impacts. For instance, providing appropriate trauma-informed services and supports at the youth and caregiver levels may reduce the youth's risk of placement disruption, promote youth wellbeing, and improve resource parent retention.

Limitations and Future Research Directions

This study had several limitations that need to be considered. First, the measure of the number of placement changes (i.e., main caregiver changes since birth) may not be a completely accurate representation of placement disruptions, since the number of changes in main caregiver since birth may have also included experiences prior to the youth's child welfare entry. Unfortunately, the OnLAC data used in the current study did not distinguish between caregiver changes since birth and changes that occurred following the youth's entry into the child welfare system. Issues regarding the definition and measurement of placement disruptions are ongoing in the field of child welfare, with considerable variations in the definition and criteria applied in assessing placement stability and disruptions (Christiansen et al., 2010). For example, placement changes, moves, and trajectories, as well as placement history, pathways, and disruptions, are just some of the many terms used when conducting such research (Christiansen et al., 2010). These variations make comparing and summarizing previous literature a challenge.

A second limitation is with regard to the sample. In particular, a large portion of youths were eliminated from the analyses because of problematic and missing data. The exclusion of these young people may have impacted the representativeness and generalizability of the findings for all 10-17 year olds in care in the province of Ontario. In fact, there were several statistically significant differences between youths who were eliminated from analyses compared to those who were retained, though these effect sizes were small. As mentioned above, youths eliminated from the current sample had significantly higher total socio-emotional difficulties compared to those who were maintained in the sample. However, scores for total socio-emotional difficulties fell within the *normative* range for both groups, suggesting that this statistically significant difference may not be practically meaningful. Given some of the valid reasons for missing data (e.g., a youth living in residential care often does not have a caregiver to complete questionnaires), these limitations speak to the importance of how these data are collected in the first place. For example, for youth who do not have an available caregiver to complete their sections of the AAR-C2, perhaps there is the option of another individual (e.g., child welfare practitioner, youth) completing the measure to the best of their ability. This flexibility may allow for more complete data, which to some degree may reduce the barriers and limitations in addressing missing data during analyses. Addressing these barriers early on in the data collection process would allow for a more representative and generalizable sample when the data are then used for research purposes.

Third, several measures had relatively weak psychometric properties, particularly those related to parenting practices, which had subscales with few items. It would have been desirable to have more psychometrically-sound measures available to evaluate a range of parenting behaviours, particularly from a trauma- and attachment-informed perspective. It would have also

been helpful if more comprehensive measures of parenting behaviours and beliefs were available. In the current study, the weak psychometric properties may have partially explained why the parenting measures were not significantly associated with the number of placement changes. This possibility seems especially relevant given that placement satisfaction was significantly associated with the number of placement changes, as one would expect that parenting behaviours would play a role in how satisfied young people are in their placement.

Fourth, in terms of the analysis, the variables in the current study accounted for 17.7% of the variance in the number of placement changes so it is important to consider other potentially relevant factors. I did not include child welfare organizational factors, nor did I include wider socioeconomic factors (e.g., poverty) that may be indirectly related to the number of placement changes that a young person experiences (Esposito et al., 2017). Specifically, distal risk factors related to child welfare policy, including staff turnover, organizational communication and responsiveness, and child welfare practitioner psychological functioning, have all been associated with placement disruptions (Glisson & Hammelgarn, 1998; Ryan et al. 2006; Yampolskaya et al. 2011). Policy decisions may also impact placement changes, such as modifications to a young person's permanency plan or sibling reunification (Cross et al., 2013). Finally, additional caregiver-related factors that can result in a placement change may be related to circumstances in the caregiver's life, such as a change in employment or moving out of the province (Cross et al., 2013). It was also not possible to control for sibling correlation in the current study.

Fifth, the current study could not answer questions related to long-term placement trajectories because of its cross-sectional design. It would be useful for future research to examine the trajectories of placement changes from the time a youth first enters the child welfare

system in order to track the number of and context surrounding placement changes. The study design also did not permit the investigation of causal factors. The timing of the independent and dependent variables limits the conclusions that can be drawn regarding the predictors of placement disruption, as the current study could not determine the temporal order of variables. A longitudinal study may clarify the temporal order of independent variables and placement disruption, which would provide a more rigorous analysis of possible predictors of placement changes.

Finally, few studies have considered placement satisfaction in relation to placement changes. These findings emphasize the importance of including youth perspectives, especially regarding their own lives. Future research may help to better understand underlying mechanisms that contribute to placement satisfaction. Better understanding the factors that contribute to placement satisfaction would have important implications for practice, particularly for possible areas of intervention.

Study 2: Evaluation of a Trauma-Informed Parenting Program for Resource Parents

Resource parents (i.e., kinship, foster, and adoptive caregivers, group home providers) play a crucial role in the lives of young people involved in the child welfare system. They bear much responsibility, as they are tasked with parenting young people who have complex needs, stabilizing their environment, helping ensure they have access to needed services, promoting their physical and mental health and development, navigating the child welfare system, and facilitating connections between the young person and their biological family (Pasztor et al., 2006; Rich, 1996; Robertson, 2006).

Resource Parent Recruitment in Ontario

In Ontario, resource parent applicants complete the following requirements: (1) a SAFE home study and (2) pre-service training consisting of PRIDE or HEART and SPIRIT (Association of Native Child and Family Services Agencies of Ontario, 2022). The SAFE home study is a standardized assessment that includes the resource parent's application, home safety checklist and questionnaires, medical report, police and child welfare clearance, and references (OACAS, 2022b). The assessment, which is completed by a child welfare worker or ministry-approved licensed practitioner, takes four to six months to complete and is valid for up to two years (OACAS, 2022b). The PRIDE training is a nine-module program designed to prepare families for fostering by learning about the child welfare system's processes and laws, attachment and loss, child development and the needs of child welfare-involved youths, maltreatment effects, identity formation, and the importance of connections and continuity for youth (OACAS, 2022b). HEART and SPIRIT, which is pre-service alternative to SAFE and PRIDE, supports Indigenous family systems by delivering content aligned with the learning of Indigenous peoples, is applied flexibly to meet the diverse needs within the Indigenous

population, and provides greater understanding and supports for intergenerational trauma (Association of Native Child and Family Services of Ontario, 2022). While these requirements help ensure the recruitment of qualified resource parents and help prepare them for their role prior to caring for youth, there currently is no mandated in-service training in Ontario for resource parents once they welcome youth in their care.

In the 2021-2022 fiscal year, there was a monthly average of almost 8,700 youth in out-of-home care in Ontario (OACAS, 2022a). Unfortunately, this number is increasing faster than the rate of available resource parents and is related to difficulties with resource parent recruitment and retention (Barbell & Freundlich, 2001; Ciarrochi et al., 2012; MacGregor et al., 2006; Rhodes et al., 2001; Rodger et al., 2006). There also is a discrepancy between supply and demand, explained in part by the increased length of stay of youth in foster homes (Farris-Manning & Zandstra, 2003). While recent literature was not available, the Ontario Association of Children's Aid Societies consistently calls for ongoing recruitment of resource parents (OACAS, 2022b).

Resource Parent Retention: The Importance of Training

With a limited number of resource parents available to meet the growing population of youth in care, resource parent retention is imperative. The recruitment and retention of resource parents are key factors in the delivery of quality foster care services (Hanlon et al., 2021; Sellick & Howell, 2003). To understand the factors that impact resource parent retention, it is important to consider why they choose this role in the first place. Previous literature has identified both intrinsic and extrinsic motivations for becoming a resource parent. Intrinsic motivations include a desire to help children, increase family size, adopt, and/or fill an "empty nest", as well as personal values/belies (e.g., religious, moral, social responsibility; Andersson, 2001; Denby et

al., 1999; Gouveia et al., 2021; Roger et al., 2006). An extrinsic motivation includes supplementing family income (Denby et al., 1999; Gouveia et al., 2021; Isomaki, 2002; Redding et al., 2000; Roger et al., 2006).

Factors related to resource parent retention include the child welfare system, resource parent personal/family characteristics, and youth characteristics (Gouveia et al., 2021). At the level of the child-welfare system, resource parent retention is supported when there is regular, quality communication with the child welfare practitioner, when resource parents receive appropriate training, and when the child welfare practitioner provides information and shows approval (Denby et al., 1999; Hanlon et al., 2021). Resource parent retention is compromised when there is insufficient financial support, lack of information about the youth's history, exclusion from service planning, and challenges accessing appropriate services (e.g., assistance with transportation, respite care, mental health professionals; Buehler et al., 2003; Coakley et al., 2007; Hanlon et al., 2021; Whenan et al., 2009). Resource parent personal/family characteristics that support retention include adequate social support, feeling confident and competent to handle the needs of the youth, and maintenance of the initial motivations for caregiving. On the other hand, high stress and mental/emotional pressure, and higher tension in the family system may compromise retention (Adams et al., 2018; Buehler et al., 2003; Coakley et al., 2007; Geiger et al., 2013; Hanlon et al., 2021; Mihalo et al., 2016; Whenan et al., 2009). Youth characteristics that support retention include a positive youth-caregiver relationship, while emotional and behavioural difficulties, as well as few perceived improvements in the youth's progress, have been identified as barriers to retention (Adams et al., 2018; Geiger et al., 2013; Hanlon et al., 2021; Mihalo et al., 2016; Whenan et al., 2009). In sum, resource parents bear much responsibility in their role and manage high levels of stress and pressure.

Not only is resource parent retention important, but good quality resource caregiving is crucial for ensuring positive youth outcomes and resource parent satisfaction (Baum et al., 2001; Barth, 2001; Denby et al., 1999; Piescher et al., 2008; Sanchirico & Jablonka, 2000). Due to the shortage of resource parents, they are increasingly being asked to care for youth with complex needs that extend beyond the scope of their training (Whenan et al., 2009). Young people coming into care experience high levels of developmental trauma related to adverse circumstances within their own birth families and to their separation from primary caregivers, coupled with involvement in the child welfare system. Consequently, it is imperative that resource parents who provide a home for these young people are well supported by their agency and have opportunities to develop competencies in trauma-informed care. Trauma-informed care considers the impact of trauma on those involved in the child welfare system, including young people and their families, resource parents, and child welfare staff (NCTSN, 2022$_a$). Such an approach facilitates subsequent responses that take into account a young person's trauma history to avoid re-traumatization, provide opportunities for healing, and promote stability, predictability, and safety. Without a trauma-informed approach, resource parents may be more likely to interpret challenging behaviours (e.g., lying, stealing, aggression) in terms of manipulation and disobedience as opposed to stemming from resourceful adaptations that the young person had to make to survive in an unpredictable, unsafe, and/or chaotic environment (Murray et al., 2019).

When caregivers feel unprepared in caring for youth with high needs, the youth's mental health difficulties may persist and caregivers may feel less satisfied in their caregiving role (Farmer et al., 2005). These factors contribute to early placement termination and resource parent dropout (Farmer et al., 2005). In fact, a lack of sufficient training has been cited as a main reason for resource parent dropout (Buzhardt & Heitzman-Powell, 2006). The need for high-quality

resource parent training has been a consistent theme in the literature. Murray et al., (2011) conducted structured interviews with 17 foster caregivers in New Zealand regarding their perceptions of the support and training they receive as well as existing gaps. Findings showed that resource parents reported a large unmet need for training and support along with high parenting stress caring for youth with a range of mental health challenges. They indicated their highest need was for training in managing and responding to these difficulties.

Kaasbøll et al., (2019) conducted a systematic review of 13 studies that were primarily quantitative from four countries (i.e., US, UK, New Zealand, and Canada) to examine foster caregiver needs, satisfaction, and perceptions of training. For those who completed foster caregiver training, there were high levels of satisfaction across various programs. Several unmet training needs were identified, including topics related to youth mental health, trauma, attachment, foster caregiver needs (e.g., burnout), and cultural needs/diversity. For training delivery, foster caregivers noted a desire for flexibility in the delivery of the program and requested online training formats to reduce barriers in attendance, particularly for those living in rural areas. They also reported a desire for interactive exercises, using accessible and understandable language, and use of real-life examples. Foster caregivers further noted that it would be helpful to have tangible materials they can use after the completion of the program. The authors noted that few studies exist that focus specifically on the training needs of kinship caregivers despite the large number of youths in kinship care. The needs of a kinship caregiver may differ from a foster caregiver given their personal connection to the youth's family system, which may bring about unique challenges and support needs.

One way to reduce the likelihood of placement breakdowns is to ensure that resource parents feel prepared prior to caring for a young person and then supported and equipped once a

youth enters into their care. Resource parent training has been associated with higher parenting skills (Akin et al., 2017), increased self-efficacy and role satisfaction (Randle et al., 2018), willingness to support connections with the youth's family of origin (Cooley & Petren, 2011; McNeil et al., 2005; Sanchirico & Jablonka, 2000; Solomon et al., 2017), and fewer reported youth behaviour difficulties (Solomon et al., 2017). Further, effective training of resource parents results in greater retention, placement stability, permanency for youth, and resource parent satisfaction (Barth, 2001; Baum et al., 2001; Denby et al., 1999; Piescher et al., 2008; Sanchirico & Jablonka, 2000). These supports must be promoted at the organizational level within the child welfare system. While offering access to effective training for resource parents is an important component, resource parents also require regular follow up by child welfare staff to feel well-supported (Kaasbøll, 2019).

Existing Training Programs and Supports

There are a number of parent training programs with a wide variety of content designed for biological, foster, or adoptive caregivers that emphasize various domains such as child development, strategies for managing challenging behaviour, and working within an agency. Kemmis-Riggs et al. (2017) conducted a systematic review of effective program components of psychosocial interventions for resource parents. These components had clear program objectives, included trauma psychoeducation, addressed specific stages of development, and problem-solved particular parenting challenges. Interventions that were found to improve parent-child relationships included helping resource parents to develop empathic, sensitive, and attuned responses to the youth in their care. Kaasbøll et al. (2019) noted that in-service programs incorporating resource parents' experience, combined with teaching on theoretical knowledge was most preferred. Uretsky and Hoffman (2017) conducted a systematic review and meta-

analysis of four manualized, multi-session training interventions delivered to resource parents that targeted externalizing behaviours. The four intervention models consisted of: Incredible Years, Keeping Foster and Kin Parents Supported and Trained (KEEP), Middle School Success Program, and Cognitive Behavioural Parent training. All studies included in the review reported a significant decrease in youth externalizing problems. Results on various parenting outcomes (e.g., parenting stress, positive parenting, parenting skills) were mixed, with only some studies finding evidence of increased parenting skills and reduced parenting stress (Uretsky & Hoffman, 2017).

While many parenting programs could be tailored to fit a resource parent context, I will focus solely on reviewing a selection of in-service programs delivered in a group setting and designed to meet the needs of a resource parent population. Pre-service programs were excluded because PRIDE training is mandated in Ontario, and the focus of the current study is on in-service training for resource parents. In addition, despite the presence of many pre- and in-service programs, they all have various levels of supporting research evidence. The training programs outlined below were selected due to their applicability to both children and adolescents. Thus, programs designed for infants and very young children were not reviewed.

Together Facing the Challenge (TFTC)

Developed in the United States, TFTC is designed for treatment foster care, a form of out-of-home care by resource parents who have specialized training to care for youth with significant emotional, behavioural, social, or medical challenges. TFTC is a 7-session course with delivery consisting of one two-hour session every other week. The goals of the program include building therapeutic relationships, teaching cooperation skills, implementing parenting techniques, promoting independence within the youth, and creating a positive home environment

(CEBC, 2022d). A U.S. randomized controlled trial of the TFTC program was conducted by Farmer et al. (2010) with 247 youth, aged 2-21 years, and their resource parents. Data were collected at baseline and at 6- and 12-month post-intervention with both youth and their resource parents. Results indicated that, compared to youth in the control group, TFTC youth showed significantly greater improvements in emotional symptoms, externalizing behaviours, and strengths (i.e., scores on the Behavioral and Emotional Rating Scale; Epstein, 2000). These effects remained significant at 6- and 12-month follow-up.

Keeping Foster and Kin Parents Supported and Trained (KEEP)

Originating in the United States, the KEEP program was developed for children ages 4-12-years in out-of-home care with externalizing behaviour difficulties (Chamberlain et al., 2008). KEEP was adapted from Treatment Foster Care Oregon (originally Multidimensional Treatment Foster Care), which is a family-based alternative for juvenile justice system-involved adolescents with mental health problems. Resource parents first complete 20 hours of pre-service training. Once the child is in the home, resource parents have access to ongoing supports that include daily phone contact, crisis intervention, weekly group meetings that focus on training and supporting parenting practices, and skill management strategies (Price et al., 2008). There have been a number of evaluations of the KEEP program to date. Price and colleagues (2008) conducted a randomized controlled trial in California involving 1,400 resource parents of youth ages 5 to 12 years. Findings indicated that resource parents trained in this program had children with fewer behavioural problems and increased placement stability, and greater retention of resource parents (Price et al., 2008). In fact, the KEEP program mitigated the detrimental impact of a history of multiple placements (Price et al., 2008). A number of additional randomized controlled trials have been conducted on the KEEP program and have found similar positive

results (Chamberlain et al., 1992; Chamberlain et al., 2008; Greeno, et al., 2015; Price et al., 2015). Piescher et al. (2008) rated this program as a promising practice, due to the emphasis on managing challenging behaviours and mental health problems, as well as its positive gains in parenting skills, youth behaviours, and placement success.

Attachment, Regulation, and Competency Framework (ARC Reflections)

Developed in the United States, ARC Reflections is a skills-based curriculum designed for resource parents of youth from birth to 18 years. Based on the Attachment, Regulation, and Competency framework for the treatment of traumatic stress in children and adolescents (Blaustein & Kinniburgh, 2018), the goals of ARC Reflections are to promote understanding of youth behaviours using trauma-informed perspectives, develop positive and safe relationships, support youth self-regulation, and resource parent roles (CEBC, 2022$_a$). The curriculum is delivered in a group format over nine 2-hour sessions. According to the California Evidence-Based Clearinghouse for Child Welfare, there are currently no peer-reviewed studies on program outcomes (CEBC, 2022$_a$).

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents (Resource Parent Curriculum; RPC)

RPC is an 8-module curriculum delivered over 2-hour weekly sessions. It was designed to help therapeutic, foster, adoptive, and kinship caregivers (all referred to as resource parents) build their trauma-informed caregiving skills. This program was developed in the United States and intended for resource parents of youth from birth to 21 years. The overall goals of RPC are 4-fold: 1) Increase knowledge and beliefs related to trauma-informed parenting; 2) Increase caregivers' ability to tolerate challenging youth behaviours; 3) Increase parenting self-efficacy; and 4) Increase awareness and importance of self-care and connections with other resource

parents (CEBC, 2022b). RPC focuses on nine essential elements of trauma-informed parenting: recognizing the impact of trauma; providing physical and psychological safety; managing difficult behaviours and emotions; promoting relationships; developing a strength-based life story; advocacy; promoting trauma-informed services; and self-care (California Evidence Based Clearinghouse for Child Welfare, 2022b; Grillo et al., 2010). The eight modules include: Module 1- Welcome and Introductions; Module 2- Trauma 101; Module 3- Understanding Trauma's Effects; Module 4- Building a Safe Place; Module 5- Dealing with Feelings and Behaviours; Module 6- Connections and Healing, Module 7- Becoming an Advocate, and Module 8- Taking Care of Yourself (Grillo et al., 2010). Appendix C provides an outline of the learning objectives for each module. Throughout the modules, there are interactive group activities, case examples, and discussions. Training resources, facilitator manuals, and participant materials are freely available online through NCTSN (www.nctsn.org).

Four published evaluations of RPC have been conducted to date. Sullivan et al. (2016) conducted a pre-post evaluation with 159 resource parents in North Carolina, and findings showed that both kinship and non-kinship caregivers demonstrated significant self-reported increases in their knowledge and beliefs regarding trauma-informed parenting. There also were significant self-reported increases in parenting self-efficacy after participating in the program. While non-kinship caregivers demonstrated significant increases in their self-reported ability to care for challenging behaviours, kinship caregivers did not report such changes. Though, this may have been due, in part, to existing group differences prior to participating in the RPC program. Caregivers also expressed high satisfaction with the curriculum content and delivery. Another evaluation with 112 resource parents in the Netherlands explored resource parents' recognition of youth post-traumatic stress symptoms before and after completing RPC, and at 6-

month follow-up (Gigengack et al., 2017). Results indicated that resource parents showed an increase in recognition of their youth's post-traumatic stress symptoms and decreases in their parenting stress over time, which were maintained at the 6-month follow-up. The authors noted that resource parents reported fewer post-traumatic stress symptoms in their youth after completing RPC and at follow-up, compared to baseline.

A pre-post evaluation conducted by Strolin-Goltzman and colleagues (2018) examined RPC plus two parent management training modules adapted from the Child and Adult Relationship Enhancement (CARE; Messer et al., 2018) and Helping the Non-compliant Child (HNC; McMahon & Forehand, 2003). Findings showed that parents who completed the training showed increases in knowledge, increases in parenting self-efficacy, and decreases in negative perceptions of their children. Other research on RPC conducted by Murray et al. (2019) found that RPC resulted in increases in resource parents' knowledge regarding trauma-informed parenting from pre-to-post intervention, including tolerance of challenging behaviours and self-efficacy in caring for a child who has experienced trauma. Results also suggested that these results occurred regardless of resource parent gender, race/ethnicity, or type (i.e., foster, adoptive, kinship, or treatment foster caregiver).

I selected the RPC program as the focus of this evaluation for three reasons: (1) sustainability; (2) program components; and (3) previous research. For sustainability, the RPC program is freely available through NCTSN which is critical from a sustainability perspective due to the limited resources and high staff turnover within the child welfare system. Facilitator training for RPC is easily accessible and flexible due to its online format. Ease of facilitator training also supports an agency's capacity to continue offering the program past this current project's duration because it is possible to more easily train new facilitators should there be staff-

turnover. For program components, the RPC program includes all of the necessary "ingredients" outlined in the systematic review by Kemmis-Riggs et al. (2017). RPC includes clear program and learning objectives (see Appendix C). The modules include psychoeducation on trauma, including understanding trauma and addressing how trauma impacts youth at certain stages of development. Finally, RPC addresses particular parenting challenges (e.g., Module 5- Dealing with Feelings and Behaviours). Lastly, for previous research, there have been several initial evaluations of the program, as outlined above, which show promising results, but more rigorous methodology using a control group is needed to further understand the program's efficacy.

Study Objectives and Hypotheses

Study 2 builds on the information gathered from Study 1. While Study 1 focused on *understanding* the associations with the number of placement changes and the functioning of both resource parents and youth in care, the objective of Study 2 was to *address* some of these factors by conducting a preliminary evaluation of the RPC program. Specifically, I aimed to gather feedback from resource parents who completed the program on training content relevance and satisfaction and to assess the program's impact on youth and caregiver outcomes. This study consisted of a quasi-experimental design including within- and between-subject factors. The repeated measures or within-subject factor was time point with three levels (baseline, post-program, and 2-month follow-up), and the between-subjects factor was group condition with two levels (waitlist control or experimental). While a longer follow-up period was considered, it was beyond the scope of the current evaluation.

Outcomes included resource parent-reported youth and caregiver variables that map onto the RPC learning objectives (Table 7). Results from Study 1 also informed the selection of outcome measures. Specifically, I included some psychometrically-sound measures at the youth

and caregiver-levels utilized in Study 1 that were found to be associated with the number of placement changes. Specifically, for youth socio-emotional functioning, the Strengths and Difficulties Questionnaire (SDQ) was used in both Study 1 and Study 2. Given it was beyond the scope of Study 2 to collect data from youth directly, youth self-report measures (e.g., placement satisfaction, positive mental health) were not utilized in Study 2. For caregiver variables, while certain measures (e.g., parenting practices) in Study 1 were not found to have statistically significant associations with the number of placement changes, this measure had weak psychometric properties and these findings were inconsistent with previous research (Konijn, 2019). Thus, caregiver variables were still important to examine in Study 2, but different measures were used due to the weak psychometric properties of the caregiver variables in Study 1. Consequently, alternative caregiver variables were included in the current study.

Study Evaluation Framework and Outcome Variables

Outcomes were organized according to Kirkpatrick and Kirkpatrick's (2016) four levels of training evaluation. Level One (Reaction) corresponds to the degree to which resource parents found RPC engaging and relevant in their work with young people. Outcomes evaluating resource parents' reactions to RPC included module evaluations and a post-program satisfaction questionnaire. Level Two (Learning) is the degree to which resource parents acquired knowledge, skills, and confidence as a result of their participation in RPC. Outcomes evaluating resource parents' learning consisted of self-reported knowledge and beliefs regarding trauma-informed parenting. Level Three (Behaviour) is the degree to which resource parents applied what they learned during their participation in RPC. Outcomes evaluating changes to resource parents' behaviour consisted of resource parent-reported outcomes at the youth (i.e., youth socio-emotional difficulties) and caregiver (i.e., parenting stress and family protective factors) levels.

Kirkpatrick and Kirkpatrick (2016) indicate that Level Four (Results) is the degree to which the targeted outcomes occur as the result of RPC. This level is not intended to encompass individual outcomes as measured in Level Three (Behaviour), but rather address higher-level organizational or more global impacts. Due to the preliminary nature of this evaluation, global or more distal outcomes such as placement disruptions were not addressed. In summary, if the desired results (Level Four) are to reduce placement disruptions for young people in care and support resource parent retention within the child welfare organization, the facilitating behaviours (Level Three) may include providing resource parents with adequate support and resources that could contribute to improvements in family functioning and reductions in parenting stress. RPC aims to equip resource parents with knowledge and skills regarding trauma-informed parenting (Level Two) and to do so using content and delivery methods to which parents will react favourably (Level One).

Primary outcomes consisted of key variables deemed essential to the research question and directly assessed by the RPC program (Schulz et al., 2010). Thus, all outcomes measuring resource parents' learning (i.e., knowledge and beliefs regarding trauma-informed parenting, tolerance of challenging behaviours, and parenting self-efficacy) were considered primary. Given the nature of this preliminary evaluation and the inclusion of multiple measures, outcomes at the behavioural level (Level 3) were distinguished between primary and secondary.

Outcomes measuring changes to resource parents' behaviour were determined by examining the items within each questionnaire to determine how the constructs map onto RPC program content. Primary behaviour outcomes consisted of: (1) attachment; (2) social supports; (3) concrete supports; and (4) resource parent-youth difficult interactions. For attachment, resource parents were provided with information and taught specific skills to support their

attachment relationship with the youth throughout several modules, including Module 3: Understanding Trauma's Effects, Module 4: Building a Safe Place, Module 5: Dealing with Feelings and Behaviours, and Module 6: Connections and Healing. For instance, some concepts included providing comfort and support to youth during times of distress; facilitating physical and psychological safety through which youth can explore their world; and helping youth manage their emotional experiences.

Social supports were directly targeted through the way in which the RPC program was delivered. In particular, the group format supported the development of positive relationships among resource parents and allowed them to exchange perspectives and strategies. Resource parents were provided a space in which to share their experiences that often resulted in validation, encouragement, and emotional support from facilitators and other resource parents. The topic of social supports was also covered in Module 8: Taking Care of Yourself, which addressed the ways in which resource parents can access informal supports to bolster their emotional wellbeing. Concrete supports were also directly addressed in Module 8: Taking Care of Yourself, which covered the importance of ensuring that resource parents' basic tangible needs (e.g., balanced diet, sufficient sleep) were met.

Finally, resource parent-youth difficult interactions (i.e., qualities of the youth's behaviour that impact the resource parent) were addressed throughout multiple modules that included Module 2: Trauma 101, Module 3: Understanding Trauma's Effects, Module 5: Dealing with Feelings and Behaviours, and Module 8: Taking Care of Yourself. For example, resource parents were presented with information about the impact of trauma on development, including the beliefs and expectations youth often develop about themselves, the adults who care for them, and the world around them (e.g., "Invisible Suitcase"; Grillo et al, 2010). Through learning about

the contents of their youth's invisible suitcase, resource parents are better positioned not to take the youth's responses and reactions personally, which allows resource parents to better understand and support the youth to develop positive beliefs and experiences (Grillo et al., 2010).

Secondary outcomes constitute additional constructs of interest that are considered to be indirect effects of the intervention (Schulz et al., 2010). In the current study, secondary outcomes consisted of: (1) family functioning; (2) parental distress; (3) youth functioning difficulties; (4) youth conduct problems; (5) youth emotional problems; (6) youth hyperactivity/inattention; (7) youth peer problems; and (8) youth prosocial behaviour. Family functioning may be indirectly impacted through the RPC program by improving the resource parent-youth relationship and providing effective methods for managing challenging behaviours. These factors may in turn facilitate a more positive, regulated family environment, thereby improving family functioning. Similarly, parental distress included factors that are specific to the resource parent's well-being outside of their relationship with the youth (e.g., not enjoying the activities that they used to enjoy). While RPC did not directly address factors in the lives of resource parents outside of their caregiving role, various program components may serve to reduce parental distress through, for example, equipping resource parents with the knowledge and skills to parent effectively, with greater awareness of their own reactions, and with the importance of self-care. Finally, youth socio-emotional functioning (i.e., youth functioning difficulties, conduct problems, emotional problems, hyperactivity/inattention, peer problems, and prosocial behaviour) was not directly addressed, as the intervention did not directly involve youth and did not focus on behaviour management strategies per se. Instead, RPC may facilitate improved youth socio-emotional

functioning through providing resource parents with knowledge regarding the impact of trauma, as well as skills to effectively manage the youth's emotional reactions and behaviours.

Hypotheses Related to Resource Parents' Reactions to RPC (Level One)

It was hypothesized that resource parents who participated in RPC would respond positively to each module, including the presentation of material and module content. It was also hypothesized that resource parents would report high levels of satisfaction with the program as a whole, including program content, delivery, and teaching methods (e.g., case examples).

Hypotheses Related to Resource Parents' Learning (Level Two)

Compared to the waitlist control, it was hypothesized that resource parents who participated in RPC would report significantly greater knowledge and beliefs in trauma-informed parenting, greater tolerance of challenging youth behaviour, and improved parenting self-efficacy. It was hypothesized that these gains would be maintained at the 2-month follow-up.

Hypotheses Related to Resource Parents' Behaviour (Level Three)

Primary Outcomes. Compared to the waitlist control, it was hypothesized that resource parents who participated in RPC would report significant improvements in their attachment relationship with their youth, fewer parent-youth difficult interactions, and improved social and concrete supports. It was hypothesized that these gains would be maintained at the 2-month follow-up.

Secondary Outcomes. Compared to the waitlist control, it was hypothesized that resource parents who participated in RPC would report improvements in their family functioning, reduced parental distress, improvements in youth functioning difficulties, fewer conduct problems, fewer emotional problems, fewer problems with hyperactivity/inattention,

fewer peer problems, and greater prosocial behaviour. It was hypothesized that these gains would be maintained at the 2-month follow-up.

Methods

Study Design

The study consisted of a 2 x 3 quasi-experimental design using between- and within-subjects factors. The repeated measures or within-subjects variable was time point with three levels (baseline, post-program, and 2-month follow-up), and the between-subjects variable was group condition with two levels (waitlist control or experimental).

Participants

There were 43 participants in total, with 22 in the experimental group and 21 in the waitlist control. The majority of resource parents (n = 38; 90.5%) identified as female and were 47 years on average (range between 23-70 years). The majority identified their racial background as White (n = 38; 90.5%), and most were married (n = 27; 62.8%). For educational background, almost half had completed some community college (n = 20; 46.5%); followed by a bachelor or undergraduate degree (n = 10; 23.3%); trade, technical or business college (n = 3; 7.0%); some college/university but no degree (n = 3; 7.0%); elementary school (n = 1; 2.3%); master's degree (n = 1; 2.3%); and doctoral degree (n = 1; 2.3%). In terms of work, 39.5% of resource parents (n = 17) identified their main activity as caring for family, and the same percentage identified both caring for family and working for pay/profit (39.5%), followed by working for pay/profit (n = 3; 7.0%), going to school (n = 2; 4.7%), retired (n = 2; 4.7%), recovering from illness/disability (n = 2; 2.3%), or other (n = 2; 2.3%). For total household income in Canadian funds, 23.3% (n = 10) reported an income of less than $59,999; 30.3% (n = 13) had an income between $60,000

and $99,999; 27.8% (n = 12) had an income exceeding $100,000; and 18.6% preferred not to disclose. Demographic information provided by resource parents can also be found in Table 8.

The majority of resource parents were foster caregivers (n = 30; 69.7%), followed by adoptive (n = 14; 32.6%), therapeutic/treatment foster care (n = 12; 27.9%), kinship (n = 4; 9.3%), future adoptive parents (n = 3; 6.9%), and group home providers (n = 2; 4.7%). Note that values exceed 100% because resource parents could select more than one option. Given the sizeable portion of resource parents who identified as therapeutic foster parents, it should be noted that therapeutic foster care is typically designated for young people with complex mental health or medical needs. Some agencies in Ontario specify that at least one caregiver must be a stay-at-home caregiver or available to the young person at all times (Kenora-Rainy River Districts Child and Family Services, 2022). These caregivers are also required to attend specialized training and are expected to participate as part of a treatment team. On average, resource parents had been in their role for just under 10 years and had an average of two non-birth youth in their care. In collecting some basic information on up to four non-birth youth in the home, findings showed that the average age was 10 years (range from 5 months to 25 years). Most of the youth in resource parents' care were female (64.0%). In terms of placement, most were in foster care (62.1%), followed by adoptive homes (21.8%) and other types of placements (16.1%). Among those youth in foster care, 30.1% of resource parents noted that they intended to adopt the youth while 6.1% identified as kinship caregivers. The majority of resource parents (79.1%) indicated that they attended the PRIDE training. They identified additional trainings they completed, and responses were wide-ranging (e.g., workshops on various mental health challenges).

Measures

Background Information

Prior to the RPC program, resource parents provided information on several demographic variables (Appendix D; i.e., age, gender, education, income), resource parent background (e.g., resource parent type, number of years as a resource parent, previous training), and number of non-birth youth in their care (e.g., number and ages of youth in the home).

Resource Parents' Reactions (Level One)

Module Evaluations. Resource parents completed an NCTSN-developed brief feedback questionnaire immediately upon completion of each training module (Appendix E to L). They were emailed a Qualtrics link to the questionnaire after each module. Resource parents rated the extent to which module objectives were achieved and their satisfaction with both training content and delivery. Each item was rated on a 5-point scale: 1(*strongly disagree*); 2 (*disagree*); 3 (*neutral*); 4 (*agree*); and 5 (*strongly agree*). Several items of each module evaluation also asked about specific module activities, varying from 3 to 7 items rated on the same 5-point scale along with one open-ended question eliciting any additional feedback.

Post-Workshop Satisfaction Survey. Resource parents completed an NCTSN-developed post-program satisfaction survey of 11 close-ended items (Appendix M). They were sent a Qualtrics link to this questionnaire after the final module. Five of these items gathered resource parents' reactions to the training content and delivery along a 5-point scale: 1 (*strongly disagree*); 2 (*disagree*); 3 (*neutral*); 4 (*agree*); and 5 (*strongly agree*). The six remaining items asked about specific teaching strategies along a 5-point scale: 1 (*very unhelpful*); 2 (*unhelpful*); 3 (*neutral*); 4 (*helpful*); and 5 (*very helpful*). There were also three open-ended questions about the most impactful concepts, aspects that were harder to understand, and any parts of the training

that were not very useful. I added one additional open-ended question to gather feedback about the online delivery.

Resource Parents' Learning (Level Two)

Knowledge and Beliefs Survey. To assess learning, resource parents completed the Knowledge and Beliefs Survey (Sullivan et al., 2016; Appendix N), which is a 33-item questionnaire designed to measure caregiver beliefs and attitudes about caring for youth who have experienced trauma. Sullivan et al. (2016) reported that this measure demonstrated acceptable discriminant and factorial validity, and reliability. Items are rated along a 6-point Likert scale from 1 (*strongly disagree)* to 6 (*strongly agree)* and measure three subscales: Trauma-Informed Parenting; Tolerance of Misbehaviour (referred to as Tolerance of Challenging Behaviours in this dissertation); and Parenting Self-Efficacy. For *Trauma-Informed Parenting*, 24 items assess knowledge about the impact of trauma on youth (e.g., I routinely think about how my child is physically safe in my home, but might not feel safe). This subscale possessed excellent internal consistency across the three assessments (Cronbach α = .90-.93). The four items on the *Tolerance of Challenging Behaviours* subscale measure resource parents' beliefs about their ability to care for youth with behaviours that commonly occur within a trauma context (e.g., I can care for a child who says mean and hurtful things to me). This subscale had good to excellent internal consistency across the three time points (Cronbach α = .83-.92). For *Parenting Self-Efficacy*, five items assess resource parents' confidence in their ability to care for a youth with a trauma history (e.g., When things are going badly between my child and me, I keep trying until things begin to change). This subscale demonstrated good to excellent internal consistency across all three time points (Cronbach α = .83-.90). See Table 9 for more detailed information about the internal consistency values.

Resource Parents' Behaviour (Level Three)

Protective Factors Survey, Second Edition. Resource parents completed the Protective Factors Survey- Second Edition (PFS-2; Appendix O; Counts et al., 2010), which is a 19-item questionnaire that measures five domains of multi-level family protective factors on a 6-point Likert scale from 0 (*not at all like my life)* to 5 (*just like my life*). Counts et al. (2010) reported that this measure demonstrated acceptable levels of internal consistency, content validity, construct validity, and criterion validity. Three items measure *Family Functioning/Resilience* (e.g., The future looks good for our family) and demonstrated low to adequate internal consistency across the three assessment time points (Cronbach α = .69 to .74). Four items measure *Nurturing/Attachment* (e.g., I have frequent power struggles with my kids) and demonstrated low to adequate internal consistency across the three time points (Cronbach α = .47-.75). Five items measure *Social Supports* (e.g., I have people who believe in me) and had low to adequate internal consistency across the three time points (Cronbach α = .66 to .79). Four items measure C*oncrete Supports* (e.g., I have trouble affording what I need each month) and showed low to adequate internal consistency (Cronbach α = .48-.70). The three items that measure *Caregiver/practitioner Relationship* were not included in the current study because they were not relevant to study goals. See Table 9 for more detailed information about the internal consistency values.

Parenting Stress Index-Short Form, Fourth Edition. Resource parents caring for youth under 12 years of age completed the Parenting Stress Index-Short Form, Fourth Edition (PSI-SF; Abidin, 2012). The PSI-SF is a 36-item measure of parenting stress across three domains and is considered a valid (e.g., good convergent and factorial validity) and reliable measure (e.g., test-retest and internal consistency; Abidin, 2012). Twelve items measure

Parental Distress (the overall level of stress a parent is experiencing) and demonstrated good to excellent internal consistency across the three assessment time points (Cronbach α = .86-.93). Twelve items measure *Parent-Child Dysfunctional Interactions* (referred to as Resource Parent-Youth Difficult Interactions in this dissertation; the quality of the parent-child interactions) and demonstrated good to excellent internal consistency across the three time points (Cronbach α = .85-.9). Twelve items measure the *Difficult Child* subscale (referred to as Youth Functioning Difficulties in this dissertation; a parent's perception of their child's functioning) and possessed adequate internal consistency across the three time points (Cronbach α = .84-.89). See Table 9 for more detailed information about the internal consistency values.

Strengths and Difficulties Questionnaire. Resource parents completed the Strengths and Difficulties Questionnaire (SDQ; Appendix P; Goodman et al., 2001) to evaluate youth social, emotional, and behavioural functioning across five domains. Goodman et al. (2001) reported that this measure was judged to have satisfactory validity, cross-informant correlation, and retest stability. Table 10 presents data for the internal consistency estimates. Items are rated along a 3-point Likert scale ranging from 0 (*not true)* to 2 (*true)*. There are three versions of the questionnaire depending on the age of the youth (i.e., 2-3 years, 4-17, 18 and older) but cover the same subscales. In this study, data across all age groups were combined. Five items measure emotional symptoms (e.g., nervous in new situations, easily loses confidence; Goodman, 2001). This subscale demonstrated low to adequate internal consistency for 2-3 year olds (Cronbach α = .65-.78) and good internal consistency for 4-17 year olds (Cronbach α = .81-.82) across all three time points. Internal consistency could not be computed for the 18 and older questionnaire because this version was only completed by one resource parent. Five items measure conduct problems (e.g., often fights with other youth or bullies them; Goodman, 2001). This subscale

demonstrated adequate to good internal consistency for 2-3 year olds (Cronbach α = .79-.89) and 4-17 year olds (Cronbach α = .79-.82) across all three time points. Five items measure hyperactivity/ inattention (e.g., constantly fidgeting or squirming; Goodman, 2001). This subscale demonstrated low to excellent internal consistency for 2-3 year olds (Cronbach α = .47-.90) and adequate to good internal consistency for 4-17 year olds (Cronbach α = .79-.87) across all three time points. Five items measure peer problems (e.g., picked on or bullied by other youth; Goodman, 2001). This subscale demonstrated low to adequate internal consistency for 2-3 year olds (Cronbach α = .46-.72) and 4-17 year olds (Cronbach α = .54- .73) across all three time points. Five items measure prosocial behaviour (e.g., kind to younger children; Goodman, 2001). This subscale demonstrated adequate to excellent internal consistency for 2-3 year olds (Cronbach α = .77-.91) and adequate to good internal consistency for 4-17 year olds (Cronbach α = .72-.85) across all three time points.

Procedure

Following ethics approval from the University of Ottawa (see Appendix Q), I recruited resource parents through collaboration with two Ontario child welfare agencies. Due to difficulties reaching a sufficient sample size, I also recruited resource parents through the community by distributing information letters to various resource parent organizations in Ontario and social media platforms (i.e., Twitter and Facebook). Interested resource parents contacted me, and I provided information about the RPC program and research study. Resource parents could complete the program without participating in the research. To participate in the RPC program, individuals were required to be a current resource parent in Ontario and have access to a computer or phone with internet. To participate in the research study, they were required to be a current resource parent in Ontario with a young person currently in their care, and agreed not to

participate in other parenting programs throughout the duration of the research. Information from the consent form was reviewed with resource parents verbally. Figure 1 depicts a consort diagram for participant recruitment and attrition.

While the original intention was to conduct a randomized controlled trial, only four resource parents agreed to randomization. The remaining resource parents elected not to be randomized due to scheduling issues (e.g., several resource parents could only attend one particular group due to the date and time it was offered). Thus, the decision was made during recruitment to use non-random assignment to groups. Therefore, the majority of group assignment was non-randomized based on resource parents' availability. For the four resource parents who were randomized, a random numbers generator was used to assign them to either the experimental or waitlist control condition. These resource parents were informed of the group they would be attending after completing the first baseline questionnaire.

Data Collection Prior to the Program

Baseline assessment occurred approximately two weeks prior to the beginning of the first module. Resource parents were able to choose between an online questionnaire or a mailed paper copy. All resource parents completed the same questionnaire package prior to the start of the first training (i.e., those in experimental and waitlist control groups). For those who elected to complete the online version, a link to the online questionnaire was emailed. The questionnaire was available through Qualtrics (www.qualtrics.com) and contained measures on socio-demographics, Knowledge and Beliefs Survey (Sullivan et al., 2016), Protective Factors Survey - second edition (Counts et al., 2010), Parenting Stress Index - Short Form (Abidin, 2012), and the Strengths and Difficulties Questionnaire (Goodman et al., 2001). At the beginning of the questionnaire package, resource parents were asked to review the consent form and to indicate

that they had read it and agreed to participate in the research study. Those who were mailed a questionnaire package were given a paper copy of the consent form. All resource parents involved in the research developed a code that they entered for this questionnaire and the subsequent post-program and 2-month follow-up questionnaires so that responses across time points could be linked. The questionnaire package took approximately 30 minutes to complete. Resource parents were able to terminate the survey at any time without interfering with their program participation. Resource parents received a $25 gift card for their participation at each data assessment cycle.

Program Delivery

Delivery of the RPC program followed NCTSN implementation guidelines. It was the intention to deliver the RPC program in-person because this was how the program was designed to be delivered. However, COVID-19 public health measures occurred prior to the start of the first group. Thus, the program was adapted to a virtual format in consultation with professionals affiliated with NCTSN and RPC. The program was conducted virtually using Zoom, a videoconferencing platform. Despite its novel virtual format, facilitator guidelines were closely followed. All groups involved the use of PowerPoint slides, group activities, case examples, and discussions. Resource parents were provided with either a paper or pdf copy of the participant workbook. Only minor modifications to the format were required (e.g., adjusting materials required for particular activities to what resource parents would likely have at home such as pen and paper). Ideally, the RPC program is delivered over 8 two-hour modules once per week. However, through discussions with resource parents and child welfare agency staff, I chose a-priori to shorten the modules to 1.5 hours in length to reduce barriers in attending and to better

accommodate resource parents' schedules. No content had to be eliminated as a result of shortening the modules.

There were six groups in total, including three experimental and three waitlist control groups. I was the main facilitator for all six groups. It was the intention to deliver all groups over eight 1.5 hour modules once per week for eight weeks with a facilitator and a co-facilitator with lived experience. However, some adjustments had to be made during the course of the study. In particular, five of the six groups were delivered over eight 1.5 hour long modules once per week for eight weeks. Due to scheduling constraints, one waitlist control group was delivered over 1.5 hour modules twice per week over four weeks. As per RPC guidelines (Grillo et al., 2010), every effort was made to conduct the program with a co-facilitator with lived experience. Five of the six groups were conducted with a co-facilitator. There was one group (experimental) that did not have a co-facilitator due to difficulties finding an available co-facilitator. The curriculum was reviewed with the co-facilitator in detail prior to delivering the program. The facilitator and co-facilitator completed all necessary training available through NCTSN in preparation for facilitating the training. Training consisted of completing the RPC training modules online through the National Child Traumatic Stress Network Learning Center (www.learn.nctsn.org).

Fidelity Monitoring. For the experimental groups, a fidelity monitor attended each module to ensure the program was being delivered as intended according to facilitator guidelines. The fidelity monitor was a trained, graduate-level research assistant. This trained research assistant was present at all RPC modules for the experimental groups to conduct a fidelity checklist (see Appendix R to Y) to assess the facilitators' adherence to the facilitator guidelines. All program components were covered according to the fidelity checklist, as completed by the research assistant.

Program Attendance. Program attendance was monitored for all resource parents by a graduate-level research assistant. I developed a plan prior to the program's implementation to ensure resource parents who missed a module were exposed to the module's content. In particular, I contacted all resource parents who missed a module and conducted a phone catch-up call to ensure resource parents were exposed to the material, including the slides, case examples, and a summary of relevant group discussions. Approximately 60% of resource parents in the experimental condition attended all eight modules, 27% attended seven, 9% attended six, and 4% attended five modules. Twelve resource parents in the experimental group did not complete the post-program questionnaire. One resource parent dropped out of RPC mid-way through the program due to scheduling issues while 11 attended the program but did not complete the post-program questionnaire. Eight resource parents in the waitlist control group did not complete the post-program questionnaire. Six of these resource parents dropped out of RPC mid-way through the program due to scheduling issues (the majority of these individuals were group home providers) while two attended the program but did not complete the post-program questionnaire. In addition, six resource parents in the experimental and six in the waitlist control did not complete the 2-month follow-up questionnaire. Ultimately, the analyses included 22 resource parents in the experimental group and 21 in the waitlist control.

Data Collection Following the Program

Within one week after the completion of the training for the experimental group, resource parents in both experimental and waitlist control groups were sent the same questionnaire package that was administered prior to the training, excluding the demographic questions. Two months after the completion of the program, resource parents completed the same questionnaire package for a third time. They received a $25 gift card each time they completed the

questionnaire package. Following this data collection, resource parents in the waitlist control group participated in the RPC program. At both the post-program and 2-month follow-up, resource parents indicated whether they had participated in additional parenting supports throughout the duration of the evaluation (Appendix Z). In particular, two resource parents in the waitlist control endorsed engaging in other forms of parenting interventions. No resource parents in the experimental condition reported participating in other parenting interventions. Of the two parents who endorsed participating in other parenting supports, follow-up responses included participation in the PRIDE training. While further context or details are not known, depending on the resource parent type, it is possible they had not yet taken PRIDE when they began caring for their youth, or were mandated to take it given ministry requirements.

Statistical Analysis

Power Calculations

Several researchers have noted that, for preliminary evaluations, a priori power calculations for sample size targets have limited utility depending on the nature of the evaluation (e.g., testing procedures and further understanding outcome variables of importance; Thabane et al., 2010; Whitehead et al., 2016). Nonetheless, a power analysis was conducted to determine an estimated target sample size using G*Power. A total sample size of 36 (18 in each condition) was suggested to find a large effect, $f = .04$, with 80% power and alpha probability level of .05.

Data Screening

Questionnaire items were screened prior to statistical analyses for data entry accuracy, missing values, and univariate assumptions. A Missing Values Analysis (MVA) determined the pattern and rate of missing data for questionnaire items. The Little's MCAR test was not significant and therefore, the data were determined to be missing at random ($\chi^2 = 614.96$, $p =$

1.00). Missing data ranged from 0 to 4.8% at baseline, post-program, and 2-month follow-up. Missing data were imputed using single imputation using the Expectation-Maximization (EM) method, which is an acceptable method for low levels of missing data (Tabachnick & Fidell, 2013). No significant issues with outliers, skewness, or kurtosis were found (Tabachnick & Fidell, 2013). The data were also screened for issues with non-linearity, heteroscedasticity, cell numbers, tolerance, and homogeneity of the variance-covariance matrix using scatterplots. The data met all these assumptions according to guidelines by Tabachnick and Fidell (2013).

Pre-Program Group Equivalence

Chi-squared and *t*-test analyses were conducted to determine whether there were any statistically significant differences between the experimental and waitlist control groups on various demographic factors and outcome variables. As shown in Table 8, there were no significant differences between groups on the number of youth in care in the home, resource parent age, and number of years' experience as a resource parent. There were no significant differences between waitlist control and experimental groups on any baseline dependent variables (i.e., scores from the Knowledge and Beliefs Survey, PFS, PSI-SF, or SDQ). There were significantly more kinship caregivers in the control condition (n=4) compared to the experimental condition (n=0; χ^2 = 4.62, p = .03). Overall, these results suggest that the two groups were fairly well matched despite the lack of randomization.

Inclusion of the Covariate

Kinship Caregivers

Given there were significantly more kinship caregivers in the waitlist control than in the experimental group, this variable was used as a covariate throughout analyses for resource parents' learning and behaviour. The inclusion of the covariate ensures that the variance

associated with the covariate is removed from error variance which can provide a more powerful test for examining mean group differences (Tabachnick & Fidell, 2013). Given that random assignment to groups was not possible, including this covariate allowed the groups to be better matched statistically and ensured that prior differences between groups were better accounted for (Tabachnick & Fidell, 2013). Additionally, since all material was covered according to the fidelity checklist and resource parents who could not attend a particular module were exposed to the content through individual follow-up phone calls, the fidelity and module attendance variables were not included as covariates.

Therapeutic/Treatment Foster Caregivers

Further analyses were conducted given the sizeable proportion of self-identified therapeutic/treatment foster caregivers. Therapeutic/treatment foster caregivers may have had more exposure and training experiences in trauma-informed parenting because they are required to complete specialized training. They also may have more experience caring for young people with high complex mental health and/or medical needs. Thus, this group of resource parents may respond differently to RPC than resource parents without such specialized training and caregiving experiences. As a result, independent samples *t*-tests were conducted to compare resource parents who identified as therapeutic/treatment foster caregivers to other resource parent types (i.e., foster, adoptive, kinship caregivers) on baseline outcome measures. Therapeutic/treatment foster caregivers reported significantly higher knowledge and beliefs in trauma-informed parenting (M = 4.90) compared to other resource parent types (M = 4.48, $t(41) = -1.83$, $p = .04$, Hedges' $g = .63$) at baseline. Therapeutic/treatment foster caregivers also reported significantly higher tolerance of challenging behaviours (M = 4.74) compared to other resource parent types (M = 3.92; $t(41) = -2.72$, $p = .01$, Hedges' $g = .93$) at baseline.

Therapeutic/treatment foster caregivers reported significantly higher parenting self-efficacy (M = 5.16) compared to other resource parent types (M = 4.61; $t(41) = -2.09$, $p = .02$, Hedges' $g = .72$) at baseline. Finally, therapeutic/treatment foster caregivers reported significantly higher attachment with their youth (M = 3.01) compared to other resource parent types (M = 2.45; $t(41) = -2.61$, $p = .01$, Hedges' $g = .89$). All of the statistically significant differences outlined above constitute large effect sizes. No significant differences were found between groups for family functioning, social support, concrete support, parental distress, resource parent-youth difficult interactions, youth functioning difficulties, or any youth socio-emotional variables (i.e., prosocial behaviour, conduct problems, emotional difficulties, hyperactivity/impulsivity, or peer problems). Despite these baseline differences between therapeutic/treatment foster caregivers and other resource parent types, no significant differences were found for the number of therapeutic/treatment foster caregivers in the experimental and waitlist control groups. While this does have implications for the generalizability of the results, the number of therapeutic/treatment foster caregivers was evenly dispersed between groups.

Additional Training Completed

I carefully considered including additional training completed as a covariate given that two resource parents in the waitlist control endorsed participating in another parenting program (PRIDE) throughout the duration of the evaluation. Multiple factors were considered, including the nature of the parenting program and the possible statistical impact of including this variable as a covariate. I ran the analyses both with and without additional resource parent training as a covariate. The impact of this covariate was not significant for any of the analyses thus did not change the results in any meaningful way. Additionally, given the small sample size, the inclusion of a second covariate would have lowered the observed statistical power. Given the

majority of resource parents did not engage in outside training, the preliminary nature of the evaluation, and concerns regarding the small sample size, multiple analyses, and low power, I decided to present the results without additional resource parent training as a covariate. Moreover, given PRIDE is a mandated pre-service training, it may not be considered additional as the expectation would be that most resource parents would have already completed this training.

Resource Parents' Reactions to RPC

Data were analyzed using SPSS Version 28. Addressing the reaction level of Kirkpatrick and Kirkpatrick's (2016) model, descriptive statistics for the module evaluations were considered separately for material presentation and activities. Descriptive information was also calculated for the post-program satisfaction questionnaire. I grouped the responses into *positive* (a score of 4 or 5), *neutral* (a score of 3), or *negative* (a score of 1 or 2) categories to generate percentages. For one item in the module evaluations (*I already knew a lot of what was covered*), I categorized responses with a score of 4 or 5 as negative and 1 or 2 as positive. While knowing much of the information covered in the RPC program is not inherently positive or negative, I decided to take a conservative approach in categorizing the frequency of these responses.

Open-ended responses were examined through qualitative analysis using both deductive and inductive coding (Fereday & Muir-Cochrane, 2006). A deductive coding scheme was first developed a priori based on the open-ended questions in the post-program satisfaction questionnaire. Within these categories, I identified sub-themes through inductive coding and then computed associated frequencies. Open-ended responses tended to be brief and specific and so a second coder was not deemed necessary.

Resource Parents' Learning

Primary learning outcomes included knowledge and beliefs in trauma-informed parenting, tolerance of challenging behaviours, and parenting self-efficacy. A series of univariate analyses were conducted using a repeated-measures General Linear Model. Kinship caregiver was included as a covariate throughout the analyses to account for baseline differences between experimental and waitlist control groups and, as such, to reduce possible error variance (Dimitrov & Rumrill, 2003). The repeated-measures variable was time point with three levels (baseline, post-program, and 2-month follow-up), and the between-subjects variable was group condition with two levels (waitlist control or experimental). Significant effects of time were followed up with paired samples *t*-tests, and significant interactions were followed up with independent samples *t*-tests to determine the nature of the effects.

While multivariate analyses were considered, several outcome variables had differing sample sizes due to the nature of the questionnaires. First, the PSI-SF was designed for caregivers of youth aged 12 years and younger, so data were not available for all resource parents. Second, five resource parents in the waitlist control and one resource parent in the experimental group were no longer caring for the particular young person on whom they based their baseline questionnaire responses for the SDQ. While they were still caring for other young people in care, it would not have been appropriate for them to complete this particular measure given they were no longer caring for the young person. Due to listwise deletion and the importance of preserving adequate sample size for sufficient statistical power, it was not possible to conduct analyses using a multivariate repeated measures General Linear Model. In addition, due to the preliminary nature of the evaluation, univariate results were still of interest even with potentially non-significant time and/or interaction effects (see Post-Hoc Exploratory Analyses

and Experiment-Wise Error sections below).

Resource Parents' Behaviour

Primary behavioural outcomes consisted of attachment, social supports, concrete supports, and resource parent-youth difficult interactions. Secondary outcomes consisted of family functioning, parental distress, youth functioning difficulties, youth conduct problems, youth emotional problems, youth hyperactivity/inattention, youth peer problems, and youth prosocial behaviour. Kinship caregiver was included as a covariate throughout the analyses. A series of univariate analyses were conducted for each of the primary and secondary outcomes using a repeated-measures General Linear Model. Significant effects of time were followed up with paired samples *t*-tests, and significant interactions were followed up with independent samples *t*-tests to determine the nature of the effects.

Post-Hoc Exploratory Analyses

Although it is not typical to follow-up on non-significant effects of time or time x group interactions, post-hoc exploratory analyses were conducted for non-significant primary learning outcomes as well as for primary and secondary behavioural outcomes to further explore potential effects given the preliminary nature of this evaluation. Post-hoc exploratory analyses consisted of independent samples *t*-tests to examine between-group differences at post-program and 2-month follow-up, as well as paired samples *t*-tests to examine within-group differences from baseline to post-program and from post-program to 2-month follow-up. In terms of effect sizes used, Cohen's *d* was used for variables with sample sizes over 20, and Hedges' *g* was used for variables with sample sizes less than 20. While Hedges' *g* is similar in magnitude to Cohen's *d*, it corrects for possible bias due to small sample sizes (What Works Clearinghouse, 2017, pp.13-14).

Experiment-Wise Error

Experiment-wise error was a concern due to the inclusion of a series of analyses. While use of the Bonferroni correction was carefully considered, these adjustments focus primarily on Type 1 error. Due to the preliminary nature of this evaluation, results with substantial effect sizes that failed to reach significance were still worth considering as areas to explore in future research (Armstrong, 2014; V. Huta, personal communication). Additionally, the consideration of effect sizes in preliminary evaluations can support the calculation of the sample size needed for larger and more robust evaluations (Hallingberg et al., 2018). Thus, the results were analyzed both with and without the Bonferroni correction. I presented the non-corrected results, but have indicated whether the results differed when the Bonferroni correction was applied. There were 15 hypotheses being tested at an alpha level of .05, thus the Bonferroni-corrected results were based on an alpha level of .003 (.05/15). Given the post-hoc analyses were considered exploratory, they were not included in the calculation of the Bonferroni-corrected alpha.

The benefits and drawbacks of including a high number of outcome variables were carefully considered. Given resource parent training has been associated with fewer youth behavioural challenges, higher parenting skills, and greater placement stability (Akin et al. 2017; Baum et al., 2001; Solomon et al., 2017), it was important to include variables related to both the youth and caregiver. Composite scores were available for particular measures (e.g., SDQ, PSI-SF, and Knowledge and Beliefs Survey; see below) in addition to individual subscale scores. The use of composite scores would allow for a more parsimonious evaluation of particular outcomes which may reduce experiment-wise error due to the smaller number of comparisons. However, subscale scores may provide a more nuanced understanding of outcomes of interest. In particular, Study 1 found certain youth socio-emotional difficulties were associated with a higher

number of placement changes (i.e., conduct problems and peer problems) but that other socio-emotional difficulties were not (e.g., emotional difficulties). The use of a composite youth socio-emotional difficulties score would not fully capture these distinct differences. In addition, the use of subscale scores, particularly regarding learning outcomes, allows for the examination of objectives directly outlined by RPC developers. Thus, the use of a composite score for learning objectives would not have fully evaluated the learning objectives of RPC (see Appendix A). Finally, a major component of this preliminary evaluation was to inform avenues for future research, and the use of subscale scores provided a more nuanced understanding of particular outcomes of future interest (V. Huta, personal communication, 2022).

Results

Resource Parents' Reactions to RPC

Table 11 indicates that overall, most resource parents reported a positive experience with both the content and presentation of modules. For the presentation of material, the number of resource parents with a positive experience ranged from 72.6% (Module 4: Building a Safe Place) to 80.6% (Module 8: Taking Care of Yourself). For program activities, positive experiences ranged from 72% (Module 7: Becoming an Advocate) to 93.2% (Module 8: Taking Care of Yourself). For the post-program satisfaction questionnaire, Table 12 shows that the number of resource parents reporting a positive experience in terms of reactions to training content and delivery ranged from 62.9% (less likely to request a future placement change) to 100% (would recommend this training to other resource parents). For teaching strategies, positive experiences ranged from 74.2% (group activities) to 100% (information from slides and presenters). Resource parents noted that they found the slides easy to follow and indicated feeling better prepared to meet their youth's needs. It should be noted that approximately 20% of

resource parents indicated needing additional training to understand the information presented through the RPC program. For teaching strategies, resource parents generally felt that each component was helpful, such as applying the "My Child Worksheet" (e.g., identifying their child's trauma and losses, developing a trauma-informed safety message for their child). Another example of a teaching strategy that resource parents reported being helpful involved following the de-identified stories of children ranging in age (i.e., infant to adolescent) to illustrate program concepts (e.g., identifying a child's strengths and resilience, brainstorming areas of intervention to address compassion fatigue and vicarious trauma).

Turning to the post-program open-ended feedback, for the most impactful program aspects, 11 of the 14 responses (79%) identified learning about the invisible suitcase (Module 3: Understanding Trauma's Effects). This aspect covers the expectations and beliefs that a young person has about themselves, others/their caregivers, and the future due to their past trauma and adversity (Grillo et al., 2010). One resource parent commented: "The invisible suitcase was definitely my 'a ha' moment [that I] have used since we learned about it. As I believe so strongly that we all have invisible suitcases that we carry around. Ones that some people have never unpacked or want to." Five resource parents (36%) identified the most helpful aspect as being the cognitive triangle (Module 5: Dealing with Feelings and Behaviours module), which involves identifying the connections between a young person's thoughts, feelings, and behaviours to help understand challenging behaviours. Four resource parents (29%) identified balancing encouragement (e.g., supporting positive behaviours, providing opportunities for success and mastery) and correction (e.g., collaborating with the young person to determine workable alternatives to certain behaviours; Module 5: Dealing with Feelings and Behaviours) as the most helpful aspect of the program. Two resource parents (14%) noted that the whole module on self-

care was most impactful. One resource parent commented: “Self-care is a tough one. We all know the concept of it, it's the practice of it that is hard. Blocking space and committing to it is a huge step in giving back to me.” Two resource parents (14%) indicated that all the aspects of the RPC program were impactful. One resource parent commented: “This is a great program and should be required training for foster parents. Really, really excellent! The facilitators were awesome and the materials, both in the workbook and as provided as supplementary supports to participants, were excellent!”. Individual resource parents also identified the following concepts as being most helpful: an experiential exercise depicting what it is like for youth in care to lose important connections (Module 6: Connections and Healing; Grillo et al., 2010); the concept of an emotional container (a supportive adult to “be with” youth during difficult emotions; Module 4: Building a Safe Place; Grillo et al., 2010); finding strength and resilience; case examples (e.g., sexual abuse); group discussions; and the issue of secondary traumatic stress (Module 8: Taking Care of Yourself).

In terms of difficult concepts, most resource parents (n = 13 of 15; 87%) indicated that there were none. Similarly, for aspects of the program that were least helpful, 13 of the 15 responses (87%) indicated there were none. Individual resource parents identified the following concepts as not being particularly helpful: the first module orienting resource parents to what would be covered in the program; case examples for age groups that did not correspond to the ages of children and youth for whom the resource parents were caring (e.g., a case example of an infant if the parent was caring for older children); insufficient discussion related to the role of religion.

Turning to the online delivery, 12 of the 15 resource parents (80%) commented that it was an effective and overall positive experience and six (40%) specified that the online delivery

removed barriers in attending (e.g., childcare, travel time). One resource parent commented: "I have become a fan of online delivery ... it allows me to attend, saves me hours of driving, the turnout was excellent, so we had lots of viewpoints, and it gives me the opportunity to respond, ask questions [and] get feedback ... great." Five resource parents (33%) indicated that they would have liked the modules to be longer and more interactive to allow for greater discussion and questions. However, two (13%) resource parents indicated that the length and level of interaction were just right.

Resource Parents' Learning

Primary outcomes related to changes in resource parents' learning consisted of trauma-informed parenting, tolerance of challenging behaviours, and parenting-self efficacy.

Trauma-Informed Parenting

General Linear Model. A repeated-measures General Linear Model was conducted for trauma-informed parenting. Mauchly's Test of Sphericity was not significant for trauma-informed parenting (Mauchly's W = .99, p = .80), suggesting the assumption of sphericity was not violated. Mean baseline scores for trauma-informed parenting were 4.69 for the experimental group and 4.51 for the waitlist control, which were not significantly different (see Table 13; $t(41) = -.81$, p = .21). These scores were generally on the higher end of the 6-point Likert scale. There was a significant impact of time ($\eta^2 = .27$, large effect) and time X group interaction ($\eta^2 = .09$, medium effect; see Table 14 and Figure 2). While the effect of time remained statistically significant, the time X group interaction was no longer statistically significant after applying the Bonferroni-correction. For the effect of time, resource parents in the waitlist control reported statistically significant increases in trauma-informed parenting from baseline to post-program ($t(20) = -2.38$, p = .01), but no significant differences were found between post-program and 2-

month follow-up ($t(20) = 1.29$, $p = .11$). Similarly, resource parents in the experimental group also reported significant increases in trauma-informed parenting from baseline to post-program ($t(21) = -6.37$, $p < .001$), but no significant differences were found between post-program and 2-month follow-up ($t(21) = -.86$, $p = .20$). For the interaction, the experimental group reported greater increases in trauma-informed parenting at both post-program ($t(41) = -3.04$, $p = .002$) and 2-month follow-up ($t(41) = -2.37$, $p = .01$), compared to the waitlist control. Due to the significant impact of time and time X group interaction, exploratory post-hoc analyses were not required.

Tolerance of Challenging Behaviours

General Linear Model. A repeated-measures General Linear Model was conducted for resource parents' tolerance of challenging behaviours. Mauchly's Test of Sphericity was not significant (Mauchly's W = .91, $p = .16$), suggesting the assumption of sphericity was not violated. Mean baseline scores were 4.30 for the experimental group and 3.99 for the waitlist control, which were not significantly different (see Table 13; $t(41) = -1.04$, $p = .15$). Scores were generally on the higher end of the 6-point Likert scale. There was no significant impact of time ($\eta^2 = .01$, small effect) or time X group interaction ($\eta^2 = .05$, small effect; see Table 14).

Post-Hoc Exploratory Analyses. In terms of potential changes over time, resource parents in the waitlist control did not report changes to their tolerance of challenging behaviours from baseline to post-program ($t(20) = .22$, $p = .42$, Cohen's $d = .05$, small effect) or from post-program to 2-month follow-up ($t(20) = -.88$, $p = .19$, Cohen's $d = -.19$, small effect). Conversely, those in the experimental group reported significant increases in their tolerance of challenging behaviours from baseline to post-program ($t(21) = -2.48$, $p = .01$, Cohen's $d = .53$, medium effect) but not from post-program to 2-month follow-up ($t(21) = .69$, $p = .25$, Cohen's $d = .14$,

small effect). For between group differences, despite no statistically significant baseline differences, the experimental group reported a significantly higher tolerance of challenging behaviours at post-program, compared to the waitlist control ($t(41) = -2.07$, $p = .02$, Cohen's $d = -.64$, medium effect). However, the scores for the two groups did not differ significantly by the 2-month follow-up ($t(41) = -1.60$, $p = .06$, Cohen's $d = -.49$, small effect).

Parenting Self-Efficacy

General Linear Model. A repeated-measures General Linear Model was conducted for parenting self-efficacy. Mauchly's Test of Sphericity was significant (Mauchly's W = .82, $p = .02$) and thus, the assumption of sphericity was violated. As a result, the Huynh-Feldt corrected results were used. Mean baseline scores for parenting self-efficacy were 4.86 for the experimental group and 4.66 for the waitlist control, which were not significantly different (see Table 13; $t(41) = -.81$, $p = .21$). Scores were on the higher end of the 6-point Likert scale. There was no significant impact of time ($\eta^2 = .04$, small effect) or time X group interaction ($\eta^2 = .04$, small effect; see Table 14).

Post-Hoc Exploratory Analyses. In terms of potential changes over time, resource parents in the waitlist control group reported no significant changes in their parenting self-efficacy from baseline to post-program ($t(20) = -.28$, $p = .39$, Cohen's $d = -.06$, small effect) or from post-program to 2-month follow-up ($t(20) = .00$, $p = .50$, Cohen's $d = .00$, small effect). Conversely, resource parents in the experimental group reported significant increases in their parenting self-efficacy from baseline to post-program ($t(21) = -2.88$, $p = .01$, Cohen's $d = -.61$, medium effect) but not from post-program to 2-month follow-up ($t(21) = -.57$, $p = .29$, Cohen's $d = -.12$, small effect). For between group differences, despite no statistically significant baseline differences between experimental and waitlist control groups, resource parents in the

experimental group reported significantly higher parenting self-efficacy at post-program ($t(41) = -2.39$, $p = .01$, Cohen's $d = -.73$, medium effect) and at 2-month follow-up ($t(41) = -3.05$, $p = .00$, Cohen's $d = -.93$, large effect), compared to those in the waitlist control.

Resource Parents' Behaviour

Primary Outcomes

The primary outcomes of interest were attachment, social supports, concrete supports, and resource parent-youth difficult interactions. For all primary outcomes reported below, the impact of the covariate (i.e., kinship caregivers) was not significant, which suggests that this variable did not have a significant differential impact on attachment, social supports, concrete supports, or parent-youth difficult interactions.

Attachment.

General Linear Model. Mauchly's Test of Sphericity was not significant (Mauchly's W = .96, $p = .41$), suggesting that the assumption of sphericity was not violated. Mean baseline scores were 2.71 for the experimental group and 2.49 for the waitlist control, which were not significantly different (see Table 13; $t(41) = -1.05$, $p = .15$). Scores fell within the mid-range of the 5-point Likert scale. Table 14 shows that there was no significant impact of time ($\eta^2 = .00$, small effect) or time X group interaction ($\eta^2 = .04$, small effect).

Post-Hoc Exploratory Analyses. In terms of potential changes over time, resource parents in the waitlist control reported no changes in their attachment relationship with the youth from baseline to post-program ($t(20) = -1.05$, $p = .15$, Cohen's $d = -.23$, small effect) or from post-program to 2-month follow-up ($t(20) = 1.59$, $p = .06$, Cohen's $d = .35$, small effect). Although resource parents in the experimental group reported no significant changes in their attachment relationship with the youth from baseline to post-program ($t(21) = .54$, $p = .30$,

Cohen's *d* = .12, small effect), they did report significant improvements from post-program to 2-month follow-up (*t*(21) = -1.81, *p* = .04, Cohen's *d* = -.37, small effect). For potential group differences, the two groups did not differ significantly at post-program (*t*(41) = -.28, *p* = .39, Cohen's *d* = -.09, small effect). However, those in the experimental group reported significantly higher attachment than those in the control group at the 2-month follow-up (*t*(41) = -1.77, *p* = .04, Cohen's *d* = -.54, medium effect).

Social Supports.

General Linear Model. Mauchly's Test of Sphericity was not significant (Mauchly's W = .91, *p* = .17), thus the assumption of sphericity was not violated. Mean baseline scores were 3.04 for the experimental group and 3.06 for the waitlist control, which were not significantly different (see Table 13; *t*(41) = .10, *p* = .46). Scores generally fell within the mid to high end of the 5-point Likert scale. There was no significant effect of time (η^2 = .03, small effect) or time X group interaction (η^2 = .03, small effect; see Table 14).

Post-Hoc Exploratory Analyses. In terms of potential changes over time, resource parents in the waitlist control reported no significant changes in their social supports from baseline to post-program (*t*(20) = -.62, *p* = .27, Cohen's *d* = -.12, small effect) or from post-program to 2-month follow-up (*t*(20) = 1.30, *p* = .10, Cohen's *d* = .28, small effect). Resource parents in the experimental condition reported significant changes in social supports from baseline to post-program (*t*(21) = -2.33, *p* = .02, Cohen's *d* = -.50, medium effect), but no significant changes were found from post-program to 2-month follow-up (*t*(21) = .33, *p* = .37, Cohen's *d* = .07, small effect). For potential between group differences, while the two groups did not differ significantly at post-program (*t*(41) = -.29, *p* = .29, Cohen's *d* = -.17, small effect), those in the experimental group reported significantly higher social supports at the 2-month

follow-up ($t(41) = -1.82$, $p = .04$, Cohen's $d = -.56$, medium effect).

Concrete Supports.

General Linear Model. Mauchly's Test of Sphericity was significant (Mauchly's W = .76, $p = .01$) and thus, the assumption of sphericity was violated. As a result, the Huynh-Feldt corrected results were used when interpreting concrete supports. Mean baseline scores were 3.80 for both the experimental group and waitlist control and were not significantly different (see Table 13; $t(41) = -.02$, $p = .49$). Scores fell within the mid to high end of the 5-point Likert scale. There was a significant effect of time ($\eta^2 = .08$, medium effect) but no significant time X group interaction ($\eta^2 = .05$, small effect; see Table 14). The effect of time was no longer statistically significant after applying the Bonferroni-correction. In terms of the significant effect of time, resource parents in the waitlist control group reported a significant decrease in their concrete supports from baseline to post-program ($t(20) = 2.12$, $p = .02$) but no significant differences were found from post-program to 2-month follow-up ($t(20) = -1.60$, $p = .06$). On the other hand, resource parents in the experimental group did not report any significant changes in their concrete supports from baseline to post-program ($t(21) = 0.39$, $p = .35$) or from post-program to 2-month follow-up ($t(21) = -1.05$, $p = .15$).

Post-Hoc Exploratory Analysis. Potential between group differences were examined. The two groups did not differ significantly at post-program ($t(41) = -1.21$, $p = .12$, Cohen's $d = -.37$, small effect) or at 2-month follow-up ($t(41) = -1.11$, $p = .14$, Cohen's $d = -.34$, small effect).

Resource Parent-Youth Difficult Interactions.

General Linear Model. Mauchly's Test of Sphericity was not significant (Mauchly's W = .93, $p = .54$). Thus, the assumption of sphericity was not violated. Mean baseline scores were 28.60 for the experimental group and 31.80 for the waitlist control, which were not significantly

different (see Table 13; $t(18) = .77$, $p = .23$). Scores fell within the mid-range of the overall scale. There was a significant impact of time ($\eta^2 = .20$, large effect) but no significant time X group interaction ($\eta^2 = .04$, small effect; Table 14). The effect of time was no longer statistically significant after applying the Bonferroni-correction. For the significant impact of time, resource parents in the waitlist control did not report significant decreases in their difficult interactions with youth from baseline to post-program ($t(9) = -.07$, $p = .47$) but did report a decrease from post-program to 2-month follow-up ($t(9) = 2.67$, $p = .01$). Resource parents in the experimental group did not report a significant change in their difficult interactions with youth from baseline to post-program ($t(9) = 1.23$, $p = .13$) or from post-program to 2-month follow-up ($t(9) = 1.42$, $p = .09$).

Post-Hoc Exploratory Analysis. Potential between group differences were examined. The two groups did not differ significantly at post-program ($t(18) = 1.39$, $p = .09$, Hedges' $g = .59$, medium effect) or at the 2-month follow-up ($t(18) = 1.48$, $p = .08$, Hedges' $g = .63$, medium effect).

Secondary Outcomes

The secondary outcomes were family functioning, parental distress, youth functioning difficulties, conduct problems, emotional problems, peer problems, hyperactivity/inattention, and prosocial behaviour. For all secondary outcomes reported below, the impact of the covariate (i.e., kinship caregivers) was not significant, which suggests that this variable did not have a significant differential impact on family functioning, parental distress, youth functioning difficulties, or youth socio-emotional functioning.

Family Functioning.

General Linear Model. Mauchly's Test of Sphericity was not significant (Mauchly's W

= .98, p = .74). Thus, the assumption of sphericity was not violated. Mean baseline scores were 3.03 for the experimental group and 3.01 for the waitlist control group, which were not significantly different (see Table 13; $t(41)$ = -.14, p = .45). Scores fell on the higher end of the 5-point Likert scale. Results indicated a significant impact of time (η^2 = .09, medium effect) but no significant time X group interaction (η^2 = .05, small effect; see Table 14). The effect of time was no longer statistically significant after applying the Bonferroni-correction. For the significant impact of time, resource parents in the waitlist control reported no significant changes in family functioning from baseline to post-program ($t(20)$ = -.57, p = .29) or from post-program to 2-month follow-up ($t(20)$ = -.12, p = .45). In contrast, resource parents in the experimental condition reported significant increases in family functioning from baseline to post-program ($t(20)$ = -3.10, p = .00), but no significant changes were reported from post-program to 2-month follow-up ($t(20)$ = -.16, p = .44).

Post-Hoc Exploratory Analysis. Potential between group differences were examined. Despite no significant group differences at baseline, resource parents in the experimental group reported significantly higher family functioning at post-program ($t(41)$ = -1.97, p = .03, Cohen's d = -.60, medium effect) and at the 2-month follow-up ($t(41)$ = -2.13, p = .02, Cohen's d = -.64, medium effect), compared to those in the waitlist control group.

Parental Distress.

General Linear Model. Mauchly's Test of Sphericity was not significant for parental distress (Mauchly's W = .78, p = .14). Thus, the assumption of sphericity was not violated. Mean baseline scores were 23.75 for the experimental group and 29.90 for the waitlist control, which were not significantly different (see Table 13; $t(18)$ = 1.62, p = .06). Scores fell within the mid-range of the overall scale. There was no significant effect of time (η^2 = .14, large effect) or time

X group interaction ($\eta^2 = .08$, medium effect; see Table 14).

Post-Hoc Exploratory Analyses. In terms of the potential change over time, resource parents in the waitlist control and experimental group reported no significant changes to their parental distress from baseline to post-program ($t_{waitlist}(9) = .19$, $p = .43$, Hedges' $g = .05$, small effect; $t_{experimental}(9) = .84$, $p = .21$, Hedges' $g = .24$, small effect), or from post-program to 2-month follow-up ($t_{waitlist}(9) = .39$, $p = .36$, Hedges' $g = .11$, small effect; $t_{experimental}(9) = 1.71$, $p = .06$, Hedges' $g = .49$, small effect). In terms of potential between group differences, despite no significant group differences at baseline, resource parents in the experimental group reported significantly lower parental distress at post-program ($t(18) = 2.29$, $p = .02$, Hedges' $g = .63$, medium effect) and at the 2-month follow-up ($t(18) = 2.36$, $p = .02$, Hedges' $g = 1.00$, large effect), compared to those in the waitlist control.

Youth Functioning Difficulties.

General Linear Model. Mauchly's Test of Sphericity was not significant for youth functioning difficulties (Mauchly's W = .82, $p = .21$). Thus, the assumption of sphericity was not violated. Mean baseline scores were 31.10 for the experimental group and 32.40 for the waitlist control, which were not significantly different (see Table 13; $t(18) = .72$, $p = .24$). There was no significant effect of time ($\eta^2 = .10$, medium effect) or time X group interaction ($\eta^2 = .02$, small effect; see Table 14).

Post-Hoc Exploratory Analyses. In terms of potential changes over time, resource parents in the waitlist control group reported significant decreases in youth functioning difficulties from baseline to post-program ($t(9) = 1.91$, $p = .04$, Hedges' $g = .55$, medium effect) but not from post-program to 2-month follow-up ($t(9) = -.29$, $p = .39$, Hedges' $g = -.09$, small effect). Resource parents in the experimental group reported no significant changes in youth

functioning difficulties from baseline to post-program ($t(9) = 1.33$, $p = .11$, Hedges' $g = .38$, small effect) or from post-program to 2-month follow-up ($t(9) = .20$, $p = .42$, Hedges' $g = .06$, small effect). In terms of potential between group differences, there were no significant differences between groups at post-program ($t(18) = 1.21$, $p = .12$, Hedges' $g = .52$, medium effect) or at the 2-month follow-up ($t(18) = 1.22$, $p = .12$, Hedges' $g = .52$, medium effect).

Conduct Problems.

General Linear Model. Mauchley's Test of Sphericity was not significant for conduct problems (Mauchly's W = .87, $p = .10$), thus the assumption of sphericity was not violated. Mean baseline scores were 3.77 for the experimental group and 4.53 for the waitlist control, which were not significantly different (see Table 13; $t(40) = .82$, $p = .21$). Scores fell within the mid-range of the overall scale, which according to British norms (Goodman et al., 2003), is considered *High* across baseline, post-program ($M_{experimental} = 4.14$; $M_{waitlist} = 4.63$), and the 2-month follow-up ($M_{experimental} = 3.76$; $M_{waitlist} = 3.88$). There was no significant effect of time ($\eta^2 = .02$, small effect) or time X group interaction ($\eta^2 = .01$, small effect; see Table 14).

Post-Hoc Exploratory Analyses. In terms of potential changes over time, resource parents in the waitlist control group reported no significant changes in youth conduct problems from baseline to post-program ($t(15) = -.28$, $p = .39$, Hedges' $g = -.07$, small effect) but did report significant increases in conduct problems from post-program to 2-month follow-up ($t(15) = 1.82$, $p = .05$, Hedges' $g = .43$, small effect). Resource parents in the experimental group reported no changes in youth conduct problems from baseline to post-program ($t(20) = -.61$, $p = .27$, Hedges' $g = -.13$, small effect) or from post-program to 2-month follow-up ($t(19) = .48$, $p = .32$, Hedges' $g = .10$, small effect). For potential between group differences, no significant group differences were found at post-program ($t(35) = .52$, $p = .31$, Cohen's $d = .17$, small effect) or at

the 2-month follow-up ($t(35) = .13$, $p = .45$, Cohen's $d = .04$, small effect).

Emotional Problems.

General Linear Model. Mauchley's Test of Sphericity was significant for emotional problems (Mauchly's W = .59, $p = .00$) meaning the assumption of sphericity was violated, so the Huynh-Feldt corrected results were used. Mean baseline scores were 3.19 for the experimental group and 4.18 for the waitlist control, which were not significantly different (see Table 13; $t(40) = 1.16$, $p = .13$). Scores fell within the mid-range of the overall scale, which according to British norms (Goodman et al., 2003), correspond to the following ranges: resource parents in the experimental group reported *Normal* baseline, *Borderline* post-program (M = 3.52), and *Normal* 2-month follow-up scores (M = 2.76). Resource parents in the waitlist control group reported *Borderline* baseline, post-program (M = 4.44), and 2-month follow-up scores (M = 4.13). There was no significant effect of time ($\eta^2 = .05$, small effect) or time X group interaction ($\eta^2 = .01$, small effect; see Table 14).

Post-Hoc Exploratory Analyses. For the potential changes over time, resource parents in both groups reported no significant changes to youth emotional problems from baseline to post-program ($t_{waitlist}(15) = -.76$, $p = .23$, Hedges' $g = -.18$, small effect; $t_{experimental}(20) = -.80$, $p = .22$, Hedges' $g = -.18$, small effect) or from post-program to 2-month follow-up ($t_{waitlist}(15) = .86$, $p = .20$, Hedges' $g = .21$, small effect; $t_{experimental}(20) = 1.44$, $p = .08$, Hedges' $g = .31$ small effect). For potential between group differences, no significant group differences were found at post-program ($t(35) = .97$, $p = .17$, Cohen's $d = .32$, small effect) or 2-month follow-up ($t(35) = 1.51$, $p = .07$, Cohen's $d = .50$, medium effect).

Hyperactivity/Inattention.

General Linear Model. Mauchley's Test of Sphericity was not significant for

hyperactivity/inattention (Mauchly's W = .98, p = .73) suggesting that the assumption of sphericity was not violated. Mean baseline scores were 6.19 for the experimental group and 6.72 for the waitlist control, which were not significantly different (see Table 13; $t(40) = .61$, p = .27). Scores fell within the mid to high range of the scale, which according to British norms (Goodman et al., 2003) corresponded to the following categories: resource parents in the experimental group reported *Borderline* baseline, post-program (M = 6.19), and 2-month follow-up scores (M = 6.75); resource parents in the waitlist control group reported *High* baseline and post-program (M = 6.75), and *Borderline* 2-month follow-up scores. (M = 6.19). There was no significant effect of time ($\eta^2 = .05$, small effect) or time X group interaction ($\eta^2 = .00$, small effect; see Table 14).

Post-Hoc Exploratory Analyses. For potential changes over time, resource parents in both groups reported no significant changes to youth hyperactivity/inattention from baseline to post-program ($t_{waitlist}(15) = -.56$, p = .29, Hedges' g = -.13, small effect; $t_{experimental}(20) = -.00$, p = .50, Hedges' g = .00, small effect) or from post-program to 2-month follow-up ($t_{waitlist}(15) = .93$, p = .18, Hedges' g = .22, small effect; $t_{experimental}(19) = 1.56$, p = .07, Hedges' g = .34, small effect). For potential between group differences, no significant group differences were found at post-program ($t(35) = .57$, p = .29, Cohen's d = .12, small effect) or 2-month follow-up ($t(35)$ = .68, p = .25, Cohen's d = .22, small effect).

Peer Problems.

General Linear Model. Mauchley's Test of Sphericity was not significant for peer problems (Mauchly's W = .97, p = .59), suggesting that the assumption of sphericity was not violated. Mean baseline scores were 3.90 for the experimental group and 3.46 for the waitlist control, which were not significantly different (see Table 13; $t(40) = -.57$, p = .29). Scores fell

within the mid-range of the overall scale, which according to British norms (Goodman et al., 2003), corresponded to the following categories: resource parents in the experimental group reported *High* baseline, post-program (M = 3.86), and 2-month follow-up scores (M = 3.71); resource parents in the waitlist control group reported *Borderline* baseline, *High* post-program (M = 3.63), and *Borderline* 2-month follow-up scores (M = 3.44). There was no significant effect of time (η^2 = .03, small effect) or time X group interaction (η^2 = .02, small effect; see Table 14).

Post-Hoc Exploratory Analyses. For potential changes over time, resource parents in both groups reported no significant changes to youth peer problems from baseline to post-program ($t_{waitlist}(15) = -.98$, $p = .17$, Hedges' $g = -.23$, small effect; $t_{experimental}(20) = .12$, $p = .45$, Hedges' $g = -.03$, small effect) or from post-program to 2-month follow-up ($t_{waitlist}(15) = .50$, $p = .31$, Hedges' $g = .11$, small effect; $t_{experimental}(19) = -.67$, $p = .36$, Hedges' $g = -.14$, small effect). For potential between group differences, no significant group differences were found at post-program ($t(35) = -.30$, $p = .38$, Cohen's $d = -.09$, small effect) or 2-month follow-up ($t(35) = -.36$, $p = .36$, Cohen's $d = -.12$, small effect).

Prosocial Behaviour.

General Linear Model. Mauchley's Test of Sphericity was significant (Mauchly's W = 12.54, $p = .00$), meaning the assumption of sphericity was violated, so the Huynh-Feldt corrected results were interpreted. Mean baseline scores were 6.09 for the experimental group and 6.57 for the waitlist control group, which were not significantly different (see Table 13; $t(40) = .49$, $p = .31$). Scores fell within the mid-range of the scale, which according to British norms (Goodman et al., 2003), is classified as *Normal* at baseline, post-program ($M_{experimental} = 6.57$; $M_{waitlist} = 6.50$), and 2-month follow-up ($M_{experimental} = 6.05$; $M_{waitlist} = 6.00$) for both the experimental and waitlist control group. There was no significant effect of time (η^2 = .02, small effect) or time X

group interaction ($\eta^2 = .01$, small effect; see Table 14).

Post-Hoc Exploratory Analyses. For the potential changes over time, resource parents in both groups reported no significant changes to youth prosocial behaviour from baseline to post-program ($t_{waitlist}(15) = -.14$, $p = .45$, Hedges' $g = -.03$, small effect; $t_{experimental}(20) = -.77$, $p = .22$, Hedges' $g = -.16$, small effect) or from post-program to 2-month follow-up ($t_{waitlist}(15) = 1.58$, $p = .07$, Hedges' $g = .38$, small effect; $t_{experimental}(19) = 1.27$, $p = .11$, Hedges' $g = .27$, small effect). For potential between group differences, no significant group differences were found at post-program ($t(35) = -.09$, $p = .46$, Cohen's $d = -.03$, small effect) or 2-month follow-up ($t(35) = -.05$, $p = .48$, Cohen's $d = -.02$, small effect).

Discussion

Despite the importance of trauma-informed care for young people involved in the child welfare system, there is no mandated in-service program available to resource parents in Ontario, Canada. While several in-service programs have been developed across North America, there is limited outcome research using rigorous evaluation methods. The focus of Study 2 was to conduct a preliminary evaluation of the in-service program, the Resource Parent Curriculum (RPC; Grillo et al., 2010), using a quasi-experimental design within a Canadian context. The program was delivered to several types of resource parents (i.e., foster, adoptive, kinship caregivers, and group home providers) across the province of Ontario, Canada. Because of COVID-19 public health protections, the program was delivered virtually to 43 research participants (22 in the experimental group and 21 in the waitlist control). To organize this preliminary evaluation, the results were situated within Kirkpatrick and Kirkpatrick's (2016) evaluation framework. Namely, there are results on resource parents' reactions to RPC, their learning and knowledge acquisition, and resulting changes to their behaviour. Refer to Table 15

for summary of the results.

Resource Parents' Reactions to RPC

To address resource parents' reactions to RPC, quantitative and qualitative information was gathered by collecting feedback after each module and in a post-program satisfaction questionnaire. Overall, most resource parents reported a positive experience with the program's content and delivery. They found the way the material was presented, as well as the specific content in each of the eight modules, to be helpful. In fact, all resource parents who responded indicated that they would recommend the training to other resource parents. These findings are important, as the program demanded quite a significant time investment from resource parents who not only had many other responsibilities but also were parenting amidst the numerous challenges stemming from the COVID-19 pandemic. A small portion of resource parents requested even more training on the topics covered by the RPC program to keep building on their knowledge and skills in trauma-informed caregiving. Although the current study did not collect information on future outcomes, such as placement disruptions, it is worth noting that over half of the resource parents agreed that the training resulted in them feeling less likely to request a future placement change. This finding suggests that resource parents may have felt more confident in their ability to manage the factors that are often associated with placement disruptions, such as challenging youth behaviours. They may have also better understood the negative impact of a placement disruption on a young person's "invisible suitcase" (i.e., their beliefs and expectations about themselves, others, and the world; Grillo et al., 2010; Konijn et al., 2019).

In terms of program content, resource parents found it helpful to learn about all aspects of how trauma impacts young people. However, the majority identified several concepts from

Module 3: Understanding Trauma's Effects and Module 5: Dealing with Feelings and Behaviours as particularly impactful, including the invisible suitcase, cognitive triangle, and the balance of encouragement and correction (Grillo et al., 2010). This finding suggests that resource parents may be particularly interested in specific, concrete strategies and concepts that they can easily apply in their homes. Several resource parents also identified that addressing the topic of self-care was beneficial, which speaks to the need for child welfare agencies to ensure that sufficient and regular support is provided to resource parents for their own well-being, given the impact of compassion fatigue and vicarious trauma.

Turning to the program delivery, many resource parents reported that the virtual format removed barriers to attendance and participation. Virtual delivery made it possible for resource parents to engage in a trauma-informed parenting program that they otherwise may not have been able to access. Another benefit to the virtual delivery was that it was possible to engage resource parents from across Ontario. Moving forward, it will certainly open possibilities in terms of offering both in-person and virtual RPC options and, in this way, reaching many more resource parents with this important training.

To date, there has been only one evaluation of RPC examining resource parents' reactions to the program (Sullivan et al., 2016). The results from the current study are consistent with findings from Sullivan et al. (2016). Namely, resource parents reported high levels of satisfaction with the program, indicated they would be less likely in the future to request a change in placement, and felt better equipped to meet the needs of the youth in their care. Sullivan et al. (2016) also reported that resource parents found the material interesting and engaging and rated the facilitators highly, which is also consistent with the results from the current study. Given that the evaluation by Sullivan et al. (2016) was based on in-person

delivery, it is noteworthy that resource parents in the current study reported similar levels of satisfaction with the virtual delivery. Findings from the current study are also in-line with previous literature on resource parent satisfaction and perceptions of training more generally, with resource parents reporting high levels of satisfaction across various programs, including a preference for interactive exercises and use of real-life examples, as well as flexibility in the program delivery (Kaasbøll et al., 2019).

Preliminary Effects of RPC on Resource Parents' Learning

The second component of Study 2 evaluated resource parents' learning and acquisition of knowledge as a result of RPC. Quantitative outcomes were gathered at three time points: baseline, post-program, and 2-month follow-up. Outcomes focused on resource parent-reported (1) knowledge and beliefs in trauma-informed parenting, (2) tolerance of challenging behaviours, and (3) parenting self-efficacy. The only demographic factor found to differ between groups at baseline was resource parent type, with significantly more kinship caregivers in the waitlist control than in the experimental group. As a result, this variable was used as a covariate in all analyses but did not significantly impact any learning outcomes.

The hypotheses about group changes from baseline to post-program, as well as from post-program to 2-month follow-up, were partially supported. The results showed that RPC had a direct impact on increasing knowledge and beliefs in trauma-informed parenting. Compared to the waitlist control, resource parents who participated in RPC developed greater knowledge and beliefs in trauma-informed parenting, which was a medium effect. These knowledge gains were maintained 2 months after the program's completion. In particular, RPC appeared to be successful at equipping resource parents with knowledge of the "essential elements" of trauma-informed parenting that were addressed (e.g., recognizing the impact of trauma on their youth,

supporting positive and stable relationships in the youth's life; Grillo et al., 2010). Given that RPC's learning objectives focus heavily on the acquisition of knowledge related to trauma-informed parenting, findings from the current study provide strong support for this particular domain. Resource parents who participated in RPC were no more likely than those in the waitlist control group to experience increases in their tolerance of challenging behaviours. However, post-hoc exploratory analyses for post-program results showed potential effects in increased tolerance of challenging behaviours for resource parents who participated in RPC compared to the waitlist control. These gains were not maintained over time because the two groups did not differ significantly at the 2-month follow-up.

Turning to parenting self-efficacy, resource parents who participated in RPC were no more likely than those in the waitlist control group to experience increases in their self-reported parenting self-efficacy. However, post-hoc exploratory analyses revealed a potential effect, as resource parents who completed RPC reported higher parenting self-efficacy at post-program and 2-month follow-up compared to the waitlist control.

These findings are somewhat in line with previous RPC evaluations using the same measure. Namely, Sullivan et al. (2016) found that resource parents showed significant increases in their knowledge of trauma-informed parenting and parenting self-efficacy from baseline to post-program. Although non-kinship caregivers reported increases in their tolerance of challenging youth behaviours, kinship caregivers did not report such changes. A more recent pre-post evaluation also found that resource parents who participated in RPC showed improvements in their knowledge of trauma-informed parenting, parenting self-efficacy, and tolerance of challenging youth behaviours (Murray et al., 2019). It appears that the most consistent findings pertain to trauma-informed parenting, with greater inconsistency for parenting self-efficacy and

tolerance of challenging behaviours.

One possible explanation for these findings was the low observed power, which impacted the chances of statistically significant findings. There was also a sizeable proportion of resource parents who self-identified as therapeutic/treatment foster caregivers. This population of resource parents is required to have specialized training in order to care for young people with complex mental health and medical needs. While there were no significant differences in the number of therapeutic/treatment foster caregivers between the experimental and waitlist control groups, there were significant baseline differences between therapeutic/treatment foster caregivers and other resource parent types. Therapeutic/treatment foster caregivers had significantly higher baseline scores in trauma-informed parenting, tolerance of challenging behaviours, parenting self-efficacy, and self-reported attachment relationship with their youth. As a result, these higher scores may have contributed to a potential "ceiling effect" given this group may already have a high degree of knowledge regarding trauma-informed parenting. Due to the small sample size, it was not possible to fully explore potential differential effects based on resource parent type. Though, it is possible that resource parents with less experience and training may respond differently than resource parents with specialized training and experience.

In addition, the program did not result in significant changes to youth socio-emotional challenges (see below), so it is possible that resource parents experienced continued difficulty caring for their youth with high mental health needs. If resource parents had reported improvements in their youth's socio-emotional challenges, they may have been more likely to persist through difficulties and continue supporting the young person, thereby impacting their tolerance of challenging behaviours. Noticeable improvements in youth socio-emotional difficulties may have, in turn, led resource parents to feel more competent in their caregiving role

and result in improvements to their parenting self-efficacy. It is also important to consider the impact of COVID-19, as the program was delivered during a time of high global stress that directly impacted families. Throughout the time the program was delivered, there were school and childcare closures, shutdowns of recreational activities, increased social isolation, work stress, and financial strain (Canadian Institute for Health Information, 2022). Moreover, resource parents faced added stressors that included communication difficulties with child welfare staff, reduced mental health and training supports, and disruptions in visitation or access visits with biological families (Chanchlani et al., 2020; Foster Parents Society of Ontario, 2021; Lee et al., 2021).

It should be noted that previous RPC evaluations did not include a comparison group. Solomon et al. (2007) noted that relatively few studies have a comparison group and as a result, there are limitations in interpreting the program's effectiveness. Given that resource parents in the waitlist control also reported increases in their knowledge and beliefs in trauma-informed parenting (though, to a lesser degree than the experimental group), it is possible that resource parents in the waitlist control learned through experience over time and acquired some knowledge through informal means (e.g., online resources or books, information from their child welfare practitioner).

Findings from the current study are also consistent with research on other resource parent training interventions using experimental or quasi-experimental designs. In particular, a meta-analysis of eight studies investigating foster parent interventions (Solomon et al., 2017) found that foster parents involved in training reported higher self-reported knowledge and skills (a combined medium effect; e.g., use of "proper discipline", understanding of child development). However, this meta-analysis excluded interventions delivered to kinship caregivers and included

pre-service programs (e.g., PRIDE), while RPC is an in-service program. Although it was difficult to identify the exact training components of the studies included in the meta-analysis, they were noted to cover concepts related to child development, discipline, and positive reinforcement. However, it was unclear whether these interventions had a trauma focus or were designed for a child welfare population.

A more recent meta-analysis including seven studies (Schoemaker et al., 2020) also found a small to medium combined effect with regard to resource parental knowledge and attitudes. This meta-analysis included both individual (e.g., Parent Child Interaction Therapy) and group interventions (e.g., KEEP) with variability in session numbers. However, it is not entirely clear what specific knowledge or attitudes resource parents acquired.

Preliminary Effects of RPC on Resource Parents' Behaviour

Primary Outcomes

The hypotheses related to attachment, social supports, concrete supports, and parent-youth difficult interactions were not supported. Post-hoc exploratory analyses revealed some potential effects to further explore. It is possible that the low observed power, poor reliability of some outcome measures, and high proportion of therapeutic/treatment foster caregivers in the sample contributed to non-significant findings. Results showed that RPC did not significantly improve the resource parent-reported attachment relationship with their youth. Post-hoc exploratory analyses indicated a potential effect. In particular, while scores for the two groups were equivalent at post-program, experimental group resource parents reported a significantly higher quality attachment relationship with their youth at the 2-month follow-up compared to the waitlist control. Results also indicated that RPC did not significantly improve the level of social supports. Again, there was a potential effect showing that, while scores for the two groups were

equivalent at post-program, resource parents in the experimental group reported higher social supports at the 2-month follow-up compared to the waitlist control, which was a small effect. RPC did not appear to be effective at significantly improving resource parents' concrete supports. Post-hoc exploratory analyses indicated that while waitlist control parents reported decreases in their concrete supports from baseline to post-program, scores for the two groups did not differ significantly at post-program or 2-month follow-up. Finally, RPC did not significantly improve parent-youth difficult interactions. Post-hoc exploratory analyses indicated resource parents in the waitlist control reported significant decreases in their difficult interactions with youth from post-program to 2-month follow-up, while resource parents in the experimental group did not report such changes, however, the two groups did not differ significantly at post-program or 2-month follow-up.

Secondary Outcomes

The hypotheses related to family functioning, parental distress, youth functioning difficulties, and youth socio-emotional functioning were not supported. Results did indicate a potential effect in improved family functioning for resource parents who participated in RPC. Specifically, at post-program and 2-month follow-up, resource parents in the experimental condition reported significantly higher family functioning than the waitlist control group. Findings also suggested that the program did not significantly improve parental distress. However, a potential effect was noted such that resource parents in the experimental group reported significantly lower levels of parental distress at post-program and 2-month follow-up, compared to the waitlist control group. In terms of caregiver-reported outcomes related to youth, the RPC program did not significantly improve youth functioning or socio-emotional difficulties. Specifically, no significant changes in youth conduct problems, emotional problems,

hyperactivity/inattention, peer problems, or prosocial behaviour were reported by the resource parents who completed RPC in comparison to those in the waitlist control.

Previous research related to the effectiveness of resource parent interventions has been inconsistent. While RPC has not been previously evaluated using the behavioural outcomes included in the current study, results can be compared to research investigating similar outcomes for other resource parent interventions. Results of the current study were fairly inconsistent with a series of eight meta-analyses conducted by Schoemaker et al., (2020) examining the effectiveness of intervention programs for kinship, foster, and adoptive caregivers across several outcomes that included sensitive parenting, dysfunctional discipline, parenting stress, and attachment security. Results indicated positive and statistically significant impacts for sensitive parenting, dysfunctional discipline, and parenting stress but not for attachment security. Interestingly, improvements in sensitive parenting in Schoemaker et al.'s (2020) meta-analysis were larger if the intervention was delivered to groups versus individuals, with even greater improvements when the intervention was delivered in groups with additional individual sessions. It is possible that resource parents in the current study may have required additional individualized or intensive resources by way of individual sessions to continue supporting their parenting work and that this added component may have resulted in statistically significant outcomes at the behavioural level. While there were opportunities for resource parents to ask specific questions pertaining to youth in their care, it was not possible in the current study to provide more extensive coaching or individualized supports due to aspects of the training delivery, including the virtual and group format and 90-minute modules. Furthermore, resource parents were facing reduced supports throughout the duration of the study due to the COVID-19 pandemic. Thus, it is possible that services such as respite, mental health services, and school-

based supports were eliminated or significantly reduced throughout the time that the program was delivered. For many families, it is possible that RPC was the only support they were receiving, and the program may not have adequately addressed the full range of parenting and mental health needs necessary for supporting youth and caregivers. The meta-analytic findings also speak to the importance of providing resource parents with multiple forms of support, including programs delivered in a group format as well as individual support to address their specific needs.

Schoemaker et al. (2020) also found that the strongest effects for dysfunctional discipline were for brief interventions for children up to five years old. In the current study, the average age of children in resource parents' care was 10 years, so it is possible that resource parents require differing parenting supports that are dependent on the youth's age. This possibility could be addressed by offering separate groups based on the age of the youth, which would allow facilitators to better tailor case examples, tackle certain parenting questions in greater detail, and allow resource parents to exchange strategies most relevant to their current parenting situation. However, this possibility would depend on available resources and clinical judgment depending on the particular circumstances of the group. For example, it may be beneficial to cover content across multiple developmental stages so that resource parents could fully appreciate the various ways in which traumatic impacts might be exhibited throughout the course of childhood and adolescence. Alternatively, some group home providers or foster parents specialize in caring for youth of particular age groups (e.g., temporary placement for infants or adolescents) so for these resource parents, a separate group focusing on their particular age group may be more beneficial.

The current study was generally consistent with previous literature related to attachment, as a meta-analysis of six studies found that with one exception, resource parent interventions

overall were not effective at improving attachment security (Schoemaker et al., 2020). Several potential effects in the current study were noted with regards to resource parents' attachment relationship with their youth. In general, measures related to attachment are not commonly included in evaluations of resource parent programs, which is problematic given the high prevalence of attachment difficulties for youth in care (Miranda et al., 2019). Perhaps resource parent interventions targeting the attachment relationship may be more effective for particular age groups (e.g., very young children) due to sensitive periods of development. Attachment security for older youth may be more challenging to target through a group-based caregiver program if youth have experienced high levels of placement instability and/or more chronic trauma within the caregiving system. It is possible that more comprehensive, extensive supports of a longer duration may be needed in order to improve the quality of youth attachment relationships in such circumstances. Healing from developmental trauma and child welfare involvement is a long-term process, and therapeutic benefits to the youth are not likely to be shown without a long period of stability and predictability (Tarren-Sweeney, 2021). Thus, it is understandable that RPC in its current 8-module format would not fully address the complexities of youth attachment challenges. Indeed, Schoemaker et al. (2020) noted that indirect youth-level outcomes may be delayed and suggested that long-term follow-up (i.e., longer than 6 months) may be necessary to examine these effects. In the current study, resource parents in the experimental group only began reporting potential improvements in the attachment relationship with their youth at the 2-month follow-up, so it is possible that these changes may continue to develop over time.

Youth Outcomes

Compared to the general population of British and Canadian young people ages 4 to 17

years, resource parents' reports of their youth's socio-emotional difficulties in the current sample were generally higher than the general population of children (Goodman et al., 2003; Hoffmann et al., 2020). These results are largely in-line with research on the prevalence of social and emotional difficulties of youth in care and signify the supports needed to improve youth wellbeing and equip caregivers with competencies required to best support these youth (American Academy of Child and Adolescent Psychiatry, 2001; Burge, 2007; Leslie et al., 2000; Nixon et al., 2008). It is also important to consider the consequences of the COVID-19 pandemic, as the current study was conducted when youth mental health needs were high but access to services was greatly reduced. Stewart et al. (2021) found that there was a reduction in mental health assessments among children and youths in Ontario during the pandemic, particularly among young people living in low-income neighbourhoods. While referrals for internalizing challenges and problematic internet use increased, referrals for hyperactivity and externalizing challenges decreased. Other Canadian research reported worsening youth mental health and increased parental stress and parent-child relational difficulties in the general population (Thomson et al., 2021). Young people in care are at even higher risk of mental health challenges due to their additional vulnerabilities and trauma histories. While research on the pandemic-related mental health impact on youth in care is limited, Zak et al. (2022) found that resource parents in Ontario were facing high levels of pandemic-related stressors and reductions in essential supports. Thus, it is no surprise that resource parents report high levels of mental health challenges within themselves and their youth.

Despite results from Gigengack et al. (2017) that resource parents reported significantly fewer post-traumatic stress symptoms in their child after completing RPC, the current study found that the experimental group of resource parents were no more likely than those in the

control group to report improvements in their youth's socio-emotional difficulties. While the measure in the current study included items that may relate to some features of post-traumatic stress symptoms (e.g., emotional and behavioural challenges, hyperactivity, impulsive behaviour), it is likely that the measure in the current study was not sufficiently sensitive to capture the range of post-traumatic stress symptoms youth may experience (e.g., intrusion symptoms, avoidance).

Results from the current study are inconsistent with two meta-analyses on resource parent interventions examining youth behavioural outcomes (Schoemaker et al., 2020; Solomon et al., 2017). In a meta-analysis of 16 foster parent interventions (Solomon et al., 2017), foster parents involved in training reported fewer child behavioural challenges than parents who did not participate in training (a combined small effect). Similarly, Schoemaker et al. (2020) conducted a more recent meta-analysis of 33 resource parent interventions examining child behavioural challenges and found a medium combined effect. Interventions with a higher number of sessions (range from 2-12 sessions among the various interventions) were most effective at decreasing behavioural challenges, and the authors noted that indirect program effects on youth outcomes may take time to be revealed because of the impact on the resource parent-youth dynamics (Schoemaker et al., 2020). Thus, a longer follow-up period may have been necessary. Additionally, much of the previous literature has focused specifically on behavioural challenges given their links to placement disruption (Oosterman et al., 2007). However, there is a lack of research on the impact of resource parent interventions on other aspects of youth socio-emotional challenges (e.g., internalizing difficulties, traumatic stress symptoms). It should be noted that both of these meta-analyses included individual and group interventions, and the authors did not report whether the intervention format moderated the effectiveness for child behaviour outcomes

(Schoemaker et al., 2020; Solomon et al., 2017). There are important distinctions between individualized therapeutic supports and programs delivered in a group format. For example, individualized supports provide a greater opportunity for a more in-depth approach tailored to the family's unique needs.

Uretsky and Hoffman (2017) conducted a narrative and meta-analytic review of seven group-based in-service programs delivered to foster parents that examined youth externalizing behaviours. Interventions consisted of the Incredible Years, KEEP, Middle School Success Program, and Cognitive Behavioural Parent training which ranged from 12 to 16 weeks for 1.5-2 hour sessions. Of note, only KEEP is originally designed for a resource parent population. In the review, all studies reported a significant decrease in child behavioural problems. While RPC includes a module dedicated to techniques for understanding and managing youths' overwhelming emotions, as well as modifying challenging behaviours (Module 5: Dealing with Feelings and Behaviours), it is possible that resource parents required further support and time spent on these topics. Indeed, some of the above programs (e.g., Incredible Years) focus primarily on behaviour management and are not trauma-informed. In contrast, RPC's content extends beyond this behavioural focus to encompass a wide range of issues commonly encountered by child welfare-involved youth and caregivers (e.g., responding to trauma reminders, building connections with biological families). As noted, learning outcome results in the current study suggested that potential improvements in resource parents' tolerance of challenging behaviours were not maintained at the 2-month follow-up. Given the robust research on the connection between externalizing difficulties and placement disruptions (Oosterman et al., 2007), supporting resource parents in managing youth behaviours is of high importance. While other aspects of trauma-informed parenting are also critical, it is possible that eight modules

were not sufficient to provide resource parents with practice in applying the techniques introduced through the program. Thus, it is likely that resource parents would benefit from additional content, booster sessions, and/or more individualized on-going supports, especially in situations where a youth has high behavioural needs. The impact of the COVID-19 pandemic may have also influenced these outcomes, as resource parents were facing interruptions to their existing services and supports while simultaneously managing increases in their youth's socio-emotional challenges.

Limitations and Future Research Directions

There are a number of limitations of the current study. In terms of sample and design, resource parents were not randomly selected from the population of all Ontario resource parents, and the majority of resource parents were not randomized to experimental or waitlist control groups. The fact that resource parents self-selected to participate in RPC likely impacted the generalizability of the current results. For instance, it is possible that resource parents who self-identified as therapeutic/treatment foster caregivers were over-represented in the current study, which may have impacted learning and behavioural outcomes. It is possible that resource parents with particular interest and existing knowledge in trauma-informed parenting were drawn to RPC, while resource parents without such interest or existing knowledge chose not to participate. While resource parents in Ontario are required to complete a certain number of training hours annually, to my knowledge there are no agency requirements for completing training covering certain topic areas. These limitations could be circumvented if agencies required resource parents to complete particular programs, or if certain in-service programs were provincially mandated (such as with PRIDE pre-service training), which would lead to a more generalizable sample from which to base future evaluations. Although the use of a quasi-experimental design was

more rigorous than a single group pre-post evaluations and other correlational designs, resource parents in the current study self-selected based primarily on scheduling needs. It should be noted, however, that the two groups were comparable on baseline outcome measures and all but one demographic variable. Future evaluations should strive for random assignment to groups, which would result in a greater likelihood of true group equivalence and superior generalizability.

Due to the preliminary nature of the evaluation and challenges of intervention research (especially during a pandemic), the sample size was small. As a result, the analyses were underpowered and may have prevented the detection of true group differences. Due to the small sample size and low power, the current findings are also subject to Type II error. Consequently, it may be more useful to consider the effect sizes found in the current study to inform avenues of future research. It would be important for future evaluations to have a larger sample to follow up on some of potential effects that were found through post-hoc exploratory analyses (e.g., tolerance of challenging behaviours, parenting self-efficacy, attachment, social supports, family functioning, and parental distress) and to examine interactions. For example, it would be important to determine whether outcomes differed by resource parent type (i.e., foster, kinship, therapeutic/treatment foster caregivers, adoptive caregivers, group home providers) or other factors such as the age of the youth and their maltreatment history. These research avenues would be especially important to further understand, as the current study included a sizeable proportion of therapeutic/treatment foster caregivers. Other important areas to further examine may include the dosage and timing of content, setting or format, and the specific intervention ingredients that are most impactful. These dismantling studies are necessary to determine what components of the program are most effective (Solomon et al., 2017).

Another limitation related to data collection was that responses were based solely on one

resource parent self-report across all measures in the current study. In an evaluation of a resource parent program, Baker et al. (2015) found that observational measures yielded drastically different results than those based on self-reports. It would have been informative to incorporate perspectives from other relevant individuals including the child welfare practitioner and youth themselves. Gathering perspectives from multiple informants would have increased the validity of the findings and as such, is a recommendation for future RPC evaluations. For example, results from Study 1 indicated that youth-reported placement satisfaction was a significant predictor of the number of placements a youth experiences. Despite this important finding, research incorporating youth perspectives is often lacking. Providing youth with opportunities for their voices to be heard supports empowerment and engagement in services and provides critical information that can be integrated into child welfare policies and practices.

In terms of the psychometric properties of the measures used, there were several that had poor internal consistency. Internal consistency can be impacted by the number of items in a questionnaire and the sample size, both of which were of concern for certain measures in the current study (e.g., SDQ subscales for 2-3 year olds). Of note, Onwuegbuzie and Daniel (2002) report that low reliability estimates are not always indicative of poor psychometric properties and could be attributable to the level of homogeneity in the sample. It is possible that resource parents' responses were homogeneous (e.g., low standard deviations) for particular measures, especially if combined with small sample size and a small number of subscale items.

Given the preliminary nature of this evaluation, it was not possible to examine more distal outcomes including placement disruption. It should be noted however, that responses on the post-workshop satisfaction questionnaire suggested that over half of resource parents agreed that they would be less likely to request a change in placement in the future. These more distal

outcomes would be critical to examine, given previous research that has found links between resource parent training and placement stability, resource parent retention, and satisfaction (Cuddeback & Orme, 2002; MacGregor et al., 2006).

In terms of the next steps, RPC is over ten years old so updates are underway to reflect current knowledge in the field (e.g., updated research regarding the impact of trauma, more recent evidence supporting particular therapeutic interventions). One important consideration includes greater sensitivity to diversity-related issues, which is particularly important given the over-representation of Black and Indigenous youth in the Ontario child welfare system (One Vision, One Voice, 2016). RPC does not explicitly address how diversity-related factors such as race, gender identity, sexual orientation, religion, and socioeconomic status impact family systems, caregivers, and youth in care. Including greater discussions on how resource parents can help youth maintain connections to their cultural identity and discussing the impact of intergenerational trauma can help resource parents better understand the lived experiences of individuals within the child welfare system. It is critical that future research be conducted evaluating the program as possible changes are made to program content. Findings from the current study may be taken into account as updates are made to the program. For instance, updates to the program may include providing sufficient opportunity for resource parents to receive adequate support for managing youth externalizing challenges, incorporating booster or follow-up modules, or pairing RPC with individualized supports.

Implications for Practice

The current study is an important first step toward evaluating RPC using more rigorous methods. This study is the first to deliver the RPC program and use a quasi-experimental design to evaluate RPC within a Canadian context using a virtual format. While it is important that two

child welfare agencies were interested and able to collaborate on the project, the majority of resource parents who expressed interest in the program sought this opportunity outside of their child welfare agency. This speaks to the ongoing training needs of resource parents and suggests that there may not be sufficient parenting supports offered within their child welfare agency. Given the COVID-19 pandemic resulted in widespread service disruptions, child welfare organizations may not have had the resources including funding or staff to be able to offer such programs as part of their regular service delivery. Child welfare agencies may also have limited capacity to collaborate with researchers on evaluations of the programs they offer to resource parents. The current study showed that resource parents were highly satisfied with the RPC program delivered in a virtual format. Virtual delivery may increase accessibility, remove barriers in attendance, and possibly reduce associated costs in offering such a program.

While training satisfaction is important, developing greater competencies including knowledge and skill acquisition is also critical (Cooley, & Petren, 2011). Preliminary outcome findings suggest that RPC has the potential to improve resource parent knowledge and beliefs regarding trauma-informed parenting. The current study highlights areas to further explore as it relates to improving family functioning, the resource parent-youth relationship, and youth socio-emotional wellbeing. While not statistically significant, the program may have the potential to impact family functioning, attachment, and parental distress, which has important implications not only for the resource parent but also the youth and family system. Improvement in these areas may serve to improve the youth-caregiver relationship and promote placement satisfaction and resource parent retention.

Findings emphasize the importance of providing multiple levels of support to resource parents, as RPC alone was not enough to address the factors commonly associated with resource

parent dropout and placement disruption. Resource parents and youth require support across all levels of the system to ensure their needs are adequately addressed, which is a challenging feat in under-resourced mental health care and child welfare systems. While it is critical to equip resource parents with competencies in trauma-informed parenting, our efforts must also widen to promote trauma-informed systems. Thus, child welfare workers, educators, mental health professionals, and other important individuals in the youth's life will also benefit from trauma-informed information and supports.

General Discussion

Experiences of developmental trauma and child welfare involvement have widespread negative impacts on young people in care. As a result, these youths often have complex needs that require a system of trauma-informed supports. In terms of the caregiving system, resource parents in Ontario are not systematically offered in-service trauma-informed parenting programs to provide them with the knowledge and skills needed to effectively care for these youths. Thus, the combination of high youth needs, coupled with limited training and support for resource parents, places both youths and caregivers at risk for negative outcomes that include placement instability and resource parent dropout (Brown & Bednar, 2006; Rock et al., 2015). Despite permanency being one of several central goal within child welfare, placement disruptions often occur, which further reinforces the burden of trauma and loss experienced by young people in care (Lockwood et al., 2015; Perry et al., 2012).

The overall objective of this two-study dissertation was to further *assess* youth and caregiver associations with the number of youth placements (Study 1) and *address* some of these factors by evaluating an in-service trauma-informed parenting program for resource parents (Study 2). Study 1 made use of multiple informant data to examine youth and resource parent factors associated with the number of placement changes among 1,624 10-17 year olds in care. The results from Study 1 also helped to provide a better understanding of the strengths and needs of young people in care and their caregivers. Study 2 focused on conducting a preliminary evaluation of the Resource Parent Curriculum (RPC), an in-service parenting program developed by the National Child Traumatic Stress Network. Resource parents who completed the program provided information on their satisfaction with the program, and data were collected to evaluate

the program's impact on youth and caregiver outcomes. The study consisted of a quasi-experimental design using within-and between-subject factors.

Major Findings

Study 1

Findings regarding youth mental health functioning were somewhat inconsistent with previous research, as youths in the sample fell within the normative ranges across multiple domains of socio-emotional functioning. Results from Study 1 pointed to several youth and caregiver factors associated with placement changes. For demographic factors, compared to residential placements, parent-model placements (i.e., foster, adoptive, kinship homes) were associated with fewer placement changes. Younger age when first placed in care, older current youth age, and a higher number of maltreatment types experienced by the youth were associated with a greater number of placement changes. For youth variables, greater conduct problems, peer problems, and prosocial behaviour, as well as fewer internal assets, were associated with greater placement changes. For resource parent variables, lower youth-reported placement satisfaction was associated with a greater number of placement changes. Parenting variables (e.g., positive parenting, inconsistent discipline, and poor supervision) were not significantly associated with the number of placement changes, which was inconsistent with previous research (Konijn et al., 2019). However, greater placement satisfaction was strongly associated with greater youth-reported positive parenting practices and greater youth-reported quality of the relationship with their caregiver. Furthermore, greater placement satisfaction was associated with fewer caregiver-reported difficulties in youth socio-emotional functioning.

Study 2

Resource Parents' Reactions. In terms of resource parents' reactions to RPC, quantitative and qualitative results suggested that resource parents reported a positive experience with the program's content and delivery. They rated the program content across each of the eight modules highly. Over half of the resource parents who responded agreed that the program resulted in them feeling less likely to request a future placement change. Resource parents identified several concepts that were particularly impactful, many of which were concrete and easily applied (e.g., the invisible suitcase, cognitive triangle).

Resource Parents' Learning. Results indicated that resource parents who participated in RPC developed greater knowledge and beliefs in trauma-informed parenting than those in the waitlist control (medium effect), which were maintained at the 2-month follow-up. Although resource parents in the experimental group were no more likely than those in the waitlist control to experiences increases in their tolerance of challenging behaviours or parenting self-efficacy, potential effects in these areas were found through post-hoc exploratory analyses. Specifically, resource parents in the experimental group reported higher tolerance of challenging behaviours and parenting self-efficacy than resource parents in the waitlist control at post-program. These gains were only maintained at the 2-month follow-up for parenting self-efficacy but not for resource parents' tolerance of challenge behaviours.

Resource Parents' Behaviour. Although there were no statistically significant interactions for primary and secondary behavioural outcomes, some potential effects to further explore were found through post-hoc exploratory analyses. While the two groups were equivalent at post-program, resource parents in the experimental group reported a higher quality attachment relationship with their youth and higher social supports at the 2-month follow-up.

Additionally, potential effects indicated possible improvements in family functioning and lower parental distress than those in the waitlist control at both post-program and 2-month follow-up. Finally, RPC did not significantly improve resource parent-youth difficult interactions, concrete supports, youth functioning, or socio-emotional difficulties, including caregiver-reported youth conduct problems, youth emotional problems, youth hyperactivity/inattention, youth peer problems, or youth prosocial behaviour.

Theoretical Implications

The findings from this dissertation contribute to advancing knowledge on the factors related to placement changes among youth in care as well as on the outcomes for one particular in-service resource parent program. The ultimate goal of this research is to promote stability and permanency for youth in care. Consistent with Bronfenbrenner's Ecological Systems Theory (1979), the child welfare system is complex, multi-layered, and involves multiple interacting systems. These interacting systems in turn influence the individual young person. This dissertation highlighted the dynamic relationship between two particular levels of the system, caregivers and youths. Both studies emphasized the importance of considering multiple levels of the system when understanding the complexity of placement disruptions, and when considering effective interventions for service planning and delivery.

This dissertation highlighted several important risk factors related to placement changes, and Study 2 findings can be interpreted within this context. For instance, RPC was associated with improvements in knowledge and beliefs in trauma-informed parenting. Potential effects to further explore include possible changes to family functioning, resource parent-youth attachment, and parental distress. Thus, is interesting to speculate how these outcomes relate to a youth's risk of placement changes. While Study 2 did not directly measure placement

disruptions, it is plausible that possible caregiver-reported improvements in their attachment relationship and family functioning contributes to the youth feeling more satisfied in their placement, which in turn is associated with better well-being (e.g., internal developmental assets) and socio-emotional functioning and a reduced risk of placement changes. Although several youth socio-emotional challenges were related placement changes (i.e., conduct and peer problems), Study 2 did not find these outcomes were impacted by the RPC program. These findings have important implications for RPC from a program development standpoint, as updates are made to the content. It will be critical to conduct additional evaluations of the RPC program using rigorous methods to further establish the program's effectiveness and explore outcomes of interest.

Research Implications

This dissertation underlined the importance of involving the individuals who have a direct impact on young people, including resource parents and child welfare practitioners. Study 1 achieved this by incorporating perspectives from multiple informants, including caregivers, the child welfare practitioner, and youth themselves. Although child welfare practitioner and youth perspectives were not obtained in Study 2, future research should strive toward gathering perspectives from multiple informants whenever possible. Taking this systemic approach allows us to consider the complex interplay across multiple levels of the system and individuals within the system, to better understand and address the needs of youth in care. For Study 1, given the variables in the study accounted for a small proportion of the variance in the number of placement changes, other relevant factors must be considered. For instance, I did not include variables related to more distal organizational factors including child welfare policies, staff turnover, and factors related to the child welfare practitioner (e.g., burnout). These data were not

available, but have been found to be related to placement disruptions in previous literature (Oosterman et al., 2007). For Study 2, while providing supports to resource parents is a critical piece to consider, delivering ongoing training in trauma-informed care to child welfare practitioners and other relevant individuals involved in the youth's life was beyond the scope of the study. In order to build a trauma-informed system, important individuals in the young person's life should have the knowledge and skills needed to support them from a trauma-informed lens, which would result in consistent messaging, and trauma-informed plans of care and service planning. Thus, these systemic factors play a role in resource parent recruitment, retention, and the services provided to youth and their caregivers.

In terms of sampling, this dissertation sought perspectives from all types of resource parents (i.e., foster, adoptive, kinship caregivers). At times, previous research has focused solely on particular types of resource parents. While excluding certain types of resource parents within a research context can contribute to more rigorous research methods, this can have practical consequences if particular interventions have only been studied for foster parents, but not kinship or adoptive caregivers. For example, although kinship caregivers are known to face added stressors (e.g., face systemic issues including fewer opportunities to access education, lower income), they tend to receive less financial support and training (Cuddeback & Orme, 2002). Thus, it is critical to ensure the perspectives of all resource parents are considered to better understand the unique needs of each group.

Implications for Practice

Several practical implications of this dissertation relate to child welfare organizational practices. Findings from Study 1 point to the utility of the AAR-C2 data in better understanding a young person's risk and protective factors as they relate to placement changes. Although the

AAR-C2 data are collected on a yearly basis due to mandates by the Ontario Ministry of Children, Community, and Social Services, they tend to be underutilized by child welfare staff for purposes of youth service planning and delivery (Romano et al., 2020; Stenason et al., 2021). Given that child welfare practitioners have access to AAR-C2 data on the youth with whom they work, the data could be utilized to examine the variables found to be related to placement changes in Study 1. Using these data may help the child welfare practitioner understand the youth's risk and protective profile and facilitate discussions with the young person and their circle of care to better plan for needed supports and services.

Child welfare organizational factors are also relevant to consider regarding the delivery of RPC. While pre-service supports provide resource parents with the necessary foundational knowledge prior to caring for the young person, they must also receive in-service supports that are trauma-informed. Despite the need for in-service supports, there were barriers in partnering with child welfare agencies during recruitment. Many agencies were contacted with an invitation to collaborate (which occurred prior to the COVID-19 pandemic), yet only two child welfare agencies had the capacity to be involved in the research project. Indeed, when recruitment was extended to the community, the demand for participation exceeded the number of available spots. One possibility for this phenomenon was that the training needs of resource parents were not being met within their child welfare organization and resource parents had to look elsewhere for information and support. Novel programs can be difficult to introduce and implement in organizations due to the complex and layered contexts, limited resources, and high staff turnover (Fixsen et al., 2009; Glisson & Schoenwald, 2005; Li et al., 2020). Furthermore, the COVID-19 pandemic had a significant impact on the supports and services offered by child welfare organizations and so it is understandable that as recruitment progressed throughout the

duration of the pandemic, resource parents sought additional supports and services in the community. It is noteworthy that resource parents committed to a program that demanded quite a bit of time as they navigated personal and parenting challenges amidst the pandemic. Resource parents' commitment speaks to their desire and need for ongoing training opportunities. Likely, the demand for the program may have been even higher had recruitment occurred outside of the context of the pandemic, as many caregivers were faced with added stressors and responsibilities (e.g., school closures). The pandemic also drove novel adaptations to the program delivery, including virtual delivery. Given the feasibility and overall accessibility of virtual delivery, it may be possible to reach a greater number of resource parents through virtual means. Virtual delivery may prove to be helpful for resource parents in rural areas, eliminate the need for child care, or when staffing shortages prevent programs from being offered on a regular basis. Virtual delivery also has the potential to connect resource parents from across the province, which may foster greater social support, as well as sharing of new perspectives and resources.

Another practice implication at the child welfare organizational level relates to placement decisions for youths. This dissertation reinforces the importance of securing and maintaining parent-model placements whenever possible. Study 1 reported that the most common placement type was a foster home, followed by group home and kinship care. It is concerning that group homes were the second most common placement type for Ontario youth in care, as parent-model homes were associated with fewer placement changes. As a result, the recruitment and retention of resource parents is critical, and caregivers in parent-model homes must be provided with supports to facilitate a positive caregiving environment to reduce the need for residential placements as much as possible.

In terms of practice implications for caregivers, in-service supports such as RPC can be one component of service delivery, as it helped to equip resource parents with knowledge regarding trauma-informed parenting and some promising potential behavioural outcomes were found. This dissertation underscored the need for a comprehensive approach to service delivery, as providing resource parents with one parenting program, such as RPC, did not fully address their complex needs (e.g., youth socio-emotional functioning). A multi-pronged approach embedded in a trauma-informed system where all individuals have their needs met (i.e., youth, resource parents, biological families, child welfare practitioners) is critical when addressing the complex issue of placement stability. For example, child welfare practitioners may utilize their youth's AAR-C2 data to identify more specific needs and tailor particular supports. While all resource parents should be given access to trauma-informed in-service supports, caregivers who are having particular struggles in their parenting role may be offered additional parenting programs, individualized supports (e.g., psychotherapy), and respite. Youth with high levels of externalizing behaviour and low internal assets may be referred for a trauma-informed psychological assessment, psychotherapy, and enrolment in extracurricular activities to promote their sense of identity and competence. Access to sufficient supports and resources must be a priority as we continue to learn about the longer-term social and emotional impacts of the pandemic. Future research may continue to examine the combination of supports that are most effective, with particular attention to the effectiveness, sustainability, and feasibility of the programs and services being implemented.

Conclusions

Young people in care cope with high levels of adversity and developmental trauma and as a result, endure many losses and associated mental health challenges. The resource parents

caring for these youth receive limited support and resources, yet are tasked with many important responsibilities in caring for youth with complex needs. Unfortunately, placement disruptions are common for youth in care and are associated with poor outcomes (Brown & Bednar, 2006; Rock et al., 2015). Dissertation findings from Study 1 and 2 advanced the understanding of the factors related to placement changes and highlighted outcomes from one particular resource parent intervention. Although the findings are promising, ongoing research is needed to further understand and prevent placement disruptions for young people in care. The evaluation of RPC by way of a quasi-experimental design was an important first step in informing additional evaluations of the program. It would be especially important for future research to gather the perspectives of youth themselves. Healing for young people with histories of developmental trauma can only occur within the context of consistent, stable, and nurturing relationships, so it is critical that resource parents be supported in their caregiving role.

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Table 1

Characteristics of Participants Included and Excluded from the Analyses

	Excluded			Included							
	%	*M*	*SD*	*%*	*M*	*SD*	df	$\chi 2$	*t*	ϕ	Cohen's d
Current age		14.64	.65		14.22	0.49	2983		5.14***		.19
Number of placement changes		4.89	.12		4.33	0.65	2824		-4.52***		.17
Age when first placed in care		7.55	4.90		7.51	5.04	2732		.20		
Sex											
Female	47			53			2983	2.08			
Placement type											
Residential	45			31			2983	168.79***		.24	
Child welfare involvement											
Physical/sexual abuse	19			22			2357	6.35**		.05	
Emotional harm	31			36			2983	9.12**		.06	
Abandonment/separation	28			24			2983	8.08**		.05	
Request for counselling	50			50			2983	1.63			
Neglect	34			66			2983	3.53			
Family based services	35			66			2983	.06			
Volunteer services	33			66			2983	.03			
Caregiver capacity	36			64			2983	1.02			
Request for assistance	38			62			2983	.12			
Request for youth services	42			58			2983	.35			

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 2

Youth Characteristics

	N	%	M	SD	Range
Ethnicity (N = 1,882)					
Black	73	3.9			
Indigenous, First Nations, Inuit, and Métis	98	5.2			
Asian (e.g., South Asian, East Asian, Southeast Asian)	25	1.3			
Latin	8	0.4			
White	1,481	78.7			
Current youth age (years; N = 1,882)			14.22	2.14	10-17
Age when first placed in care (years; N = 1,748)			7.43	4.59	0-17
Sex (N = 1,882)					
Male	1,026	54.5			
Female	856	45.5			
Type of placement (N=1,850)					
Foster home	1,262	68.3			
Group home	293	15.8			
Kinship care	200	10.8			
Independent living	24	1.3			
Customary care	21	1.1			
Other	31	2.8			
Reason for child welfare involvement (N = 1,882)[a]					
Caregiver capacity	918	48.8			
Emotional harm	680	36.1			
Neglect	542	28.8			
Abandonment	445	23.6			
Physical or sexual harm	422	22.4			
Other (e.g., request for services)	140	7.5			
Maltreatment total (N=1,776)			1.78	0.87	1-5
Number of changes in main caregiver since birth (N=1,812)			4.33	2.80	0-28
Number of years with current caregiver (N=1,532)			3.55	3.83	0-17
Permanency plan (N = 1,815)					
Remain in current placement	699	38.5			
Independent living	320	17.6			
Adoption	199	11.0			
Unspecified	198	10.9			
Planning for adult services	119	6.6			
Returning home	122	6.7			

Returning to kinship care	55	3.0
Changing status	43	2.4
Returning to customary care	25	1.4
Other	34	1.9

Note. M = mean; SD = standard deviation.
[a] More than one primary reason could be indicated

Table 3

Youth Mental Health Functioning (N = 1,882)

Measure	*M*	*SD*	Theoretical Range
Positive mental health	53.92	13.60	0-70
Developmental assets	28.42	7.51	0-40
External assets	14.33	3.29	0-20
Internal assets	14.09	4.90	0-20
Strengths and difficulties			
Conduct problems	2.53	2.44	0-10
Emotional problems	2.96	2.37	0-10
Hyperactivity/inattention	4.73	2.95	0-10
Peer problems	2.73	2.12	0-10
Prosocial behaviour	7.70	2.17	0-10

Note. M = mean; *SD* = standard deviation.

Table 4

Resource Parent Characteristics

	%	*M*	*SD*	Theoretical Range
Education (N = 1,717)				
Community college certificate	41.1			
High school diploma	23.0			
Bachelor degree	13.8			
Non-university certificate	7.2			
Trades certificate	4.5			
Less than high school diploma	4.1			
University certificate	3.4			
Masters or doctoral degree	2.9			
Completed training (N=1,882)[a]				
PRIDE pre-service	53.1			
Agency-specific training	46.4			
Foster caregiver training on parenting techniques	14.5			
Parenting practices (N = 1,882)				
Positive parenting		10.06	2.29	0-12
Inconsistent discipline		3.02	2.59	0-12
Poor supervision		2.06	2.43	0-12
Youth-reported relationship with caregiver (N = 1,882)		6.58	1.89	0-8
Youth-reported placement satisfaction (N = 1,882)		10.18	2.78	0-12

Note. M = mean; *SD* = standard deviation.

[a] More than one option could be selected

Table 5

Bivariate Correlations for the Continuous Independent Variables and the Dependent Variable

Variable		1	2	3	4	5	6	7	8	9	10	11	12	13	14	16	16
1.	Current age	-															
2.	Age when first placed in care	.22**	-														
3.	Maltreatment total	-.03	-.11**	-													
4.	Emotional problems	.01	.10**	.04	-												
5.	Conduct problems	-.09**	.02	.02	.37**	-											
6.	Hyperactivity/Inattention	-.15**	-.09**	.06*	.39**	.57**	-										
7.	Peer problems	.04	.07**	.03	.41**	.43**	.38**	-									
8.	Prosocial behaviour	-.01	-.05**	-.02	-.20**	-.51**	-.35	-.39**	-								
9.	Positive mental health	-.07**	-.14**	-.03	-.34**	-.26**	-.19**	-.33**	.30**	-							
10.	Internal assets	-.19**	-.13**	.01	-.28**	-.44**	-.38**	-.37**	.44**	.41**	-						
11.	External assets	-.28**	-.15**	.00	-.17**	-.24**	-.16**	-.25**	.30**	.36**	.68**	-					
12.	Inconsistent discipline	-.02	-.04	-.02	.07**	.13**	.08**	-.00	-.05*	-.03	.05	-.00	-				
13.	Poor supervision	.19**	.11**	-.04	.08**	.20**	.08**	.26	-.16**	-.21**	-.25**	-.23**	.32**	-			
14.	Positive parenting	-.11**	-.12**	.03	-.17**	-.21**	-.07**	-.15**	.25**	.42**	.25**	.31**	-.05*	-.23**	-		
15.	Relationship with caregiver	-.12	-.16**	.06**	-.19**	-.21**	-.07**	-.16**	.23**	.43**	.27**	.30**	-.04	-.25**	.58**	-	
16.	Placement satisfaction	-.10**	-.17**	.07**	-.25**	-.28**	-.14**	-.25**	.28**	.46**	.34**	.34**	-.09**	-.26**	.50**	.59**	-
17.	Number of placement changes	.09**	-.13**	.12**	.13**	.19**	.17**	.18**	-.11**	-.13**	-.23**	-.20**	.02	.09**	-.09**	-.11**	-.19**

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 6

Associations with the Number of Placement Changes (N = 1,624)

Variable	*B*	SE *B*	*Part correlation*	95% CI	*p*	Cohen's f^2	95% CI for Cohen's f^2	Tolerance	VIF
Model 4									
Block 1: Demographic Variables									
Placement type[a]	-1.14	.18***	-.15	[-1.46, -.77]	<.001			.76	1.32
Ethnicity									
Black[b]	-.15	.32	-.01	[-.78, .47]	.64			.95	1.06
Indigenous, First Nations, Inuit, and Métis[c]	-.34	.28	-.03	[-.88, .21]	.23			.95	1.05
Asian[d]	-.32	.60	-.01	[-1.49, .87]	.59			.97	1.03
Latin[e]	-.36	.89	-.01	[-2.12, 1.39]	.68			.98	1.02
Sex[f]	-.17	.13	-.03	[-.43, .09]	.21			.87	1.15
Age when first placed in care	-.11	.02***	-.17	[-.14, 1.08]	<.001	.03	[.01, .05]	.83	1.21
Youth current age	.10	.03**	.07	[.04, .17]	.002	<.001	[-.00, .00]	.79	1.30
Reason for admission									
Physical/sexual harm[g]	.19	.30	.01	[-.39, .78]	.54			.81	1.23
Neglect[h]	-.09	.27	-.01	[-.63, .44]	.77			.75	1.33
Emotional harm[i]	-.07	.20	-.01	[-.47, .33]	.72			.75	1.34
Caregiver capacity[j]	-.27	.16	-.04	[-.58, .03]	.08			.65	1.53
Maltreatment total	.34	.08***	.10	[.19, .49]	<.001	.01	[.00, .02]	.86	1.16
Block 2: Youth Variables									

	Internal assets	-.05	.02*	-.06	[-.10, -.01]	.01	<.001	[-.00, .00]	.39	2.56
	External assets	-.04	.03	-.03	[-.09, -.01]	.15			.47	2.15
	Emotional problems	.02	.03	.01	[-.04, .08]	.63			.67	1.50
	Peer problems	.10	.04**	.06	[.03, .16]	.01	<.001	[-.00, .00]	.66	1.51
	Prosocial behaviour	.09	.04*	.06	[.02, .16]	.02	<.001	[-.00, .00]	.62	1.61
	Hyperactivity/inattention	.02	.03	.02	[-.03, .08]	.42			.55	1.81
	Conduct problems	.08	.04*	.05	[.01, .16]	.01	<.001	[-.00, .00]	.49	2.02
	Positive mental health	.00	.01	.03	[-.00, .02]	.19			.59	1.69
Block 3: Resource Parent Variables										
	Placement satisfaction	-.11	.04***	-.07	[-.18, -.04]	.001	<.001	[-.00, .00]	.39	2.55
	Relationship with caregiver	.02	.05	.01	[-.08, .12]	.68			.44	2.29
	Positive parenting	-.06	.05	-.02	[-.16, .05]	.30			.47	2.13
	Poor supervision	.03	.04	.02	[-.05, .11]	.43			.76	1.33
	Inconsistent discipline	-.04	.04	-.03	[-.11, .03]	.26			.86	1.16
Block 4: Interactions										
	Relationship with caregiver x placement satisfaction	.00	.01	.00	[-.03, .03]	.59			.26	3.81
	Age when first placed x conduct problems	-.01	.01	-.04	[-.02, .00]	.14			.92	1.09
	Positive parenting x relationship with caregiver	-.02	.02	-.02	[-.06, .03]	.39			.24	4.12
	Positive parenting x placement satisfaction	-.02	.02	-.02	[-.05, .01]	.28			.25	3.97
	Conduct problems x relationship with caregiver	-.03	.01	-.04	[-.05, .00]	.08			.80	1.25
	Maltreatment total x conduct problems	.05	.03	.04	[-.01, .11]	.10			.97	1.04

Note. B = Unstandardized Estimate; SE = Standard Error. Cohen's f^2 is provided for statistically significant variables.
[a] 0 = residential placement, 1 = parent-model placement. [b] 0 = White, 1 = Black. [c] 0 = White, 1 = Indigenous, First Nations, Inuit, and Métis. [d] 0 = White, 1 = Asian. [e] 0 = White, 1 = Latin. [f] 0 = Female, 1 = Male. [g] 0 = other, 1 = physical/sexual assault. [h] 0 = other, 1 = neglect. [i] 0 = other, 1 = emotional harm. [j] 0 = other, 1 = caregiver capacity.
$^{*}p < .05$ $^{**}p < .01$ $^{***}p < .001$

Table 7

RPC Learning Objectives and Selected Outcome Measures

RPC Learning Objective	Outcome Measure
Increase knowledge and beliefs in trauma-informed parenting	Knowledge and Beliefs Survey
Increase resource parents' ability to tolerate challenging youth behaviours	Knowledge and Beliefs Survey Protective Factors Survey Strengths and Difficulties Questionnaire Parenting Stress Index-Short Form
Increase parenting self-efficacy	Parenting Stress Index-Short Form
Increase awareness and importance of self-care and connections with other resource parents	Protective Factors Survey

Table 8

Demographic Characteristics of Resource Parents

	All Participants (N = 43)			Experimental (N = 22)		Waitlist Control (N = 21)		*t*-test	Chi-squared	*p*
Youth										
Non-Birth Children in the Home, *M, SD, range*	2.2	1.21	1-6	2.33	1.39	1.90	0.97	-1.15		.13
Gender[a] *n, valid %*									1.83	.18
Male	32	36.0		14	29.17	18	43.90			
Female	57	64.0		34	70.83	23	56.10			
Placement type *n, valid %*									4.76	.09
Foster	54	62.1		30	61.22	24	63.16			
Adoptive	19	21.8		14	28.57	5	13.16			
Other[b]	14	16.1		5	10.20	9	23.68			
Resource Parent										
Age, *M, SD*	46.9	11.73		45.81	11.04	47.95	12.61	.59		.28
Months as resource parent, *M, SD*	118.66	114.72		96.52	101.44	141.90	125.57	1.28		.11
Number of children (past year) no longer in their care, *M, SD*	.77	1.15		.82	1.01	.71	1.31	-.29		.39
Number of placement breakdowns due to behaviour (past year)	.20	.46		.18	.39	.22	.55	.27		.39
Gender *n, valid %*									4.42	.11
Female	38	90.5		17	80.95	21	100			
Male	3	7.1		3	14.29	0	0			
Did not disclose	1	2.4		1	4.76	0	0			
Racial Background *n, valid %*									4.11	.25
White	38	90.5		20	95.23	18	85.71			

Black	2	4.8	0	0	2	9.52		
Biracial/multiracial	1	2.4	1	4.76	0	0		
Did not disclose	1	2.4	0	0	1	4.76		
Marital Status *n, valid %*							3.71	.59
Married	27	62.8	15	68.18	12	57.14		
Common law	5	11.6	3	13.64	2	9.52		
Single	5	11.6	2	9.10	3	14.29		
Divorced	4	9.3	1	4.54	3	14.29		
Separated	1	2.3	0	0	1	4.76		
Widowed	1	2.3	1	4.54	0	0		
Educational Background *n, valid %*							4.85	.68
Community college	20	46.5	12	54.54	8	38.09		
Bachelor/undergraduate degree	10	23.3	4	18.18	6	28.57		
High school	4	9.3	1	4.55	0	0		
Trade, technical, or business college	3	7.0	1	4.55	2	9.52		
Some college/university but no degree	3	7.0	1	4.55	2	9.52		
Elementary school	1	2.3	1	4.55	0	0		
Master's degree	1	2.3	0	0	1	4.76		
Doctoral degree	1	2.3	1	4.55	0	0		
Main Activity *n, valid %*							5.57	.47
Caring for family	17	39.5	7	31.81	10	47.62		
Caring for family and working for profit	17	39.5	8	36.36	9	42.86		
Working for pay/profit	3	7.0	3	13.64	0	0		
Going to school	2	4.7	1	4.55	1	4.76		
Retired	2	4.7	1	4.55	1	4.76		
Recovering from illness/disability	1	2.3	0	0	1	4.76		

Unspecified	1	2.3	1	4.55	0	0		
Work *n, valid %*								
Full time	14	73.7						
Part time	5							
Income *n, valid %*							10.98	.69
$20,000 - $29,999	1	2.3	0	0	1	4.55		
$30,000 - $39, 999	3	7.0	1	4.76	2	9.10		
$40,000 - $49, 999	3	7.0	1	4.76	2	9.10		
$50,000 - $59, 999	3	7.0	1	4.76	2	9.10		
$60,000 - $69, 999	6	14.0	5	23.81	1	4.55		
$70,000 - $79,999	2	4.7	1	4.76	1	4.55		
$80,000 - $89,999	1	2.3	0	0	1	4.55		
$90,000 - $99,999	4	9.3	2	9.52	2	9.10		
$100,000 - $109,999	4	9.3	2	9.52	2	9.10		
$110,000 - $119,999	1	2.3	0	0	1	4.55		
$120,000 - $129,999	1	2.3	1	4.76	0	0		
$130,000 - $139,999	1	2.3	1	4.76	0	0		
$140,000 - $149,999	3	7.0	1	4.76	2	9.10		
Over $150,000	2	4.7	2	9.52	0	0		
Did not disclose	8	18.6	4	19.05	4	19.05		
Caregiver Type *n, valid %*								
Foster	30	69.7	17		13		1.20	.27
Adoptive	14	32.6	10		4		3.41	.07
Therapeutic	12	27.9	6		6		.01	.92
Kinship	4	9.3	0		4		4.62	.03
Future adoptive parents	3	6.9	2		1		.31	.58
Group home provider	2	4.7	1		1		.00	.97
Training *n, valid %*								
PRIDE	34	79.1						

[a] The specific details regarding this item are not known because resource parents were not provided the option to elaborate

[b] While resource parents were provided with a third option to specify in their own words, there were no resource parents who endorsed this

Table 9

Internal Consistency Estimates for the Knowledge and Beliefs Survey, Protective Factors Survey, and Parenting Stress Index-Short Form

		Baseline		Post-Program		2-Month Follow-Up
	n	Cronbach α	n	Cronbach α	n	Cronbach α
Knowledge and Beliefs Survey	43	.94	43	.94	43	.94
Trauma-informed parenting		.93		.90		.93
Tolerance of challenging behaviours		.89		.92		.83
Parenting self-efficacy		.90		.88		.94
Protective Factors Survey	43		43		43	
Family functioning/resilience		.69		.71		.74
Nurturing/attachment		.75		.47		.72
Social supports		.73		.79		.66
Concrete supports		.57		.70		.48
Parenting Stress Index- Short Form	24		24		24	
Parental distress		.88		.86		.93
Resource parent- youth difficult interactions		.85		.88		.91
Youth functioning difficulties		.86		.84		.89
Total stress		.94		.94		.96

Table 10

Internal Consistency for Strengths and Difficulties Questionnaire

	Baseline		Post-Program		2- Month Follow-Up	
	2-3 years (n = 5)	4-17 years (n = 36)	2-3 years (n = 5)	4-17 years (n = 31)	2-3 years (n = 5)	4-17 years (n = 29)
Emotional Problems	.65	.81	.68	.81	.78	.82
Conduct Problems	.79	.82	.86	.79	.80	.82
Hyperactivity/Impulsivity	.60	.81	.90	.87	.47	.79
Peer Problems	.46	.73	.72	.58	.66	.54
Prosocial Behaviour	.89	.85	.77	.72	.91	.80
Total Socio-Emotional Difficulties	.66	.90	.75	.90	.81	.88

Note: Internal consistency was not computed for the 18 and older questionnaire because only one resource parent completed this questionnaire.

Table 11

Resource Parent Curriculum Module Evaluations

Module	Presentation of Material				Activities			
	n	Negative[a]	Neutral[b]	Positive[c]	n	Negative[a]	Neutral[b]	Positive[c]
1: Introduction	46	12.3%	13.7%	74%	31	2%	4.2%	87.9%
2: Trauma 101	36	12.8%	10.1%	77.1%	37	3.2%	17.8%	69%
3: Understanding Trauma's Effects	42	11.9%	11%	77.1%	41	0.5%	7.2%	92.3%
4: Building a Safe Place	29	15.7%	11.7%	72.6%	30	2.8%	11.3%	85.9%
5: Dealing with Feelings and Behaviours	38	11.3%	8.8%	79.9%	36	2.2%	7.9%	89.9%
6: Connections and Healing	41	14.7%	6.45%	78.3%	43	1.4%	11.4%	87.2%
7: Becoming an Advocate	28	12.2%	12.2%	75.6%	27	1.7%	26.3%	72%
8: Taking Care of Yourself	32	12.7%	6.7%	80.6%	32	0%	6.8%	93.2%

[a]Reflects a rating of 1 or 2; [b]Reflects a rating of 3; [c]Reflects a rating of 4 or 5

Table 12

RPC Post-Program Satisfaction

Training Component	Item	N	Negative[a]	Neutral[b]	Positive[c]
Reactions to Training	Slides clear and easy to follow	35	0%	2.9%	97.1%
Content and Delivery	Would recommend this training to other resource parents	35	0%	0%	100%
	Need more training to really understand this information	35	20%	42.9%	37.2%
	Less likely to request a future placement change	35	0%	37.1%	62.9%
	Better able to meet my child's needs	35	0%	2.9%	97.1%
Teaching Strategies	My child worksheet	34	2.9%	5.9%	91.2%
	Case examples	35	2.9%	5.7%	91.4%
	Large and small group discussions	35	0%	14.3%	85.7%
	Information from slides and presenters	35	0%	0%	100%
	Information from the co-facilitator	35	0%	0%	100%
	Group activities	35	0%	25.7%	74.3%

[a]Reflects a rating of 1 or 2; [b]Reflects a rating of 3; [c]Reflects a rating of 4 or 5

Table 13

Descriptive Statistics for Outcome Variables

	Theoretical range	Baseline		Post-Program		2-Month Follow-Up	
		Experimental	Waitlist Control	Experimental	Waitlist Control	Experimental	Waitlist Control
		(M, SD), n	(M, SD), n	(M, SD), n	(M, SD), n	(M, SD). n	(M, SD), n
Resource Parents' Learning							
Trauma-Informed Parenting	1-6	4.69 (.58), 22	4.51 (.79), 21	5.17 (.40), 22	4.73 (.54), 21	5.09 (.62), 22	4.64 (.63), 21
Tolerance of Challenging Behaviours	1-6	4.30 (.92), 22	3.99 (.98), 21	4.63 (.75), 22	3.94 (1.33), 21	4.56 (.79), 22	4.13 (.94), 21
Parenting Self Efficacy	1-6	4.86 (.61), 22	4.66 (.97), 21	5.17 (.51), 22	4.71 (.73), 21	5.24 (.52), 22	4.71 (.60), 21
Resource Parents' Behaviour							
Primary Outcomes							
Attachment	1-5	2.71 (.68), 22	2.49 (.68), 21	2.64 (.58), 22	2.60 (.57), 21	2.80 (.57), 22	2.43 (.76), 21
Social Supports	1-5	3.04 (.68), 22	3.06 (.62), 21	3.31 (.59), 22	3.18 (.87), 21	3.27 (.58), 22	2.94 (.61), 21
Concrete Supports	1-5	3.80 (.37), 22	3.80 (.28), 21	3.77 (.39), 22	3.58 (.62), 21	3.83 (.29), 22	3.70 (.44), 21
Resource Parent-Youth Difficult Interactions	12-60	28.60 (8.37), 10	31.80 (10.22), 10	26.10 (8.11), 10	31.90 (10.42), 10	23.30 (9.43), 10	29.40 (9.06), 10 7
Percentile Rank[a]		76th	82nd	66th	82nd	54th	62nd
Secondary Outcomes							
Family Functioning	1-5	3.03 (.54), 22	3.01 (.58), 21	3.41 (.54), 22	3.08 (.56), 21	3.42 (.50), 22	3.10 (.52), 21

Parental Distress	12-60	23.75 (6.92), 10	29.90 (9.83), 10	21.70 (5.85), 10	29.52 (9.07), 10	20.30 (6.78), 10	28.60 (8.83), 10
Percentile Rank[a]		24th	64th	32nd	64th	26th	64th
Youth Functioning Difficulties	12-60	31.10 (10.20), 10	32.40 (9.76), 10	27.50 (7.55), 10	32.40 (10.29), 10	27.12 (8.93), 10	32.75 (11.46), 10
Percentile Rank[a]		68th	70th	58th	70th	56th	70th
Conduct Problems	0-10	3.77 (3.15), 21	4.53 (2.80), 16	4.14 (2.87), 21	4.63 (2.75), 16	3.76 (2.69), 21	3.88 (2.92), 16
Emotional Problems	0-10	3.19 (2.66), 21	4.18 (2.88), 16	3.52 (3.09), 21	4.44 (2.48), 16	2.76 (2.57), 21	4.13 (2.90), 16
Peer Problems	0-10	3.90 (2.55), 21	3.46 (2.48), 16	3.86 (2.29), 21	3.63 (2.42), 16	3.71 (2.35), 21	3.44 (2.31), 16
Hyperactivity/Inattention	0-10	6.19 (2.58), 21	6.72 (3.03), 16	6.19 (2.80), 21	6.75 (3.17), 16	5.62 (2.54), 21	6.19 (2.54), 16
Prosocial Behaviour	0-10	6.09 (3.28), 21	6.57 (2.80), 16	6.57 (2.79), 21	6.50 (1.75), 16	6.05 (2.91), 21	6.00 (2.34)

[a] 16th – 84th percentiles = Normal range; 85th – 89th percentiles = High range; 90th percentile or higher = Clinically Significant range. Normative data were collected from a sample of 534 mothers and 522 fathers stratified to match U.S 2007 Census.

Table 14

Results for RPC's Impact on Resource Parents' Learning and Behaviour

	n						
	Waitlist control	Experi-mental	F	*p*	η^2	95% CI for η^2	Observed Power
Resource Parents' Learning							
Trauma-Informed Parenting	21	22					
Time			15.09	<.001	.27	[.06, .45]	.99
Time x Group interaction			3.77	.03	.09	[.00, .26]	.67
Tolerance of Challenging Behaviours	21	22					
Time			.51	.60	.01	[.00, .14]	.13
Time x Group interaction			2.30	.11	.05	[.00, .22]	.45
Parenting Self-Efficacy	21	22					
Time			1.82	.17	.04	[.00, .20]	.35
Time x Group interaction			1.71	.19	.04	[.00, .19]	.34
Resource Parents' Behaviour							
Primary Outcomes							
Attachment	21	22					
Time			.06	.94	.00	[.00, .06]	.06
Time x Group interaction			1.76	.18	.04	[.00, .19]	.36
Social supports	21	22					
Time			1.20	.31	.03	[.00, .18]	.26
Time x Group interaction			1.13	.33	.03	[.00, .17]	.24
Concrete supports	21	22					
Time			3.67	.04	.08	[.00, .26]	.62
Time x Group interaction			2.10	.14	.05	[.00, .21]	.39
Resource parent-youth difficult interactions	10	10					
Time			4.33	.02	.20	[.00, .27]	.71
Time x Group interaction			.79	.46	.04	[.00, .16]	.17
Secondary Outcomes							
Family Functioning	21	22					

Time			4.16	.02	.09	[.00, .27]	.72
Time x Group interaction			2.03	.14	.05	[.00, .21]	.41
Parental distress	10	10					
Time			2.80	.08	.14	[.00, .23]	.51
Time x Group interaction			1.43	.25	.08	[.00, .19]	.28
Youth functioning difficulties	10	10					
Time			1.80	.18	.10	[.00, .20]	.35
Time x Group interaction			.28	.76	.02	[.00, .12]	.09
Conduct problems	16	21					
Time			.69	.51	.02	[.00, .15]	.16
Time x Group interaction			.34	.71	.01	[.00, .13]	.10
Emotional problems	16	21					
Time			1.68	.20	.05	[.00, .20]	.30
Time x Group interaction			.31	.68	.01	[.00, .12]	.09
Hyperactivity/Inattention	16	21					
Time			1.85	.17	.05	[.00, .20]	.37
Time x Group interaction			.10	.90	.00	[.00, .08]	.07
Peer problems	16	21					
Time			.84	.43	.03	[.00, .16]	.19
Time x Group interaction			.57	.57	.02	[.00, .14]	.14
Prosocial behaviour	16	21					
Time			.54	.56	.02	[.00, .14]	.13
Time x Group interaction			.26	.73	.01	[.00, .12]	.09

Note: η^2, values between .01 and .05 represent a small effect, values between .06 and .13 represent a medium effect, and values larger than .14 represent a large effect.

Table 15

Summary of Outcomes for Resource Parent Learning and Behaviour

Outcome	Hypothesis Supported?	Effect Size
Resource Parents' Learning		
Trauma-Informed Parenting	Yes	Medium
Tolerance of Challenging Behaviour	Potential effect	Small
Parenting Self-Efficacy	Potential effect	Small
Resource Parents' Behaviour		
Primary Outcomes		
Attachment	Potential effect	Small
Social Supports	Potential effect	Small
Concrete Supports	No	
Resource Parent-Youth Difficult Interactions	No	
Secondary Outcomes		
Family Functioning	Potential effect	Small
Parental Distress	Potential effect	Medium
Youth Functioning Difficulties	No	
Conduct Problems	No	
Emotional Problems	No	
Hyperactivity/Impulsivity	No	
Peer Problems	No	
Prosocial Behaviour	No	

Figure 1

Flow Chart of the Study's Progress, Including Recruitment, Participation, and Attrition

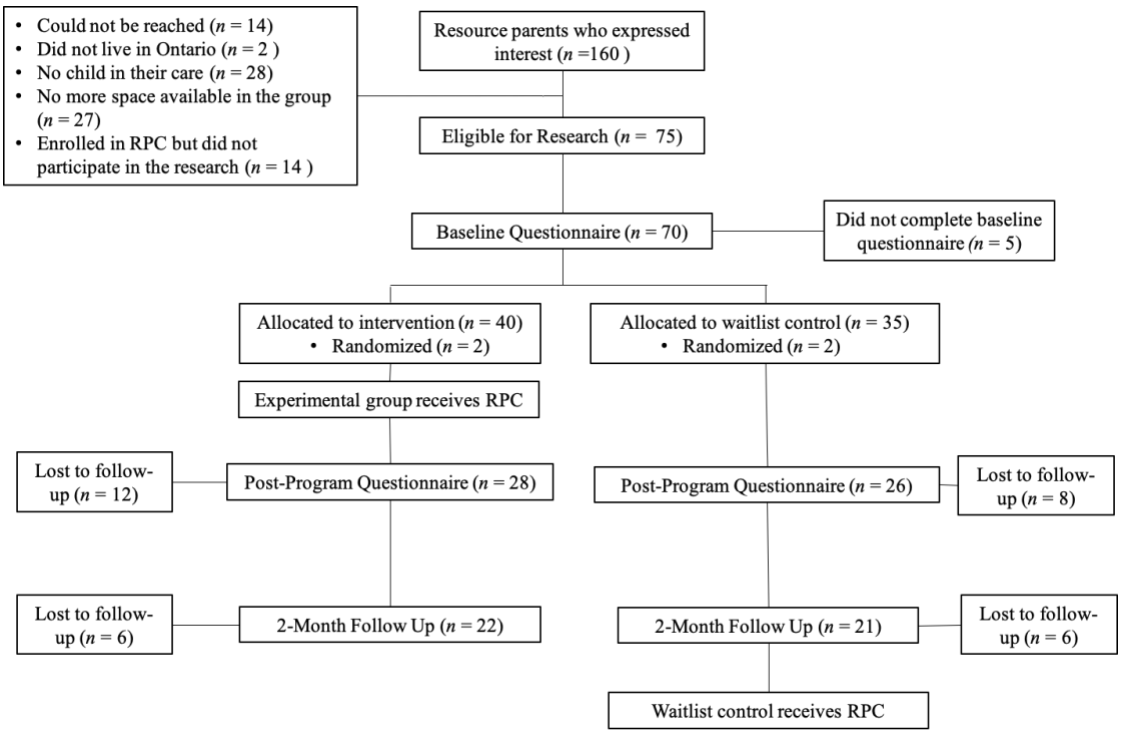
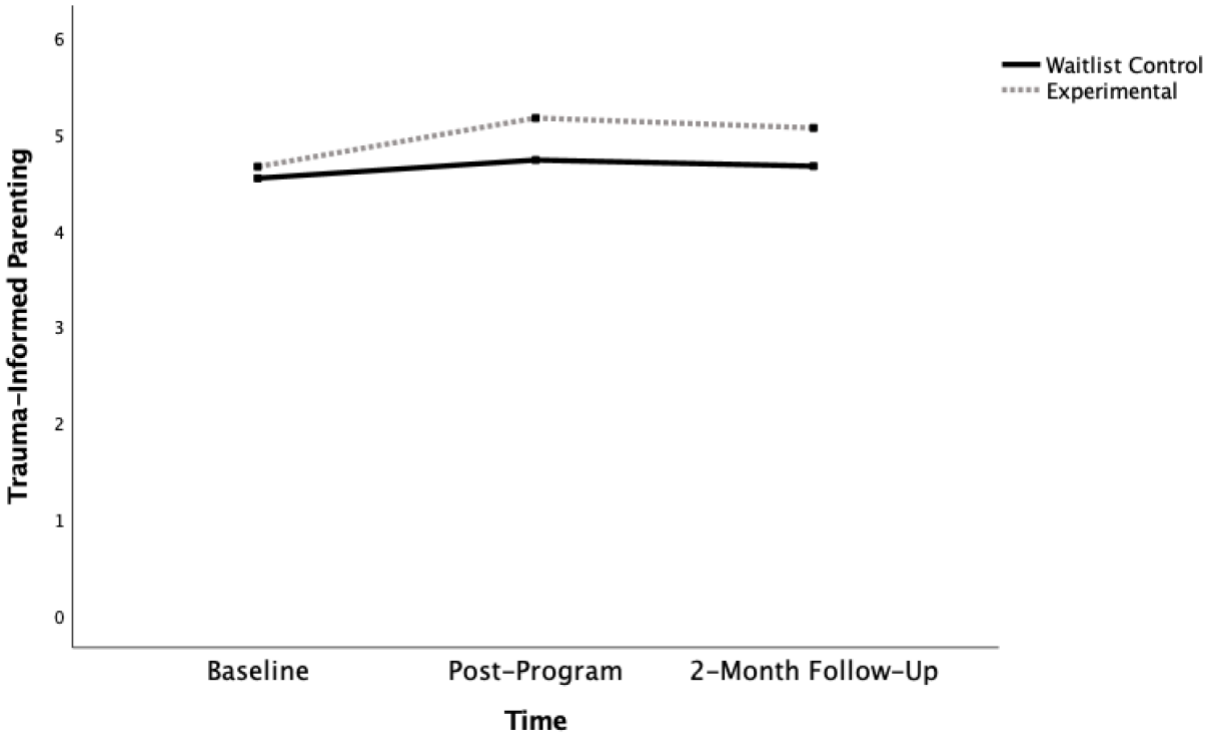


Figure 2

Knowledge and Beliefs in Trauma-Informed Parenting Across Baseline, Post-Program, and 2-Month Follow-Up



Appendix A
Logic Model (Study 2)

Resource Parent Curriculum for Ontario Resource Parents	
Needs	• As a result of their histories of developmental trauma and child welfare involvement, youth in care often have complex needs and require a high degree of support • Many resource parents feel unprepared caring for their youth and report a need for training and support • There is no systematic in-service trauma-informed program for resource parents that has been systematically evaluated for its effectiveness
Targets	• Resource parents in Ontario (i.e., foster, adoptive, kinship caregivers, group home providers)
Activities	• Deliver the Resource Parent Curriculum to resource parents in Ontario in an online format[a] • Program evaluation activities
Outputs	• Program curriculum and materials (e.g., facilitator manual, participant manual)

Outcomes	Short-Term:
	• Increased knowledge and beliefs in trauma-informed parenting
	  ○ Trauma-Informed Parenting
	  ○ Tolerance of Challenging Behaviours
	  ○ Parenting Self-Efficacy
	Long-Term:
	• Improved family functioning, attachment, social, and concrete supports
	• Reduced parenting stress
	• Improved youth socio-emotional difficulties
	• Reduced placement disruption

[a] The program was delivered in an online format using Zoom due to the impact of COVID-19 public health measures.

Appendix B

Ethics Approval (Study 1)

09/02/2018

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-02-18-338
Titre du projet / Project Title	Assessing the Parenting Needs of Foster Caregivers in Ontario
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	09/02/2018
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	08/02/2019

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Lauren STENASON	École de psychologie / School of Psychology	Chercheur Principal / Principal Investigator
Elisa ROMANO	École de psychologie / School of Psychology	Superviseur / Supervisor
Robert John FLYNN		Collaborateur / Collaborator

Conditions spéciales ou commentaires / Special conditions or comments

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Appendix C

RPC Learning Objectives (Grillo et al., 2010)

Week	Topic and Learning Objectives
1	**Introductions** Describe the concept of trauma-informed parenting and its benefits Review the essential elements of trauma-informed parenting and myths to avoid
2	**Trauma 101** Define child trauma and describe how children may respond to traumatic events Define resilience and describe how you can promote resilience in your children
3	**Understanding Trauma's Effects** Describe the ways in which trauma can interfere with children's development and functioning Describe how children of different ages may respond to trauma Describe the "invisible suitcase" and how trauma-informed parenting can "repack" the suitcase
4	**Building a Safe Space** Describe key components of a safety message and how to deliver an effective safety message to children who have experienced trauma Define trauma reminders and give an example of a trauma reminder and reaction List at least three ways you can help children to cope with trauma reminders
5	**Dealing with Feelings and Behaviours** Describe the cognitive triangle and apply it to a child who has experienced trauma Identify at least three reasons why children who have experienced trauma may act out Describe at least three ways you can help children develop new emotional skills and positive behaviours
6	**Connections and Healing** Identify at least three important connections in your child's life and ways in which you can support and maintain these connections Describe how trauma can affect children's view of themselves and their future List at least three ways in which you can help your child feel safe when talking about trauma
7	**Becoming an Advocate** List at least three of the basic elements of trauma-informed advocacy List at least four indicators that a child may need the support of trauma-informed therapists Describe specific actions you can take with an actual member of your child's team
8	**Taking Care of Yourself** Define and list the warning signs of compassion fatigue and secondary traumatic stress Identify specific self-care techniques that can help prevent compassion fatigue and secondary traumatic stress Describe at least three coping strategies you can use when a child's trauma is a reminder of your own past trauma

Appendix D

Background and Training Information

(Only Prior to the Training)
Please answer the following questions by clicking or entering the answer that seems most appropriate for you.

1. What is your gender:
   - ☐ Male
   - ☐ Female
   - ☐ You don't have an option that applies to me. I identify as: _____
2. What is your date of birth (DD/MM/YYYY)? ____/____/_____
3. Race/Ethnicity
   - ☐ Caucasian
   - ☐ Black
   - ☐ Indigenous
   - ☐ East Asian (e.g., Chinese, Japanese, Korean)
   - ☐ South Asian (e.g., Indian, Pakistani, Sri Lankan)
   - ☐ Middle Eastern (e.g., Egyptian, Iranian, Afghan)
   - ☐ Latin
   - ☐ Other (Describe:_____)
4. Please check all that apply. I am a...
   - ☐ Foster parent
   - ☐ Therapeutic/treatment foster parent
   - ☐ Adoptive parent
   - ☐ Foster care caseworker/licensing/trainer
   - ☐ Kinship caregiver (caring for grandchild, niece/nephew, or other relative/friend)
   - ☐ Future adoptive parent
   - ☐ Pre-licensed foster parent (child not yet placed in home)
   - ☐ Other, specify:
5. Please tell us more about the **non-birth children** in your care currently, excluding respite:

Age	Gender	Placement Status	If placement is foster or other, are you planning to adopt?	Is this child kinship (grandchild, niece/nephew, etc)?
	☐Male ☐Female	☐Adoptive ☐Foster ☐Other	☐Yes ☐No	☐Yes ☐No
	☐Male ☐Female	☐Adoptive ☐Foster ☐Other	☐Yes ☐No	☐Yes ☐No
	☐Male ☐Female	☐Adoptive ☐Foster ☐Other	☐Yes ☐No	☐Yes ☐No
	☐Male ☐Female	☐Adoptive ☐Foster ☐Other	☐Yes ☐No	☐Yes ☐No
	☐Male ☐Female	☐Adoptive ☐Foster ☐Other	☐Yes ☐No	☐Yes ☐No
	☐Male ☐Female	☐Adoptive ☐Foster ☐Other	☐Yes ☐No	☐Yes ☐No

6. How many non-birth children have previously been in your home over the past year and are no longer in your care: _____________ (total number)
7. How many years in total have you been providing foster care services? ______________ (total number years)
8. What language(s) are spoken most often in the home?
   - ☐ English
   - ☐ French
   - ☐ First Nations or Inuit language
   - ☐ Other (specify:__________)
9. What is your <u>current</u> marital status?
   - ☐ Married
   - ☐ Common-law/ Living with a partner
   - ☐ Single (never married)
   - ☐ Partnered, not married
   - ☐ Widowed
   - ☐ Separated
   - ☐ Divorced
10. What is the highest level of education that you have completed?
   - ☐ Grade school
   - ☐ High school
   - ☐ Trade, technical or vocational school, or business college
   - ☐ Community college, CEGEP, or nursing school

- ☐ Bachelor or undergraduate degree, or teacher's college (e.g. B.A., B.Sc., Ll.B.)
- ☐ Some college or university, but no degree
- ☐ Master's degree (e.g. M.A., M.Sc., M.Ed.)
- ☐ Degree in medicine, dentistry, veterinary medicine, or optometry (e.g., M.D., D.D.S., D.M.D., D.V.M., O.D.)
- ☐ Doctorate degree (e.g. Ph.D., D.Sc., D.Ed.)
- ☐ Other (please specify) _____

11. What do you consider to be your current main activity?
    - ☐ Caring for family
    - ☐ Working for pay or profit
    - ☐ Caring for family and working for pay or profit
    - ☐ Going to school
    - ☐ Recovering from illness/ on disability
    - ☐ Looking for work
    - ☐ Retired
    - ☐ Other (please specify) _____

12. If you are working for pay or profit, is this on a full-time or part-time basis?
    - ☐ Full-time basis
    - ☐ Part-time basis

13. In which of the following groups does your total household income fall (prior to income tax)?
    - ☐ Less than $10,000
    - ☐ $10,000 - $19,999
    - ☐ $20,000 - $29,999
    - ☐ $30,000 - $39,999
    - ☐ $40,000 - $49,999
    - ☐ $50,000 - $59,999
    - ☐ $60,000 - $69,999
    - ☐ $70,000 - $79,999
    - ☐ $80,000 - $89,999
    - ☐ $90,000 - $99,999
    - ☐ $100,000 - $109,999

- ☐ $110,000 - $119,999
- ☐ 120,000 - $129,999
- ☐ $130,000 - $139,999
- ☐ $140,000 - $149,999
- ☐ Over $150,000

14. Have you attended PRIDE pre-service training (Parent Resource for Information, Development, and Education)
    - ☐ Yes (specify the year:_____)
    - ☐ No

15. Please list below additional training received (e.g., provided by the agency, or outside the agency)

Appendix E

Module 1 Evaluation

NCTSN The National Child Traumatic Stress Network

center for CHILD & FAMILY HEALTH

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents
Module 1

The following questions are about **today's modules.**

Presentation of Material					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Today's training was interesting and engaging.	1	2	3	4	5
2. There was a good balance of presentations, discussion, and activities.	1	2	3	4	5
3. I already knew a lot of what was covered today.	1	2	3	4	5
4. The presenters/trainers were clear and effective.	1	2	3	4	5
5. The family partner cofacilitator provided insight that helped me better understand today's material.	1	2	3	4	5
Activities					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
6. It was helpful to get an overview of the case examples that will be used throughout the workshop.	1	2	3	4	5
7. It was helpful to get an overview of the main goals for the entire workshop ("Essential Elements of Trauma-Informed Parenting").	1	2	3	4	5
8. Square Breathing will be useful for me.	1	2	3	4	5
9. Please provide any other feedback about today's training:					

Appendix F

Module 2 Evaluation

NCTSN The National Child Traumatic Stress Network

center for CHILD & FAMILY HEALTH

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents

Module 2

The following questions are about **today's module.**

Presentation of Material					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Today's training was interesting and engaging.	1	2	3	4	5
2. There was a good balance of presentations, discussion, and activities.	1	2	3	4	5
3. I already knew a lot of what was covered today.	1	2	3	4	5
4. The facilitators were clear and effective.	1	2	3	4	5
5. The family partner cofacilitator provided insight that helped me better understand today's material.	1	2	3	4	5
Activities					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
6. I am more knowledgeable about the different types of trauma exposure (acute, chronic, neglect, and complex).	1	2	3	4	5
7. I am more knowledgeable about how traumatic stress reactions (hyperarousal, reexperiencing, and avoidance) can affect children's behavior.	1	2	3	4	5

8. I am more knowledgeable about recognizing strengths in children.	1	2	3	4	5
9. The case examples of Maya and/or Javier helped me to understand how trauma can affect children's behavior.	1	2	3	4	5
10. The "My Child" worksheet helped me to identify my child's behaviors that may be trauma reactions.	1	2	3	4	5
11. Please provide any other feedback about today's training:					

Appendix G

Module 3 Evaluation

NCTSN The National Child Traumatic Stress Network

center for CHILD & FAMILY HEALTH

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents

Module 3

The following questions are about **today's module**.

Presentation of Material					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Today's training was interesting and engaging.	1	2	3	4	5
2. There was a good balance of presentations, discussion, and activities.	1	2	3	4	5
3. I already knew a lot of what was covered today.	1	2	3	4	5
4. The facilitators were clear and effective.	1	2	3	4	5
5. The family partner cofacilitator provided insight that helped me better understand today's material.	1	2	3	4	5
Activities					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
6. I have a better understanding of how our brains respond to danger as a result of discussing the examples of snakes and sticks.	1	2	3	4	5
7. I have a better understanding of how trauma can impact child development and behavior.	1	2	3	4	5
8. I have a better understanding of what trauma-informed parents can	1	2	3	4	5

do to develop their children's brains in more positive ways.					
9. It was useful to learn that the beliefs in a child's invisible suitcase can impact the child's behavior.	1	2	3	4	5
10. It was helpful to use the "My Child Worksheet" to think about what I can do to repack my child's invisible suitcase with more positive beliefs.	1	2	3	4	5
11. Please provide any other feedback about today's training:					

Appendix H

Module 4 Evaluation

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents
Module 4

The following questions are about **today's module**.

Presentation of Material					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Today's training was interesting and engaging.	1	2	3	4	5
2. There was a good balance of presentations, discussion, and activities.	1	2	3	4	5
3. I already knew a lot of what was covered today.	1	2	3	4	5
4. The facilitators were clear and effective.	1	2	3	4	5
5. The family partner cofacilitator provided insight that helped me to better understand today's material.	1	2	3	4	5
Activities					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
6. It was useful to consider what *I needed* to feel safe after a time I felt endangered.	1	2	3	4	5
7. I have a better understanding that children may have different safety needs and have a harder time feeling safe than I do.	1	2	3	4	5
8. I have a better understanding of how I can handle emotional outbursts in a calm yet firm way.	1	2	3	4	5
9. I have a better understanding of what to do to make my child feel safer regarding bedtime, mealtimes, and physical boundaries.	1	2	3	4	5
10. I have a better understanding of how some of my child's behaviors may actually be due to trauma reminders.	1	2	3	4	5

11. The Stress Buster or SOS technique will be useful to use with my child.	1	2	3	4	5
12. I have a better understanding about what *to do* and what *not to do* when my child is experiencing a trauma reminder.	1	2	3	4	5
13. Please provide any other feedback about today's training:					

Appendix I

Module 5 Evaluation

NCTSN The National Child Traumatic Stress Network

center for CHILD & FAMILY HEALTH

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents

Module 5

The following questions are about **today's module**.

Presentation of Material					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Today's training was interesting and engaging.	1	2	3	4	5
2. There was a good balance of presentations, discussion, and activities.	1	2	3	4	5
3. I already knew a lot of what was covered today.	1	2	3	4	5
4. The facilitators were clear and effective.	1	2	3	4	5
5. The family partner cofacilitator provided insight that helped me better understand today's material.	1	2	3	4	5
Activities					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
6. I have a better understanding of how thoughts, feelings, and behaviors impact each other (ie. cognitive triangle) because of…					
▪ first discussing a personal example (walking into a PTA meeting).	1	2	3	4	5
▪ applying it to the case example (A. M.).	1	2	3	4	5
▪ applying it to my own child using the "My Child Worksheet".	1	2	3	4	5
7. The feelings identification game will be helpful to use with my child.	1	2	3	4	5
8. I have a better appreciation that I need to avoid repeating the negative reactions my child has received from past caregivers for their behavior.	1	2	3	4	5
9. The M&M activity helped me see how well I balance the number of positive experiences with the number of commands and consequences I give to my child.	1	2	3	4	5

10. I considered new ways to increase the number of positive interactions with my child.	1	2	3	4	5
11. Please provide any other feedback about today's training:					

Appendix J

Module 6 Evaluation

Sullivan, K., Murray, K., Kane, N., and Ake, G. (2013)

Center for Child & Family Health, NC
411 West Chapel Hill Street, Suite 908, Durham, NC 27710

NCTSN The National Child Traumatic Stress Network

center for CHILD & FAMILY HEALTH

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents
Module 6

The following questions are about **today's module**.

Presentation of Material					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Today's training was interesting and engaging.	1	2	3	4	5
2. There was a good balance of presentations, discussion, and activities.	1	2	3	4	5
3. I already knew a lot of what was covered today.	1	2	3	4	5
4. The facilitators were clear and effective.	1	2	3	4	5
5. The family partner cofacilitator provided insight that helped me better understand today's material.	1	2	3	4	5
Activities					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
6. The connection card activity helped me better understand how it feels for a child to lose their important connections.	1	2	3	4	5
7. You took on the role of one member of the family in the "A Family Tale" exercise: ▪ This exercise helped me see the behavior of my child, their siblings, and their parents in a whole new light.	1	2	3	4	5
▪ This exercise helped me see how I could help my child cope with disappointing family interactions.	1	2	3	4	5

8. It was helpful to use the “My Child Worksheet” to consider how to enhance the positive connections in my child’s life.	1	2	3	4	5
9. I have a new appreciation for the important role I can serve when my child brings up memories of trauma.	1	2	3	4	5
10. Please provide any other feedback about today's training:					

Appendix K

Module 7 Evaluation

NCTSN The National Child Traumatic Stress Network

center for CHILD & FAMILY HEALTH

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents
Module 7

The following questions are about **today's module**.

Presentation of Material					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Today's training was interesting and engaging.	1	2	3	4	5
2. There was a good balance of presentations, discussion, and activities.	1	2	3	4	5
3. I already knew a lot of what was covered today.	1	2	3	4	5
4. The facilitators were clear and effective.	1	2	3	4	5
5. The family partner cofacilitator provided insight that helped me better understand today's material.	1	2	3	4	5
Activities					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
6. I have a new appreciation that I have an important role in explaining the child welfare system to my child.	1	2	3	4	5
7. I am better prepared to advocate for my child with other professionals (educators, caseworkers, judges, etc.) about what child traumatic stress is, how trauma has affected my child, my child's strengths, and what my child needs to feel psychologically safe.	1	2	3	4	5
8. I am more familiar now with the signs I need to look for about whether my child needs therapy.	1	2	3	4	5
9. I have a better understanding about how to advocate for my child's needs with a therapist	1	2	3	4	5

and with professionals who prescribe medications for my child's behavior.					
10. You had the opportunity to practice talking with a professional about your child's needs:					
▪ I found this type of activity helpful.	1	2	3	4	5
▪ I thought this was too much practice.	1	2	3	4	5
11. Please provide any other feedback about today's training:					

Appendix L

Module 8 Evaluation

NCTSN The National Child Traumatic Stress Network

center for CHILD & FAMILY HEALTH

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents

Module 8

The following questions are about **today's module**.

Presentation of Material					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Today's training was interesting and engaging.	1	2	3	4	5
2. There was a good balance of presentations, discussion, and activities.	1	2	3	4	5
3. I already knew a lot of what was covered today.	1	2	3	4	5
4. The facilitators were clear and effective.	1	2	3	4	5
5. The family partner cofacilitator provided insight that helped me better understand today's material.	1	2	3	4	5
Activities					
Please rate the following:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
6. I am better prepared to look for some of the specific warning signs of compassion fatigue in myself.	1	2	3	4	5
7. I better recognize that working with children in foster care or with other trauma can actually cause me and other professionals to develop traumatic stress reactions.	1	2	3	4	5
8. This training should improve the chances that foster parents will be	1	2	3	4	5

able to maintain their placements of foster children.					
9. I plan on applying my self care plan in the next month.	1	2	3	4	5
10. Please provide any other feedback about today's training:					

Appendix M

Post-Workshop Satisfaction Survey

Caring for Children Who Have Experienced Trauma:
A Workshop for Resource Parents

Post Workshop Satisfaction Survey

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The slides used during the training were clear and easy to follow	1	2	3	4	5
2. I would recommend this training to other resource parents	1	2	3	4	5
3. I feel I need more training to really understand this information	1	2	3	4	5
4. Now that I've had this training I think I am less likely in the future to request a change in placement for a child in my care	1	2	3	4	5
5. Now that I've had this training I think I can better meet my child's needs	1	2	3	4	5

	Very Unhelpful	Unhelpful	Neutral	Helpful	Very Helpful
6. The following are teaching strategies used in this workshop. Which ones were helpful?					
▪ "My Child Worksheet"	1	2	3	4	5
▪ Foster child case examples	1	2	3	4	5
▪ Large and small group discussions	1	2	3	4	5
▪ Information from slides and presenters	1	2	3	4	5
▪ Information from foster parent co-facilitators	1	2	3	4	5
▪ Large group activities (M&M, connection cards, feelings game, etc.)	1	2	3	4	5

7. Which concepts covered during the training have had the most impact on you as a resource parent (for example: invisible suitcase, cognitive triangle, finding strengths/resilience, balancing positive and negative experiences, etc.)?

8. I had a hard time understanding this part of the training:

9. Was there a part of the training that was not very useful or with which you disagreed? Please specify.

Appendix N

Knowledge and Beliefs Survey

Caring for Children Who Have Experienced Trauma:
A Workshop for Resource Parents

Pre-Workshop Knowledge and Beliefs Survey:

We'd like to know a little about your experiences being a parent of non-biological children (adoptive, foster, or born to a relative, also known as a "resource parent"). There are no right answers; we are only interested in your honest thoughts and feelings.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. I understand how traumatic events can impact the way my child's brain works.	1	2	3	4	5	6
2. Almost all children who have been in foster care or institutions have experienced trauma.	1	2	3	4	5	6
3. I routinely think about how my child is physically safe in my home, but might not feel safe.	1	2	3	4	5	6
4. I routinely tell others (teachers, caseworkers, etc.) about my child's traumatic stress symptoms so they can respond more effectively to my child.	1	2	3	4	5	6
5. An important part of my role as a parent is to identify trauma reminders in my child's life.	1	2	3	4	5	6
6. My child's past experiences impact how I respond to his or her misbehavior.	1	2	3	4	5	6
7. Doing things for myself is an important part of being a good parent.	1	2	3	4	5	6
8. Praises and rewards should outnumber commands and consequences.	1	2	3	4	5	6
9. It is important for me to have a relationship with my child's therapist.	1	2	3	4	5	6
10. There is always a reason for misbehavior.	1	2	3	4	5	6
11. I feel confident talking with my child about his/her feelings about his/her biological parent(s).	1	2	3	4	5	6
12. Bedtimes and mealtimes are stressful for children who have been in foster care.	1	2	3	4	5	6
13. When I think about my child's birth mother, I feel sorry for her because I bet she had a bad childhood too.	1	2	3	4	5	6
14. I feel confident about my ability to handle challenging behaviors.	1	2	3	4	5	6
15. I think defiant kids need to be praised more.	1	2	3	4	5	6

Updated 5/12/2014 Sullivan, K., Murray, K., Kane, N., & Ake, G. (2014).

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
16. I feel confident speaking up for my child's trauma-specific needs with my child's school or daycare.	1	2	3	4	5	6
17. If my child brings up the bad things that happened to him/her in the past, I feel like it's a good idea to praise him/her or her for bringing it up.	1	2	3	4	5	6
18. I feel like I have the skills to help my child heal.	1	2	3	4	5	6
19. I know strategies to help my child express a variety of emotions.	1	2	3	4	5	6
20. It is easy for me to think about the strengths my child has gained from his or her birth family.	1	2	3	4	5	6
21. When my child has intense feelings that don't seem to make sense, I understand how those feelings might be related to his/her past.	1	2	3	4	5	6
22. I know the kinds of questions to ask a therapist to determine if he or she is trauma-informed.	1	2	3	4	5	6
23. I know the warning signs of problems that can come from caring too much for others and not enough for myself.	1	2	3	4	5	6
24. I know what I should look for in a trauma-informed assessment for my child.	1	2	3	4	5	6
25. I can care for a child who lies about everything.	1	2	3	4	5	6
26. I can care for a child who rejects me.	1	2	3	4	5	6
27. I can care for a child who curses at me or says mean and hurtful things to me.	1	2	3	4	5	6
28. I can care for a child with inappropriate sexual behavior.	1	2	3	4	5	6
29. I feel sure of myself as a parent of a child who has experienced trauma.	1	2	3	4	5	6
30. I know I am doing a good job as a resource parent.	1	2	3	4	5	6
31. I know things about being a resource parent that would be helpful to other parents.	1	2	3	4	5	6
32. I can solve most problems between my child and me.	1	2	3	4	5	6
33. When things are going badly between my child and me, I keep trying until things begin to change.	1	2	3	4	5	6

Appendix O

Protective Factors Survey (Counts et al., 2010)

Protective Factors Survey, 2nd Edition (PFS-2)

Pre/Post

Agency ID #_____ Participant ID #_____ Date Survey Completed: ____/____/____

Your responses to this survey are confidential. If you need assistance completing the form, please ask a member of the staff.

For each of the following, mark the response that most closely matches how you feel.

	A. Not at all like my life	B. Not much like my life	C. Somewhat like my life	D. Quite a lot like my life	E. Just like my life
1. The future looks good for our family.	○	○	○	○	○
2. In my family, we take time to listen to each other.	○	○	○	○	○
3. There are things we do as a family that are special just to us.	○	○	○	○	○
4. My child misbehaves just to upset me.	○	○	○	○	○
5. I feel like I'm always telling my kids "no" or "stop."	○	○	○	○	○
6. I have frequent power struggles with my kids.	○	○	○	○	○
7. How I respond to my child depends on how I'm feeling.	○	○	○	○	○
8. I have people who believe in me.	○	○	○	○	○
9. I have someone in my life who gives me advice, even when it's hard to hear.	○	○	○	○	○
10. When I am trying to work on achieving a goal, I have friends who will support me.	○	○	○	○	○
11. When I need someone to look after my kids on short notice, I can find someone I trust.	○	○	○	○	○

12. I have people I trust to ask for advice about (check all that apply):

○ A. Money/Bills/Budgeting ○ C. Food/Nutrition ○ E. Parenting/My Kids

○ B. Relationships and/or My Love Life ○ D. Stress, Anxiety, and/or Depression ○ F. None of the above

This survey was developed by the FRIENDS National Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Center for Public Partnerships and Research through funding provided by the US Department of Health and Human Services.

The following questions are about your experiences so far in this program or organization. Your answers to these questions can help staff improve services for you and others like you, so it's important you answer honestly. For each of the following, mark the response that most closely matches how you feel.

	A. Strongly agree	B. Agree	C. Neither agree nor disagree	D. Disagree	E. Strongly disagree
13. I feel like staff here understand me.	◯	◯	◯	◯	◯
14. No one here seems to believe that I can change.	◯	◯	◯	◯	◯
15. When I talk to people here about my problems, they just don't seem to understand.	◯	◯	◯	◯	◯

Sometimes it's hard for families to afford everything they need. For each of the following, check all that apply.

16. In the past month, were you unable to pay for:

◯ A. Rent or mortgage
◯ B. Utilities or bills (electricity/ gas/heat, cell phone, etc.)
◯ C. Groceries/food (including baby formula, diapers)
◯ D. Child care/daycare
◯ E. Medicine, medical expenses, or co-pays
◯ F. Basic household or personal hygiene items
◯ G. Transportation (including gas, bus passes, shared rides)
◯ H. I was able to pay for all of these

17. In the past year, have you:

◯ A. Delayed or not gotten medical or dental care
◯ B. Been evicted from your home or apartment
◯ C. Lived at a shelter, in a hotel/ motel, in an abandoned building, or in a vehicle
◯ D. Moved in with other people, even temporarily, because you could not afford to pay rent, mortgage, or bills
◯ E. Lost access to your regular transportation (e.g. vehicle totaled or repossessed)
◯ F. Been unemployed when you really needed and wanted a job
◯ G. None of these apply to me

	A. Never	B. Rarely	C. Sometimes	D. Often	E. Almost always
18. I have trouble affording what I need each month.	◯	◯	◯	◯	◯
19. I am able to afford the food I want to feed my family.	◯	◯	◯	◯	◯

This survey was developed by the FRIENDS National Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Center for Public Partnerships and Research through funding provided by the US Department of Health and Human Services.

Appendix P

Strengths and Difficulties Questionnaire (Goodman et al., 2001)

Strengths and Difficulties Questionnaire **P or T 11-17**

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

Young person's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other youth, for example books, games, food	☐	☐	☐
Often loses temper	☐	☐	☐
Would rather be alone than with other youth	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other youth or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other youth	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other youth	☐	☐	☐
Often offers to help others (parents, teachers, children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other youth	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐

Signature ..... Date .....

Parent / Teacher / Other (Please specify):

Thank you very much for your help

Appendix Q

Ethics Approval (Study 2)

28/01/2020

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE I CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-12-19-5174
Titre du projet / Project Title	Addressing the Parenting Needs of Resource Parents
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	28/01/2020
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	27/01/2021

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Lauren STENASON	École de psychologie / School of Psychology	Chercheur Principal / Principal Investigator
Elisa ROMANO	École de psychologie / School of Psychology	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

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Appendix R

Module 1 Fidelity Measure

Module 1: Welcome & Introduction

Topic	Done (√)	Comments
Welcome		
The basics - Introduce yourself - Review the schedule - Provide logistical information		
Getting to know each other - Facilitator asks each person to provide information about themselves - E.g., length of time fostering, how many children in their home right now and ages, what brought them to the workshop, what are they hoping to learn, any particular problems they are hoping the workshop will help them with?		
Why a trauma workshop? *Reviews at least some of these examples:* - Trauma is important because many children in the foster care system have lived through traumatic experiences - They bring these traumas when they come into your home - Traumatic stress reactions can be difficult to parent		
A foster dad speaks – read aloud quote		
What we'll be learning - Review topics of each module		
Ground rules - Interrupting - Disagreements - Respect - Time out		
Feelings thermometer - Explain awareness of emotional temperature - Refer participants to page 9 of their handbook		
Read-aloud quote - Direct participants to case histories on page CS1-CS28 of their handbook		
Meet the children (reviews each) - Maya		

- Rachel - Tommy - Andrea - James - Javier		
Sound familiar? - Group discussion - All have experienced some form of trauma		
The challenge - Common feelings of resource parents (confused, frustrated, unappreciated, etc.)		
The solution: trauma-informed parenting - Becoming trauma-informed will make it easier to communicate with your child, get the help they need, reduce compassion fatigue, become a more effective resource parent		
Essential elements of trauma-informed parenting - Reviews all 9 elements		
Myths to avoid - Love is enough - They should be grateful and love me as much as I love them - Shouldn't love or feel loyal to abusive parent - Better to just move on, forget and not ask about past painful experiences		
"My child" worksheet - Guides participants through completing this worksheet		
Self-care start up: square breathing - Group activity		

Appendix S

Module 2 Fidelity Measure

Module 2: Trauma 101

Topic	Done (√)	Comments
What does the word trauma mean?		
A traumatic experience …		
Types of trauma		
What about neglect?		
When trauma is caused by loved ones		
My child's traumas		
How children respond to trauma - Changes in physiological arousal and reactivity - Intrusions - Avoidance - Changes in thought and mood		
What you might see: reactions to trauma reminders		
Read-aloud quote		
What about posttraumatic stress disorder?		
What you might see: - Traumatic stress reactions - Traumatic play - Talking about trauma		
Maya's story		
Maya's response to trauma		
Javier's story		
Javier's response to trauma		
My child's response to trauma		
Recovering from trauma: the role of resilience		
Read-aloud quote		
Growing resilience		
Recognizing resilience: Maya		
Recognizing resilience: Javier		
Recognizing resilience: My child		
Read-aloud quote: resource parents are …		
Wrap up		

Appendix T

Module 3 Fidelity Measure

Module 3: Understanding Trauma's Effects

Topic	Done (√)	Comments
Review main ideas from week 2		
Essential element 1		
We learn by experience		
Your internal alarm system		
Experience grows the brain		
Trauma derails development		
Young children (0-5)		
School-aged children (6-12)		
Adolescents (13-21)		
Getting development back on track		
What trauma-informed parents can do		
The invisible suitcase		
Maya's history		
Maya's behaviours		
What's in Maya's suitcase? - Group activity		
What's in the suitcase? - Group activity		
"Repacking" the suitcase		
What trauma-informed parenting can do		
Wrap up		

Appendix U

Module 4 Fidelity Measure

Module 4: Building a Safe Place

Topic	Done (√)	Comments
Review big ideas from last week		
Essential element 2		
What is safety? Group activity		
Safety and trauma		
Read-aloud quote		
Promoting safety		
Give a safety message		
Give a safety message- group activity		
Explain rules		
Be an “emotional container”		
Read-aloud quote		
Be an “emotional container” continued		
Manage emotional “hot spots”		
Read-aloud quote		
Food and meals – group activity		
Read-aloud quote		
Sleep and bedtime – group activity		
Read-aloud quote		
Physical boundaries and group activity		
Trauma reminders		
Trauma reminders’ impact		
Identifying trauma reminders		
What’s the reminder? Group activity		
Coping with trauma reminders: what parents can do		
Coping with trauma reminders: what NOT to do		
Coping with trauma reminders: what children can do- SOS		
SOS: Identifying stress busters		
Coping with trauma reminders (group activity)		
Read-aloud quote		
Wrap up		

Appendix V

Module 5 Fidelity Measure

Module 5: Dealing with Feelings and Behaviours

Topic	Done (√)	Comments
Welcome and review of Module 4 Big Ideas		
Seeing below the surface		
Essential elements 3 and 4		
What if…? Group Activity		
The cognitive triangle		
Trauma and the triangle		
Read-aloud quote		
Trauma and the triangle (continued)		
Read-aloud quote		
Decoding the triangle (group activity)		
Read-aloud quote		
How you can help		
Differentiate		
Tune in (4 slides)		
Let's play "what's my emotion?"		
Set an example		
Read-aloud quote		
What happened? Group activity		
Encourage (2 slides)		
Taking stock group activity		
Achieving a balance		
Correct and build (2 slides)		
Dealing with problem behaviours (group activity)		
Wrap up		

Appendix W

Module 6 Fidelity Measure

Module 6: Connections and Healing

Topic	Done (√)	Comments
Welcome and Introductions - Review last week's "Big Ideas"		
Read-aloud quote		
What keeps you connected?		
Name your connections (group activity)		
Children define themselves through their connections		
Read-aloud quote		
Essential elements 5 and 6		
A family tale		
A family tale group activity		
What can be done? (group activity)		
What about Jane?		
Lessons from Sandy, Joey, and John (group activity)		
Read-aloud quote		
Making it safe to talk		
Read-aloud quote		
Talking about trauma		
Talking about trauma (group activity)		
Building new connections		
Helping your child (group activity)		
Wrap up		

Appendix X

Module 7 Fidelity Measure

Module 7: Becoming an Advocate

Topic	Done (√)	Comments
Welcome - Review big ideas from last week		
Essential elements 7 and 8		
Know your child's team (group activity)		
Working as a team		
Read-aloud quote		
Trauma-informed advocacy		
Advocacy in action (group activity)		
Partnering with birth families		
Read-aloud quote		
Thinking about my child (group activity)		
Helping your child heal		
When to seek help		
Trauma assessment		
The basics of trauma-informed treatment		
Ineffective or harmful treatments		
Trauma-informed therapy: the real world		
Medications and trauma		
Putting your advocacy skills to work (group activity)		
Resources in our communities (group activity)		
Wrap up		

Appendix Y

Module 8 Fidelity Measure

Module 8: Taking Care of Yourself

Topic	Done (√)	Comments
Welcome and review big ideas		
Essential element 9		
Caregivers also need care		
Read-aloud quote		
Compassion fatigue: warning signs		
Self-care checkup (group activity)		
Self-care basics		
Secondary traumatic stress (STS)		
Stress and exposure to trauma		
When your child's trauma becomes your own		
The story of Ralph and Susan		
The story of Ralph and Susan (group activity)		
Getting past STS (group activity)		
When your child's trauma is a reminder		
The story of Betty and Janis		
Can this placement be saved? (group activity)		
Coping when a child's trauma is a reminder		
Committing to self-care: making a plan		
Committing to self-care - Daily - Weekly or monthly		
Putting it all together (group activity)		
Essential elements of trauma informed parenting		
Workshop wrap up		

Appendix Z

Additional Questions for Data Collection Following the Program

Please enter your code here: _____

When are you completing this questionnaire?

Before RPC has started
I just finished the RPC group
2- months after the RPC group ended
I am still waiting to take RPC but the first group just finished

Have you participated in any other parenting programs either at your agency or elsewhere while you were completing RPC or waiting to complete RPC?
No
Yes
If yes, please specify which program(s):