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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Juan Medina

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Walden University
2022

Abstract

Development of a Capacity Building Program to Promote Trauma-Informed Services

by

Juan M. Medina

MSW, Walden University, 2015

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

Summer 2022

Abstract

Wichita County, Texas experienced decreased academic performances of elementary level children in 24 out of 45 communities. Higher numbers of traumatic experiences increase a child's risk of not meeting developmental benchmarks. The purpose of this capstone project is to support the development of a trauma-informed capacity-building program. Ungar's resiliency theory was used to understand the factors related to building resilience in children to prevent trauma. Using action research, the researcher explored how developing program content may improve an agency's system readiness to deliver effective trauma-informed care. Data were collected from a focus group with local social workers. Content analysis was used to explore and organize the data. The study’s research questions are: (a) What capacity-building program content will help assess and improve an agency’s policy and procedures for entire system readiness in delivering effective trauma-informed care and help improve a client’s ability to develop resiliency? (b) What are the challenges or barriers to creating a trauma-informed capacity-building program and how may those challenges be overcome? Five primary themes emerged: the need to expose all community agencies to trauma-informed care; use of a universally accepted trauma-informed language, preventing re-traumatization of service recipients, use of Person-Centered Treatment; and encouraging complete agency buy-in with follow through. Those themes lay the foundation to create an action plan to deliver effective trauma-informed care in the community. By improving community agency’s response to the toxic effects of trauma, the overall health of children will be improved, and thus creating positive social change.

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Dedication

This dissertation is dedicated to my mother in heaven, Blanca Perez, who has inspired me to lead a life of service, and to my partner in crime, Esther Medina, who has given me restored hope.

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It is with sincere appreciation that I thank Dr. Peter Meagher for his commitment to academic excellence and his incredible talent as a doctoral chair. He is a gift to the Walden University faculty and student body. I would also like to thank Dr. Doug Crews and Dr. Debora S. Rice for their support of my doctoral journey. I wish to extend gratitude to the participants who volunteered to assist me with my focus group research. Many know how important it was for me to have your voices heard and included in my final analysis.

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Section 1: Foundation of the Study and Literature Review

For several decades, the Adverse Childhood Experiences (ACE) survey has been used nationwide to identify the exposure of children to traumatic events that have an immediate and lifelong impact (Blodgett & Lanigan, 2018). Researchers completing literature for the ACE have documented the relationship between those traumatic childhood experiences and an extensive amount of adverse physical and mental health outcomes in adulthood (Centers for Disease Control and Prevention [CDC], 2016; Sacks et al., 2014). For example, Blodgett and Lanigan (2018) concluded that higher numbers of identified traumatic experiences exponentially increased children's risk of not meeting developmental benchmarks across the life stages.

Researchers studying this relationship in Wichita County, Texas have identified similar concerns of continued subpar standard performances in 24 out of 45 communities in the region. The Early Childhood Coalition (ECC), a coalition of local agencies, was formed to address this concern. The ECC agrees with Ungar (2011) that children are not born able to develop resilience against trauma, which is an essential skill for healthy school and life achievement. One of the ECC members' benchmark goals is to develop a capacity-building program to help local agencies improve trauma-informed care (TIC) services. Capacity-building is the improvement of any facet of an agency's service to a client (Paynter & Berner, 2014). ECC members desire to assist community agencies that help children and their families address the impact trauma has had on them. The capacity-building program would help agencies improve trauma informed care by becoming more versed in evidence-based treatments. This study helped the researcher and participants

recognize and gather valuable data to identify trauma-informed program building content. TIC provides services based on understanding the effect and pervasiveness that adverse experiences have on children (Levenson, 2017). Social workers play a significant role in the ECC and in all Wichita County communities. Using an action research model, the researcher worked with the social work committee of the ECC to address the goal of creating a trauma-informed capacity-building program.

In Wichita County, symptoms of childhood trauma have severe implications in the community on childhood development (ECC, 2018a). To address this need in Wichita County, Texas, the ECC was formed in 2014 (ECC, 2018a). To support the process of developing a trauma-informed capacity-building program, action research was used. Action research is a systematic inquiry that is performed with individuals who are stakeholders in a community problem (Herr & Anderson, 2015). Social workers partnering with ECC were used as collaborative participants in the action research study due to their direct influence on a population of individuals who need assistance with addressing their trauma. This systematic inquiry was addressed by the participants when answering the research questions with the goal of leading to an intervention or solution to the problem of local childhood trauma. Through action research, the researcher had the goal of not just understanding local social work practices through critical and self-reflective collaboration, but to pragmatically improve field practices with an implemented action plan that aligned well with the purpose of the study (Herr & Anderson, 2015).

The potential social change implications of this doctoral study were for social

service agencies, social work practitioners, and their clients. Social workers may be able to develop trauma-informed competencies related to their understanding of their client's trauma (Wilson, 2016). In turn, social workers may then develop or improve professional approaches in treating these clients. On the mezzo level, agencies benefit by using the capacity-building program for strengthening their ability to fulfill their mission and impact clients' lives.

More specifically, the ECC actively works on addressing protective factors on three levels (Ungar, 2013). Prominent resiliency theorists agree that the individuals, their family, and their community are the three levels of society that need to be equally addressed when the individual develops resilience towards adversity and trauma (Shean, 2015). ECC members are using a collaborative approach for the action research methodology to develop a capacity-building program for trauma-informed services. This capacity-building program may help local agencies increase the effectiveness of TIC and resiliency building in the individual child, their family, and their community.

The overall organization of this paper includes the problem and purpose statements, which consists of the practice-focused research question, as well as the nature of the project and its significance. The theoretical and conceptual framework is discussed by me, followed by how this study embodied the values and ethics of social work. In the Review of the Professional and Academic Literature, I identify the common challenges in social work settings that provide services to trauma-exposed families. Through exploration of the literature, the researcher identifies relevant capacity-building methods for TIC services. This action research project is a framework to assist the ECC to

conceptualize, create, and help improve current services that implement protective factors against trauma in Wichita County for the individual child, family, and varied community service levels.

Problem Statement

Wichita County, Texas, has experienced an increased number of children who experienced trauma at home, and reported 998 abused children in 2016 after 651 in 2013 (ECC Area, 2018b). Those same children are vulnerable or at risk as they are not on track for healthy development. Higher incidences of trauma exposure have been associated with a substantial risk of repeating a grade, absenteeism, and decreased academic participation (Bethell et al., 2014). In Wichita County, area officials found that 24 out of 45 communities had developmentally delayed children (ECC, 2018b). The social work practice problem therefore involves the development of a capacity-building program to implement TIC throughout the community to address local children, their families, and the social work agencies that serve them.

The social work action committee is one of five committees in the ECC that addresses trauma in their field of training, expertise, and practice. The ECC has identified the need to develop capacity-building to address childhood trauma. Social workers can play a crucial role in addressing trauma in the communities of Wichita County, Texas as they commonly serve populations with traumatic (Siebert, 2001; Straussner et al., 2018). The social work action committee addressed the problem by deciding to create a trauma-informed capacity-building program. The social work action committee wants to gather valuable data to identify trauma-informed program building content. The capacity-

building program would be used by the ECC to help agencies improve social services across Wichita County, Texas by developing a trauma-informed capacity-building program.

Purpose Statement and Research Questions

The purpose of this capstone project was to support the development of a trauma-informed capacity-building program to assist service providers. This action research project aligned with the efforts of the social work action committee as they developed services to address developmental delays that children experience due to trauma. The practice-focused research questions were the following:

Q1: What capacity-building program content will help assess and improve an agency's policy and procedures for entire system readiness in delivering effective trauma-informed care and help improve a client's ability to develop resiliency?

Q2: What are the challenges or barriers to creating a trauma-informed capacity-building program and how can those challenges be overcome?

This study has an underlying call to action: to return to social work's strength-based foundations. Throughout this study, I agreed with a consortium of social workers to learn how to develop a capacity-building program based on the participants' own experiences and understanding of successfully providing trauma-informed services in Wichita County communities. That capacity-building program has the potential to assist multiple agencies which help children develop resilience against adverse experiences. By improving social service provisions, the results of this study can affect overall health in the field of social work and help the children in the communities of Wichita County,

Texas. This project will contribute to the professional literature by documenting the strategies to promote trauma informed care throughout the service area.

Key Terms and Concepts

The key terms and concepts of the study are the following:

Trauma: Trauma is an event or experience that leaves a measurable imprint not only on the psyche of a patient but also to their physiological wellbeing (American Psychological Association [APA], 2013). Trauma may become a problem with an individual and their inner world (Van der Kolk, 2014). Ungar et al. (2007) identified a range of experienced risks that are considered a traumatic event such as war, poverty, social dislocation, genocide, violence, marginalization, drug and alcohol addictions, familial breakdown, mental and physical illness, and early pregnancy.

Trauma-informed care (TIC): Trauma-informed care is the integration of relevant evidence-based treatments with a foundational understanding of the effect and pervasiveness adverse experiences can have on children (Levenson, 2017). It views the varied problems of a child in the context of their traumatic experiences instead of only addressing the historical trauma or symptom management (Brown et al., 2012). Trauma is viewed as the center of an individual's identity that is arranged and defined by that experience. Trauma-informed care assists the client with skill building and resource acquisition to help them acquire self-efficacy and a sense of control (Harris & Fallot, 2001).

Capacity-building: Capacity-building is the improvement in mission fulfillment and how well client groups are served by an agency by evaluating policy and procedures

to make them more effective (Paynter & Berner, 2014).

Compassion satisfaction: Compassion satisfaction is the happiness, personal and professional value, and meaning that comes from assisting individuals find self-efficacy (Stamm, 2010).

Resilience: Resilience is the processes and practices employed by an individual exposed to trauma to develop, restore, and maintain a healthy lifestyle both professionally and personally (Adamson et al., 2014). Resilience is more than just the characteristics of an individual, but the capacity of that person to use health-sustaining or restorative resources to experience feelings and conditions of wellbeing for themselves, their family, and their community (Ungar et al., 2007).

Trauma-informed walkthrough: This is a collaborative model of agency created by Brown et al. (2013) to identify trauma triggers and implement developed strategies that mitigate retraumatization to clients while they are served. The assessment reviews and evaluates all policy and daily procedures beginning from a client's first to termination of services and everything in between.

Posttraumatic growth: Tedeschi and Calhoun (1996) identified posttraumatic growth as the development of a positive belief system and healthy recovery process for self and relationships as a consequence of directly enduring a trauma. Posttraumatic growth is a positive life development after an adverse experience (Jirek, 2017).

Self-efficacy: Self-efficacy is an individual's extent to which they can engage their protective resource that promotes well-being (Cieslak et al., 2013).

Adult capacity: The ECC identifies adult capacity as the ability to sustain the

family with less dependence on government and nonprofit assistance (ECC, 2018). The ECC stipulates that increasing adult capacity is pivotal in reducing trauma exposure in children and families. It is considered a protective factor.

Adverse Childhood Experiences survey (ACE): The ACE Survey is a short survey that has been used extensively to identify 10 categories of childhood adversity (CDC, 2016). ECC members receive extensive and ongoing training on ACE.

Empathy: Empathy is viewed as professional rapport, attunement, and understanding that is often enhanced and developed by the social worker who personally experienced trauma, adversity, and treatment (Adamowich et al., 2014; Goldberg et al., 2014).

Burnout: Ben-Porat and Itzhaky (2014) identified that burnout was primarily defined by how an individual arrived without the natural and social resources to maintain their overall wellbeing. It is a result of the "gradual process leading to emotional exhaustion, cynicism, and detachment from work" that can be resolved through emotional and mental health recovery, couped with practical applications on the job (p. 2).

Secondary traumatic stress: Secondary traumatic stress is fatigue that may be experienced by a social worker. It manifests as the emotional strain that often naturally develops when a social worker is empathetic to an individual's account of injury or trauma (Cieslak et al., 2014).

Impaired: Impaired means to be weakened or damaged by trauma. A social worker may be impaired when they have not analyzed nor treated their traumatic experiences; such a worker may be at risk for not having or maintaining a healthy work

practice and personal life (Cvetovac & Adame, 2017).

Vicarious trauma: Vicarious trauma is the transformation of a social worker who empathizes with a client to the degree that their past is emotionally and mentally reexperienced (Wilson, 2016). This experience can be damaging to both the practitioner and the client.

Nature of the Doctoral Project

Through this study, I aligned with action research as it was a collaborative approach to systematically address the complex and pervasive issue of trauma in our communities (Stringer, 2007). The study's exploratory results further inform local social work practices to create a process of building resiliency in clients. The primary source of data was from one focus group that was approximately 90 minutes in duration. Seven participants formed the focus group that represented the ECC's social work action committee. Those volunteers also professionally provided varied services for families in Wichita County, Texas. The focus group developed a collective story while working together on a common community problem (Creswell, 2013). The innate exploratory design of an action research study helped the researcher to identify and understand the process of building resilience from participating social workers who have provided TIC services. In the study, my focus was the social work committee's development of a capacity-building program to assist service providers in various agencies.

Convenience sampling is defined as a choice of individuals who are available to participate and easily accessible (Creswell, 2016).

Content analysis was used to analyze the data provided by the focus group.

Content analysis is a straight-forward method to identify trends and patterns by assigning codes to the data that helps answer the research questions (McNiff, 2016). To maintain rigor, I used standard methods of trustworthiness that included conducting member checking, keeping a reflective journal, and the using a validation group (McNiff, 2016; McNiff & Whitehead, 2011). The validation group was composed of the researcher, chair, and committee members, and provided feedback and clarity of the participant's input.

Significance of the Study

It was necessary to have social workers with trauma-informed professional training and understood the process of trauma recovery in Wichita County. More specifically and urgently, the ECC has identified trauma as the primary cause of developmental delays in children (ECC, 2018a). There is a lack of trauma-informed resilience intervention practices in this region, and social work as a whole (Shean, 2015). Therefore, a community-based action research project with local social work stakeholders could inform criteria, standards of trauma-inform policy, and practice within and beyond the region. Through the study, the researcher's informed practices could have an influence on how the field of social work formulates and develops best practices for TIC in the profession. The social work action committee members have identified the lack of substantial, relevant, and effective TIC across Wichita County. In response to their own professional experiences in this region, the committee voted to create a trauma-informed capacity-building program. Through seasoned experiences and relevant training with trauma, the social work action committee members hoped to assist all Wichita County

agencies to improve trauma-informed services while advancing social work practice knowledge. The trauma-informed capacity-building program has potential implications for positive social change by assisting agencies to improve their ability to help local children reduce the toxic effect that trauma has on their lives.

Theoretical and Conceptual Framework

The ability to answer this project's two research questions are intertwined with building individual resilience and providing effective trauma-informed care interventions as identified in both problem and purpose statements. In this study, the researcher used the resiliency theory as the theoretical framework. There are currently six prominent theorists with varied versions of the resiliency theory (Shean, 2015). This study was based on Ungar's resiliency theory (Ungar, 2008). The key to understanding the construction of resilience is the key to creating effective interventions for others (Ungar, 2011). Those interventions help families to access, develop, and offer their children safety, support, structure, consequences, connections, relationships, identity, control, and belonging (Ungar, 2015). Ungar identified that the effect of an individual's characteristics combined with their environmental resources and ability to access resources would determine resilience (Ungar, 2008).

Ungar stated that a child who was considered resilient had to cope well with adversity. To be regarded as an individual experiencing trauma or adversity, they had to have at least three significant risk factors. The significant risk factors include having experienced the following: war, poverty, violence, marginalization, addictions, family structure loss, mental or physical illness, and early pregnancy (Ungar et al., 2007).

Ungar’s resiliency theory was unique because he placed more emphasis on the environment and culture and less focus on the actual individual.

Capacity-building services built around these nine components can help a child flourish (Ungar, 2015). The nine protective factors for resiliency stem from an ecological perspective that necessitates interventions to help children realize their potential. Ungar (2011) argued that a child’s family, peers, and community members, such as educators, social workers, and nurses, must be involved in interventions such as the creation of trauma-informed programs and tools.

The trauma-informed capacity-building program has the potential to be an effective community intervention and resource for agencies working with trauma. Creating a trauma-informed capacity-building program assists social service agencies in using a solution-oriented resource. They can identify gaps and effective solutions for local services. This is critical for the development of a trauma-informed capacity-building program that improves service provisions in the building of resilience in children.

The resiliency theory identified that when a child is exposed to trauma, they often respond in order to sustain their wellbeing (Ungar, 2008). During a significant trauma, the child can negotiate, access, and utilize resources to address their psychological, social, cultural, and physical needs. Ungar (2013) further defined his resiliency theory as the “capacity of both individuals and their environments to interact in ways that optimize developmental processes so the child can flourish and have meaning” (p. 256). The intent behind creating a trauma-formed capacity-building program is to assist service providers who help children negotiate, access, and utilize resources to address their challenges with

trauma exposure.

The resiliency theory was founded in understanding the effect of challenging life experiences on people (Antonovsky, 1979). The common elements within resiliency research are adversity or trauma, mediating factors, and outcomes. The difficulty in varied research is identifying whether resilience is a process or a result. Conceptually, the researcher focused on the belief that the resiliency theory is a process that leads to an outcome (Southwick et al., 2014; Van Breda, 2018). The result of this action research process identified the components needed to create a trauma-informed capacity-building program to help children and their families combat trauma.

Values and Ethics

The primary goal of social work is to strengthen and enhance the wellbeing of people (Cox & Steiner, 2013). As identified in the National Association of Social Work ([NASW], 2019), the primary principle of social work is to help people in need and to address social problems. This NASW core value is the foremost goal of the ECC and its social work action committee that participated in the study. The focus group directly addressed clinical social work problems found in children's high exposure rates to trauma and the lack of trauma-informed care intervention resources available in communities across Wichita County, Texas. In response to the social work problem of trauma in the community, the focus group worked on capacity building for system readiness in delivering effective trauma-informed care. The social work values of the NASW are evident in the purpose of this project.

Identifying how an agency addresses trauma aligns with the ethics and principles

of social work is imperative. When a person experiences trauma, dignity and self-worth can suffer, which then affects their ability to remain competent and unimpaired in different aspects of their life (Van der Kolk, 2014). This experience is a component that the social work action committee can address when creating a capacity-building tool to enhance services to children (see Appendix H). A trauma-informed, capacity-building program equips agencies and their professionals to understand trauma better and effectively serve clients who endure the challenges that trauma brings. This project can assist social workers and other social service professionals to increase their professional knowledge and skills and to apply them in practice such as trauma-formed care (NASW, 2019).

The results of this study support social work values and ethical principles of dignity and worth of the person (Cox & Steiner, 2013; NASW, 2019). Identifying the health and effectiveness of social workers and social work practices will include assessments of social work ethical standards of competence, private conduct, professional and personal development (Cox & Steiner, 2013). This maturation involves exploring the processes needed to develop and maintain resilience through trauma-informed practices in social services and their clients (Cox & Steiner, 2013; Knight, 2014; Newcomb, 2018; Newcomb et al., 2015; Ogińska-Bulik, 2013). The results of this study can influence or begin a call to action by promoting the general welfare of social work agencies, social workers, and their clients. The study also has the potential to assist in the wellbeing of community members in Wichita County, Texas, as trauma-informed programs are directly developed or enriched by the results of it. In turn, the researcher fulfilled the

ethical responsibility to promote the general welfare of society by taking care of those who serve.

Review of the Professional and Academic Literature

A review of the professional and academic literature was conducted to explore all topics associated with trauma-informed care. The literature review also included the challenges social work personnel often encounter. The researcher limited the literature review to research published between 2013 and 2019 unless otherwise specified. Prior studies were included for when it connected to current and relevant research. Searches were conducted using the following databases: Ebscohost, ProQuest, Google Scholar, and PsychINFO. Key words searched for were the following: *capacity-building, social work, social worker, trauma-informed, trauma, resilience, Adverse Childhood Experiences (ACE), adversity, posttraumatic growth, self-efficacy, empathy, burnout, secondary traumatic stress, impaired*, and *vicarious trauma.*

In this literature review, I covered key concepts to the current study such as adverse childhood experiences and resilience theory to grasp the challenges related to the community practice problem. This writer used the literature review to explore the development of a child's resilience as it applies to trauma and the development of trauma-informed care. Those topics were interconnected with Ungar's resilience theory and nine protective factors against trauma. The literature review illuminated the current study's practice problem and explored possible solutions through agency trauma assessments, capacity building examples and challenges, including the influences of social workers who are and are not trauma informed.

Adverse Childhood Experience

The CDC-Kaiser Permanente ACEs was an important study on the effects of childhood abuse and neglect (CDC, 2020). The study participants completed a 10-score survey that described childhood experiences as they related to health status and behaviors as an adult. Almost two thirds of 17,000 study participants reported at least one adverse childhood experience, and more than one in five reported three or more traumatic experiences. Felitti et al. (1998) identified that an adult who experienced four or more adverse childhood experiences may have a four- to 12-fold chance for increased health risks, alcohol or drug abuse, depression, and suicide. That same individual may have a two- to four-fold chance of being a smoker or have a sexuality transmitted disease. There were also connections to reduced life span, heart disease, cancer, bone fractures, chronic lung and liver disease, showing the emotional, mental, and physical health risks connected to trauma.

Biglan et al. (2017) stipulated that the primary cause for children who struggle with mental, behavioral, and physiological health problems is experienced trauma in their lives. They agree with Putnam (2015) that an increase of traumatic experiences is associated with the deterioration of a collective community involvement (Biglan et al., 2017). McGavock and Spratt (2017) identified that the higher an ACE score is, the more severe a child's cognitive and behavioral challenge are. McGavock and Spratt suggested that a more evidence-based or informed approach would be helpful to utilize the ACE screening assessment and determine high risk factors for children.

McGavock and Spratt (2017) added to the extensive research that illustrated the

prevalence and consequence of having an ACE or trauma. More specifically, McGavock and Spratt's research suggested that an ACE is predictor of an adult's disposition due to the stunting of their childhood developmental capabilities. The number of an individual's ACE score is a consistent predictor of later psychological and social dysfunction (Campbell et al., 2016). If predictive factors can be identified, then preventative factors can be created to increase a child's resilience. McGavock and Spratt identified that children who have an ACE score of four or more are 23 times more likely to work with a social work service provider in the future.

Developing a Child's Resilience: Ungar's Nine Protective Factors

Protective factors promote resilience and reduce the effect that trauma or ACEs have on children (Larkin et al., 2014). The nine protective factors defined by Ungar (2015) were referred to throughout the study as the best practices when helping children build resilience. Building resilience is a multisystemic response and is better understood at the family or community level (Arat & Wong, 2019). The multisystemic nine components include structure, consequences, adult connections, relationships, powerful identity, sense of control, sense of belonging and purpose, rights and responsibilities, and safety; they each help build resilience in children (Ungar, 2015). The ECC expressed the desire to consider resilience-building protective factors in any community social service program that assists children and their families. Figure 1 details a concept map that visually illustrated the nine protective factors that are needed to develop resilience against the effects of trauma. This illustration reflected the depth of involvement that Chi et al. (2015) believed a family and community needs to have when helping a child build

resilience. A tailored program was successful when it was created and implemented towards its target population (Chi et al., 2015). The ECC was firmly dedicated to helping children and families by researching and developing a service that reflected its community and helped the community implement those plans (ECC, 2018b).

Ungar's (2015) nine components or protective factors outline how to support and build resilience in youth and families. There should be an intentionally designed, stabilizing affect that details protective processes when addressing trauma (Luthar et al., 2000). As the social work action community works through creating a trauma-informed capacity-building program, these nine protective factors help established the design parameters. Those parameters can connect multiple systems together to help build resilience, especially if there are several adverse childhood experiences or vulnerabilities involved with the child (Landau et al., 2008). The ECC expressed the desire to reduce a child's retraumatization while receiving social services, but to be proactive in helping the child build resilience. Helping families grow in building resiliency is more effective, in varied levels, as a community effort using interconnected systems (Nederhof et al., 2014).

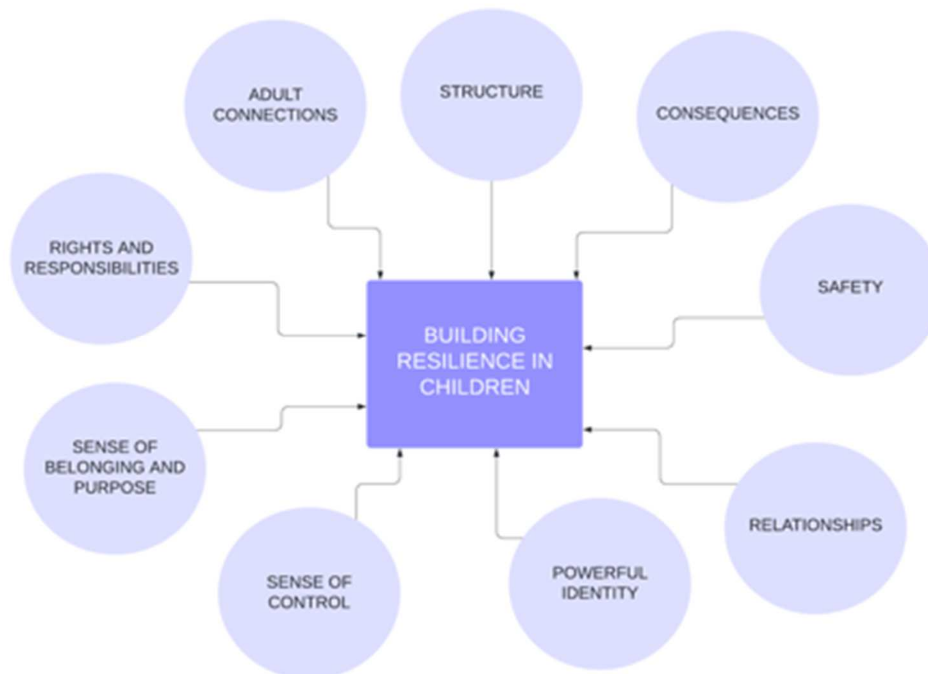
Ungar (2015) maintained that children actually desire and thrive within structure, even when they are told, "no." Children desire to have security that comes from reasonable consequences to their choices and actions (Ungar, 2015). Children also desire to solve their own problems but yearn to have parents who are readily available when needed (Ungar, 2015). Relationships help children feel important and that they are needed. Adults model to the child how much they are valued and who they are. This helps the child form a healthy identity, unless there is potential for long-term danger

(Ungar, 2015). In that case, a parent can offer to help identify alternative identities when children have a difficult time in varied domains (Pietrzak & Southwick, 2011). At the same time, consequences of actions must be learned by children, which afford children opportunities to learn how to control their own lives (Coulacoglou & Saklofske, 2017). Although children need to be actively protected by adults, they need to know when and how to advocate for themselves, especially when their rights are being taken away. A child needs a dynamic system to healthily adapt to challenges (Masten, 2014). Children need to be given responsibilities at home, be allowed to make mistakes, and feel safe when errors are made (Cadima et al., 2016; Ungar, 2015). Ultimately, children need physical and emotional nourishment to flourish (Ungar, 2015). Ungar argued that a child's resiliency is a mirrored reflection of the community that they live in, and just not of the individual themselves. Therefore, a program should reflect the varied levels and types of environments that the family is exposed to (Southwick et al., 2014).

Figure 1

Concept Map of Nine Protective Factors Needed for Children to Build Resilience

Note. This figure is a concept map of protective factors needed for children to build resilience. Adapted from *I Still Love You: Nine Things Troubled Kids Need From Their Parent*, by A. Ungar, 2015, Dundurn. Copyright 2015.



Trauma-Informed Care

Levenson (2017) identified that the core principles of TIC were designed to avoid repetitive patterns in a helping relationship that is unhealthy, especially dynamics that are inadvertent. Levenson claimed that social service workers often viewed clients as broken or defective and, in turn, created a parental relationship that often exacerbated the client's problems. ACEs or trauma exposure can influence a child's cognitive, academic, social, emotional and behavioral functioning (McLaughlin et al., 2013). There must be awareness that 61.8% of students reported experiencing one or more traumatic events by 17 years old (Pataky et al., 2019). About one in four children endured trauma before their third birthday (Briggs-Gowan et al., 2010). A trauma-informed social worker must understand that trauma is common, and practitioners should focus on the strength perspective instead of a client's pathologies.

TIC assists service delivery by ensuring there is a safe environment, so trust, choice, collaboration, and empowerment is present in interactions. Cutuli et al. (2019) performed a literature review to promote TIC. They found that TIC helps service providers to support adaptation and resilience in the face of trauma. Through the literature, researchers revealed the imprint of trauma on every aspect of practice. TIC recognizes that impact. Cutuli et al. identified that TIC, at its core, acknowledges how a child and their family may have been exposed to an adverse experience or more. Therefore, TIC policy and best practice framework must provide evidence-based practices, have relevant trauma-informed resources, and maintain continuity of TIC

throughout their agency (Ko et al., 2008). A major component of TIC is ensuring children are screened for trauma exposure, such as by utilizing the ACE questionnaire. A family's experience with trauma may impact how the family functions and responds to everyday challenges. An agency with TIC incorporates these understandings into their service provisions and normalize the client's experiences, making treatment less traumatic (Pataky et al., 2019).

The questions of whether a practice or procedure could trigger or retraumatize a client was the primary concern of the walkthrough assessment designed by Brown et al. (2013) in partnership with the National Center on Substance Abuse and Child Welfare (2015). Identifying the symptoms of retraumatization is necessary in order to answer that question. Exhibiting stress upon exposure to retraumatization is one of several symptoms that a child may display (Lieberman & Knorr, 2007). Other symptoms often displayed at a social service provider by children and families exposed to traumatic experiences are avoidance of individuals, avoidance of certain locations, and avoidance of activities (Scheeringa et al., 2003). Some clients display hyperarousal, aggression, anxiety, and poor concentration. A client may seem overtly hyperpositive, or have mood swings (Jones & Cureton, 2014). Other microbehaviors such as eye contact avoidance, social withdrawal, quietness, or diminish participation are also symptoms of retraumatization (De Young et al., 2011).

Brown et al. (2013) participated in a large-scale collaboration in the child state welfare multisystem with a focus on family recovery, early identification, access to treatment, and engagement in services. Their conclusion of the Trauma-Informed

Walkthroughs was the following: (a) service care was designed and delivered with the client's perspective in mind; (b) staff were better equipped to identify and understand dynamics of retraumatization; (c) staff identified service assumptions, inconsistencies and limitations of service provisions; and (d) they were created an environment that allowed and encouraged system improvements. The study determined that these evaluations followed by implemented policy changes helped staff become more adept at addressing the safety of their clients, staff felt safer, events of retraumatization were reduced, empowerment increased with both staff and clients, and practice consistency was improved.

Before the study, Brown et al. (2013) identified that their assessment (see Appendix H) was used to develop an action plan. Agencies reported that the assessment was nonjudgmental and was a mutual data gathering strategy that helped them evaluate the patient while considering their trauma and how they could be unintentional retraumatized due to services provided. Service providers became empowered by their newfound knowledge and training and, therefore, became more comfortable around trauma-exposed clients. Brown et al. reiterated the beliefs of Herman (1992, who believed that the initial service provision must address safety of the client and control the service environment. This includes a trauma-informed agency that has a physical building with security safety protocols, good lighting, and comfortable and quiet rooms. A client's safety must be addressed before any other therapeutic service can be established (Brown et al., 2013). In another statewide study, Bartletta et al. (2018) examined the effectiveness of three trauma treatments in a trauma-informed child welfare initiative to improve

treatment outcomes for children who are trauma exposed. A total of 842 children participated in one of three trauma treatments, and then participated in the evaluation. The programs were Attachment, Self-Regulation, and Competency (ARC); Child-Parent Psychotherapy (CPP); and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Based on the study's results, the researchers suggested the need for statewide, trauma-focused policies and practices in Massachusetts due to the findings across multiple child outcomes in all participating trauma treatment programs.

Similarly, Salloum et al. (2018) identified that self-care practices connected to using organizational resources and practices, compassion satisfaction, well-being, and agency supports. A trauma-informed foundation identified the tolling effect that trauma has on clients and service providers in-so-much that the organizational policies and practices must reflect TIC (Substance Abuse and Mental Health Services Administration, 2017). In their study, a sample of 177 child welfare workers completed paper and pencil surveys to develop the Trauma-Informed Self-Care (TISC) measure. Researchers identified the need for continual trauma-informed training for staff to combat burnout and secondary traumatic stress. This measure was designed to identify organization resources, organizational practices, and personal, trauma-informed self-care practices that are used by the professional and are successful in high-stress environments. The TISC was found to be an indicator of the level of utilization of trauma-informed self-care practices. TIC may improve staff performance and increase intrinsic meaningful work value through job satisfaction, improving client treatment outcomes (Hales et al., 2017).

Along the same lines, Wolf et al. (2013) studied 10 focus groups with staff

members from 69 agencies. They were interviewed on their knowledge and implementation of TIC within their company. Through the study, Wolf et al. aimed to explore whether those organizations had policies and practices that used the five principles of TIC. The principles identified were safety, trustworthiness, collaboration, empowerment, and choice as experienced, not just by the clients but also the staff. Providers often forget or do not know the profound effect that trauma has on them while they are treating their clients (Child Welfare Committee National Child Traumatic Stress Network, 2008). Unaddressed effects of work-exposed trauma on the professional can destroy or prevent implementation of the very principles set forth to help their clients (Griffiths & Royse, 2017). The goal of the study was to help prevent further traumatization and encourage healing from past trauma with agency services shifting toward trauma-informed systems of care.

Primarily, Wolf et al. (2013) identified that TIC requires an organizational change process that completely revolves around understanding that every single person in that agency has been indirectly or directly exposed to adverse experiences. Systemic barriers, such as organizational cultures and organizational factors, like unsupportive colleagues or management, must be addressed to avoid retraumatization of clients (Bettney, 2017; Schelbe et al., 2017). Every agency studied had policy and procedures in place that reflected the principles of TIC, but very few individuals reported consistent experiences of those principles. The data results indicated that staff was able to verbalize some of those elements, but none were able to associate them with TIC practices. Those researchers indicated that a predictive factor of staff burnout was working with agencies

that did not employ TIC principles. One primary concern was the need to create a safe environment for both the employees? and consumer. Another primary concern was a lack of trust within an organization's staff, as trust reflects confidence within its clients.

Carello and Butler (2015) performed a literature review to justify TIC. When TIC is taught, most social work college students have an adverse response to trauma content, revealing the potential of a worse response with exposure to real-life traumatic scenarios (Butler et al., 2016). Unfortunately, the literature review identified that the foundation of social work in education is barely addressing the concern of TIC in the classroom. Consequently, there should not be surprise that field practices are not consistently addressing TIC either. TIC must be a key part of any clinical training (Courtois & Gold, 2009). Carello and Butler (2015) identified that most social work educators are not equipped or trained to respond to a retraumatized student who is in a clinical program. In turn, they questioned how field staff are equipped, educated, or prepared to respond to retraumatized clients or peers. The field of social work continues to have a gap in applied TIC.

Agency Trauma Assessment

If a client does not feel safe, no social service provision can be successfully maximized by the participant (Brown et al., 2013). In fact, a vulnerable client may become retraumatized if physical and emotional safety is not established as a consistent priority during social services by any agency (Brown et al., 2013; NCSACW, 2015). In a nationwide study of multiple agencies, it was identified that patients' effective response to treatment improved when trauma-informed services were utilized (Brown et al., 2013;

NCSACW, 2015). The participating agencies worked in a mutual partnership with the SAMHSA funded National Women with Co-Occurring Disorders and Violence Study (WCDVS) and the Network for the Improvement of Addiction Treatment to evolve the trauma assessment and walk through protocol initially created Harris and Fallot in 2001 (Brown et al., 2013). In the study, researchers identified that trauma among clients should be expected as the standard, and researchers identified extensive, generalized data to improve agency services for clients with that trauma-informed standard. Overall, the study resulted in a trauma-informed agency assessment (see Appendix F) that reflected social work values that identified the wellbeing and safety of clients and staff, prevention and reduction of retraumatization, consistency of agency policies and practices, and the empowerment of clients (Brown et al., 2013).

The trauma-informed agency assessment is a walk-through and brings a team through the entire process as a client, from calling for services in an agency through each step of using the components in the initial stages of service provision (see Table 1). The participating agency members should entail a manager, staff member, and senior clients. Before the walk-through assessment, a member of the social work action committee must present trauma-informed education. The assessment is collaborative work with agency representatives and social work action committee members to identify and document any barriers to service. A key component to ensure success is relationship-building between the two representative groups with the goal of helping one other. There is heightened awareness of the service provisions that may cause triggers by recalling historic or creating emotional or physical harm to the client.

Action plans are developed after assessment categories are reviewed in the walk-through. The assessment categories include safety, client choices, service policies, trauma screening-assessment service planning, services, administrative support for trauma-informed services, and staff trauma training. The assessment is designed to be solution orientated without focusing solely on the problem, which can make collaboration an easier task. In this process, agencies may naturally develop their community network support and identify advocates and champions of TIC as other communities have found (Brown et al., 2013). Meaningful system changes have occurred as shifts in culture, practices, and theoretical frameworks have become trauma-informed (Harris & Fallot, 2001; NCSACW, 2015).

Capacity Building

Strand et al. (2017) identified the increasing prevalence of adverse trauma experiences of children and the need for increased trauma-related treatment capacity in community agencies that serve them. They identified barriers that agencies experience when unsuccessfully serving trauma-exposed children and their family. The barriers are the following: (a) poor understanding of how to implement evidence-based treatment; (b) superficial programming guidelines for choosing trauma-informed treatment; (c) inadequate fiscal resources and time to train staff and supervise them; and (d) lack of trauma-informed staff and management.

The inability to develop collaborations, partnerships, and the reduction of service resources create barriers to trauma-informed interventions (Taylor et al., 2012). Taylor et al. (2012) identified the need to evolve an agency's infrastructure, skillset, and intent,

which is the goal of capacity-building. They stipulated that this can only occur within the creation of community partnerships that develop relationships while working on focused interventions, such as TIC. Those agencies seek to use or create the most effective and empirically supported practices. Healthcare reform across the county has demanded the implementation of evidence-based practices and an evaluation of the system's efficacy (Holbrook et al., 2017). Holbrook et al. identified the role social workers and educators play in helping organizations build capacity for evidence-based practices. They conducted a study with a randomized control trial, and the results revealed how the effectiveness of system tools that measured practice outcomes positively affected capacity and outcomes. Using evidence-based system measurement not only favors healthy client outcomes, but aids in reducing staff turnover and clinician burnout.

The Harvard School of Public Health (2012) identified that using a collaborative model among social service workers had the potential to improve capacity-building in trauma interventions. They cited a concern of a lack of literature in training and professional development of social service workers in low- and middle-class income with an increase of trauma exposed community members. The researchers believed that feasibility, acceptability, and cost-effectiveness of service provisions can be improved through capacity-building within a collaborative model.

Similary, Lang et al. (2016) evaluated Connecticut's statewide initiative to address system readiness and the need for capacity-building in TIC. The initiative was made in response to identifying the prevalence of childhood trauma as a major public health concern. Results indicated significant improvements in capacity after using the

Trauma System Readiness Tool. The measured comprehensive domains covered trauma-informed knowledge, trauma-informed principles, practice, and collaboration of 223 child welfare staff participants. Popescu et al. (2016) determined that the main contributor to improve capacity and increase an organizations readiness for trauma-informed services is staff training, commitment, and education. They stated that a commitment to engage in partnerships is a pivotal component in building such capacity. Vision and leadership within administration, including increased access to resources, are foundational to implement any capacity-building for trauma-informed services. Popescu et al. hoped that leadership could create an environment that makes leaders who are not simple followers in each program. Strand et al. (2017) believed that it was not enough to train employees in evidence-based trauma treatment. To be effective in capacity-building, training must be based on the understanding on the impact of trauma. The most effective barrier to effective family services is not having access to this kind of trauma-informed training. Strand et al. asserted that organizations need an implementation framework to assess their readiness to introduce trauma-informed training and improved practices.

Capacity-Building Challenges

Unfortunately, any collaboration model is time-intensive and mandates community engagement at all stages (Despard, 2016). Organizations often do not have a framework to perform capacity evaluation, or leadership may be consumed with current services. Capacity-building requires leaders who not only have vision, but the ability to articulate the vision to engage social work agencies (McDermott & Bawden, 2017). The ECC may be able to provide assistance with leadership vision and practical application to

improve TIC. Despard (2016) identified how capacity-building interventions improved evaluative capabilities and therefore, service provision. The agency may not have a leader that has the time to identify the needed change (Clark & Corbett, 2018). These evaluations, however, are imperative as nonprofit organizations are pivotal in their work of addressing homelessness, violence, and poor treatment of children. Despard (2016) identified how agencies struggled due to deficits in service evaluation and organizational capacities. He cited capacity-building in organizational learning and strategic planning as a means to improve a nonprofit's program efforts.

Brewer and Flavell (2018) argued that interdisciplinary approaches should be required as no single discipline can adequately find solutions to address region wide effects of traumatic experiences. Measuring outcomes with changes in knowledge, skillsets, behaviors, and environment is not enough. A major challenge was determining an agency's readiness to accept support (Kesten et al., 2014). Anderson-Carpenter et al. (2017) stipulated that capacity-building encouraged community changes, but the challenge was determining how to encourage participation. Despard (2016) identified improved results of agencies who received capacity-building in group and individual based training, and results revealed that it strengthened their agencies' evaluative abilities.

Capacity-Building Model Examples

Anderson-Carpenter et al. (2017) identified a significantly strong correlation between collaborative partnerships and improved community readiness. Service capacity, community partnerships, leadership and staff development are common deficits in

community agencies (Gilmer, 2012),The readiness dimensions were initiative efforts, community knowledge of organization efforts, leadership, community climate, community knowledge of an issue such as trauma, and resources to respond. Overall, they identified that a majority of the agencies' coalitions experienced an increase in knowledge and implementation of evidence-based strategies due to building capacity. Watson-Thompson et al. (2013) identified that the process of improving an agencies skillsets, capabilities and access to resources facilitated change to a specified problem over time. The building capacity and readiness was delivered by relational collaboration, training, and even technical support. Liberato et al. (2011) ascertained that creating community change must involve collaboration among social networks that involve leaders. Anderson-Carpenter et al. (2017) argued that capacity-building resulted in policies and practices that produced healthy community changes.

Jacobs et al. (2014) tested regional evidence-based capacity-building efforts in the states of Michigan, North Carolina, Ohio, and Washington. They identified the effectiveness and value of training curriculum to increase competencies and overall capacity-building. Brownson et al. (2012) identified that this method of workforce capacity-building is key for field practice effectiveness. This is particularly important as many service providers represent an interdisciplinary force so the approach should reflect the needs of that varied educational and professional backgrounds of staff (Koo & Miner, 2010). A social work action community can meet that need due to the very nature of social work pedagogy that covers so many varied levels and perspectives of training and

practice. The challenge is ensuring the agency leadership is participating as the largest gaps are in skillsets are found at this local level (Jacobs et al., 2014). Knowledge, skill, and ability measures improved from this type of capacity-building efforts. They concluded that administering evidence-based practices or increasing approaches in this methodology was pivotal for improving community fieldwork.

Hurlburt et al. (2014) described the interagency collaborative team process model which supports service innovations in a large geographic region. It is particularly designed to address family and child services. The social work action committee can assist other service agencies by implementing a similar capacity-building program. This claim is based on the fact that social workers are the primary service providers of behavioral and mental health services across the United States (Beronio et al., 2015). This model focused on community and agency collaborations as the key for effective service implementation, particularly the need for local expertise across varied service providers and teams. Collaborative learning can improve an agency's self-efficacy (Macke & Tapp, 2012). Hurlburt et al. (2014) identified the lack of framework that address interagency mission accomplishment, and this model fills that gap.

The Building Communities of Care is a strength-based organization model that is trauma-informed and focuses on capacity-building within the system provider's management strategies. Forrest et al. (2018) evaluated this train-the-trainer model. Users of this model consider the environment, clinical treatment, community engagement, and behavioral interventions. It is imperative that an agency's policies, procedures, and practices must be designed to actively resist retraumatization of the clients (Substance

Abuse and Mental Health Services Administration, 2014).The benefits of this capacity-building model were show by less external supports used by clients, decreased staff turnover, improved physical safety, and reduced staff burnout. Most importantly, the wellbeing of clients improved after integration and capacity-building of trauma-informed services. People are complex, therefore the developed treatment must reflect the individuality of that person to avoid that one size fits all agency approach (Cloitre, 2015). TIC is an approach that not only comprehends trauma but fully identifies the long-reaching effect it has on physical, psychological, and emotional safety of a client. Forrest et al. (2018) identified that TIC addresses the need for regaining personal control which provides empowerment.

Social Worker Unique Influence on Trauma-informed Capacity-Building

Holbrook et al. (2017) argued that social workers have a unique skillset with a systems theory to develop and implement capacity-building projects. As the primary attendants to behavioral and mental health services, social workers implemented most of this work (Beronia et al., 2015). Despard (2016) stated that capacity-building challenges prevent nonprofit organizations from meeting community needs. Durst and Ives (2012) identified that social workers need to be flexible to adapt to regional, community, cultural, and individual contexts. Cultural sensitivity in relationships should be a concern of service organizations. Capacity development of knowledge and skillset is imperative in TIC within a community that has empirical evidence of concern for trauma experiences among children. Henry et al. (2011) concluded that to improve the services provided to children who experience adverse experiences, it is necessary to increase trauma-informed

capacity within an agency's varied systems. Despite challenges, trauma-informed capacity-building was improved with the integration of multileveled assessment training strategies. These strategies addressed the organizational characteristics that retraumatize the clients being treated.

Resiliency in Social Work Practice

The goal of creating a trauma-informed capacity program was to assist the client in creating resilience while reducing the effects of trauma, and potentially eliminating the effects of the trauma. Unfortunately, if an agency and their staff are not trauma-informed, those goals cannot be met. Luthar et al. (2000) identified resiliency as a process that is not solely based on intrinsic characteristics. In contrast, Ballenger-Browning and Johnson (2010) detailed how resiliency is based on the individuals' ability to remain stable. Smith-Osborne and Whitehill Bolton (2013) defined resiliency as a social worker's ability to not allow adversity or trauma to disrupt functionality.

In their study, Adamson et al. (2014) identified resiliency as achieved when an individual developed positive adaptation to a specific challenge. They stipulated that resiliency is a process, and not an intrinsic characteristic. Some of their study participants who self-identified as resilient also highlighted mastery and job satisfaction even in the face of work exhaustion, a personal sense of meaning coupled with organizational navigation, and being process driven as opposed to result driven (Adamson et al., 2014). Joubert et al. (2013) understood that a challenge in workplace resiliency is the propensity to become self-sacrificing without experiencing renewal of internal and external resources.

Adamson et al. (2014) concluded that supervisory and management support and improvements in assessment and intervention skill sets were significant factors in reducing the symptoms of trauma in the workplace. Those are components that Joubert et al. (2013) believed mitigated stressors, along with improved levels of meaningful work and satisfaction. Adamson et al. recognized a bias or weakness in their study, identifying that their samples were experienced clinical social workers who most likely have advanced cognitive and processing skill sets that identify their vulnerability and manufacture protective factors.

Adamson et al. (2014) identified that flexibility, reflection, and experience were key components of workplace resiliency building. Interrelation skill sets and professional and personal balances, along with coping response behaviors, were also important components. In addition, time management and goal orientation were influential factors in workplace resiliency. Meyers (2016) highlighted that using the resiliency theory should not be solely focused on removing the pain brought by trauma, but about using creative outlets and support relationships to navigate the adversity. Resiliency is emphasized within processes, specifically within biological, environmental, and psychological attributes. Adaptability is underscored. For example, feeling safe is a priority when providing services to an individual who may have been experienced trauma. An agency staff member may want to evaluate and ask how the client would describe the reception and waiting areas to see whether they are comfortable and inviting. A trauma-informed workplace's characteristics, among many others, are discussed in the trauma-informed assessment found in Appendix H.

From a different perspective, Hyatt (2014) ascertained that developing deeper professional empathy and compassion comes from processing a trauma exposure. Further, Hyatt argued that story telling an individual's life experience in group therapy is the foundation for approaching healing and resiliency. Protective factors, such as a sense of humor, intelligence, outlook on life, personal view of self and self-esteem, realistic perceptions, self-efficacy, adaptability, organize approaches to adversity, and spirituality are all components to provide hope, release tension, and decrease sadness during a challenging time (Gitterman & Knight, 2016). Gitterman and Knight (2016) also identified how less attention has been given to studying how those concepts can be integrated into a clinical practice. It was not until recently that an analytical approach to measure resilience in social work practices has begun (Smith-Osborne & Whitehill Bolton, 2013). Michalopoulos and Aparicio (2012) conceded that resiliency is a dynamic process that takes into consideration biological, psychological, person-in-environment and the contexts of adversity experienced by both client and practitioner. There is a need for further exploration of how to systematically encourage resiliency in the social worker's place of employment.

Empowerment

A resiliency program can instill empowerment in both social worker and client as each have their owned defined role and responsibilities (Brown et al., 2013). Self-empowerment includes the ability to have input and control in trauma-informed services, which is important when addressing trauma with both service provider and client (Ungar, 2013, 2015). The current social work environment claims the strength-based perspective,

which includes using the resiliency theory. Unfortunately, organizational standards of operations that set the pace solely for business procedures often do not consider sound social work doctrine (Gitterman & Knight, 2016). This results in a focus on deficits or problem-solving instead of individual empowerment as fiscal statistics become the monthly goal (Gitterman & Knight, 2016). A major characteristic of the trauma-informed walk-through assessment is to help develop self-efficacy, control, and empowerment in the child and their family (Brown et al., 2013)

Today's practices are often permeated by the social worker doing more work than the client. Gitterman and Knight (2016) proposed a renewed effort to return to group work modeling, when appropriate, with the goal of adversarial and mutual aid that is naturally facilitated in group work practice. This group work is often found within a family dynamic. Gitterman and Knight stipulated that the dynamics between clients in a group often encourage individual progress that is less reliant on the social worker. Inexperienced social workers find it easier to carry the workload themselves instead of assisting the client through development of empowerment and maturing self-efficacy (Gitterman & Knight, 2016). This provides opportunities for families to develop their own resiliency among one other as they find they are not alone through interconnectedness.

Empathy

A core component of TIC is empathy, which also supports social worker and client resilience (Wagaman et al., 2015). Empathy is defined as professional rapport, attunement, and understanding (Goldberg et al., 2014). Becoming trauma-informed

enables a social work professional and possibly an entire agency to develop empathy. A trauma-informed, capacity-building program can assist in the very goal of understanding what a client has endured and what they may need (Harris & Fallot, 2001). Wagaman et al. (2015) identified a significant statistical relationship in the sampling of 185 social workers. They concluded that empathy may reduce or prevent secondary traumatic stress and burnout in social workers while increasing their ability to have compassion for clients. Wilson and Brwynn (2004) expressed that empathy is a social worker's capacity to be fully aware of another person's experience. Nilsson (2014) and Adams et al. (2006) agreed that sincere empathy and compassion is beneficial to both client and social worker. Wagaman et al. (2015) identified that previous social work research focused on environmental influences and not on the social worker, resulting in negative symptoms being treated instead of creating a focus on prevention. Identifying contributors within an individual's control can be the key to addressing traumatic responses. Addressing adversity and the effects of trauma can be a learned skill set within the client's and social worker's control. A trauma-informed capacity-building program creates a work culture that inspires accurate understanding of the client due to balanced workforce and client roles (Brown et al., 2013). Empathy based on trauma-informed programming can improve the relationship between the client and provider which can improve a client's success when dealing with trauma.

Self-Efficacy

Self-efficacy is defined as an individual's extent to which they can engage protective resources that promotes wellbeing (Cieslak et al., 2013). Self-efficacy is a

protective factor in the development of and maintenance of resiliency in clients and providers (Ungar, 2013, 2015). Self-efficacy plays a pivotal role in a trauma-informed capacity-building, as modeled in Appendix H. When a social worker assists a client, provider and client's feelings self-efficacy increase (Gitterman & Knight, 2016). A trauma-informed capacity-building program with defined roles for providers and clients should help a family become more independent and apt to access protect resources. A trauma-informed capacity program can help a social worker understand the perspective of the client without baring the weight of their trauma (Cieslak et al., 2013). Zoellner and Maercker (2006) believed that growth develops as individuals address their traumatic exposure. Calhoun and Tedeschi (2006) contend that such growth is initiated by self-efficacy adaptations. Shoji et al. (2014) identified from a longitudinal study that identifying when a social worker needs to harness social support during a challenging event can increase self-efficacy. That growth is viewed as positive, posttraumatic, or secondary growth from adversity. Unfortunately, social workers are a group of professionals who are at high risk of developing secondary traumatic stress, as identified in a longitudinal study by Shoji et al. (2015).

Exposure to trauma does not always have a negative effect on all practitioners (Brockhouse et al., 2011). Positive effects from trauma exposure are identified in higher rates with practitioners who are survivors that have experienced personal traumatic adversity (Zoellner & Maercker, 2006). Although job burnout has been identified as a potential gateway to secondary traumatic stress, the symptoms of emotional exhaustion, cynicism, and detachment from work do not mutually reflect the level of burnout (Ben-

Porat & Itzhaky, 2014; Shoji et al., 2015). Stamm (2010) also identified compassion satisfaction as an intrinsic quality of self-efficacy, because happiness, personal and professional value, and meaning comes from assisting individuals. There is concern of how much empathetic engagement occurs before a social worker is unable to help others in a healthy fashion. Despite this, there continues to be social workers who are able to continue their journey of positively walking with others on their path toward healing from trauma (Walsh, 2006). Hernandez-Wolfe et al. (2014) contended that negative transformation by exposure to trauma is not the only option for practitioners. Resilience and even growth can occur, as illustrated by many trauma-informed social workers.

Social Workers that are not Trauma-Informed

More social workers are beginning to understand the importance of TIC. In their research, Lee et al. (2018) reiterated that 89% of social workers occasionally supply clients with trauma-related services, but 53% of social workers provide daily trauma-related services. Bercier and Maynard (2015) performed a systematic review of 4,000 articles from 1983 to 2012 to understand the effectiveness of interventions specifically addressed to the priority of developing and assessing trauma-informed interventions for clients. They identified the lack of interventions to help social workers. Knight (2014) recognized that healthy social work practice neither focused solely on or ignored historic trauma, but trauma-informed social workers were sensitive and informed enough to place this pain appropriately.

Conchar and Repper (2014) identified that there are often retraumatized social workers in the helping profession. Effective trauma-informed social workers must

consider skill development as one of the essential components of healthy practice (Glennon et al., 2019). Richard (2012) attributed her ability to participate in a client's growth to her own capacity to grow. Joseph and Murphy (2014) identified the lack of social workers trained in working with individuals who have trauma. They also identified the gap in literature focused on social work academia that prepared social workers or developed field practices to address trauma service.

This research is surprising as social workers are the primary field of helpers who address trauma and harm to people more than all mental health fields combined (Berzoff & Drisko, 2015). According to Bercier and Maynard (2015), 40% of all emergency response staff trained by the American Red Cross are social workers performing mental health services. Since 80% of the general population in the United States experience at least one traumatic event in their life, it can be conceded that social workers work with trauma exposure (de Vries & Olff, 2009; Lee et al., 2018). For example, one out of five women and one out of 71 men in the United States are victims of rape, which accounted for over 23.6 million people (White House Council on Women and Girls, 2014). With those high rates, trauma or adversity could be considered a widespread concern or epidemic as the majority of people in the United States are susceptible to a specific form of trauma. That single sample of one form of trauma alone begs for increased and improved knowledge for a trauma-informed social work field. Lee et al. (2018) believed that self-efficacy and effective engagement in practice can be beneficial to not only the client’s wellbeing, but also to the social worker’s health.

Trauma Informed Practice

Staempfli et al. (2015) identified the need for higher qualified personnel to address the lack of training and insight into trauma among social workers. Building professional knowledge is imperative to avoid blurring personal traumatic experiences with professional work. The unique insight of TIC applied in practice can be successfully utilized (Smith, 2012). Shared professional knowledge of trauma vastly improves individual and community work as it removes stigmas and positively enhances perspectives being held by professionals (Cabiati & Raineri, 2016).

As a result of their research, Berzoff and Drisko (2015) created a call-to-action for social work academia to return to clinical education and clinical support to prepare students for real-world work. They also encouraged academia to employ practicing social work supervisors to teach in more universities. Wilkin and Hillock (2014) identified the concern that social workers often newly enter the field with minimal to no knowledge of trauma. With trauma increasing as a common experience, social workers need to learn how to address trauma professionally or even personally. Larkin et al. (2014) argued that social work researchers play a crucial role in furthering knowledge of trauma and resiliency, but they are concerned with the lack of implemented practical interventions. Knight (2014) emphasized the need to help survivors and practitioners use fundamental social work skills to develop empowerment by understanding how the past traumatic experiences influence their current timeframe for more effective life management. This practice of self-empowerment should also apply to practitioners of social work, not just their clients.

The research documented the difficulties that local children face during their developmental stages when they experience ACEs or trauma. The literature provided understanding of the unique position social workers can have in understanding what trauma is and influencing TIC. The research also provided multiple resources for creating and implementing TIC through trauma-informed capacity-building. The current gap in research is identifying local implementation of well-defined TIC in the local region of Wichita County, Texas.

Summary

In Section 1, the researcher provided a foundation of the study and a comprehensive review of the academic literature of the hardships and vulnerabilities confronting children who are trauma exposed. The academic literature identified the social worker's unique influence on trauma-informed capacity-building. Unaddressed effects from trauma exposure and uninformed practices can lead to professional and personal costs for both the client and social worker, as the professional may not be working to their full potential if they are not trauma informed (Dombo & Gray, 2013). Joseph and Murphy (2014) argued for a greater identification and understanding of trauma and posttraumatic growth among social workers to assist in how their cognitive processes work to serve this population, with added focus on practitioners who are trauma informed. To resonate with the human condition is a consistent characteristic of the social worker and promotes healing for their clients (Lawrence, 2016). Historic and current research illustrate the high rates of harm social workers have incurred prior to entering the field of social work and during practice (Black et al., 1993; Newcomb et al.,

2015; Straussner et al., 2018). Rather than social workers ignoring or unsuccessfully treating trauma, more attention needs to be given to the learned process of resilience (Newcomb, 2018). Children benefit from social workers developing insight into the healing process of TIC (Cvetovac & Adame, 2017).

Successfully addressing trauma has unexplored potential for the community that the researcher resides in. Unfortunately, local children in Wichita County, Texas have displayed continued high rates of underdevelopment in early life stages. The ECC has directly connected experienced trauma to developmental challenges. The ECC's primary goal is to decrease vulnerabilities of young children in Wichita County by addressing trauma early on. The ECC's social work action committee has decided to develop a trauma-informed capacity-building program to assist participating Wichita County social service programs in creating or enhancing their trauma-informed services. This research project was a collaborative approach of systematic action with the researcher and the ECC to help Wichita County improve trauma-informed services by identifying effective methods to help clients build resilience. In Section 2, the researcher details the research design, data collection, data analysis, ethical procedures, and summary.

Section 2: Research Design and Data Collection

In Wichita County, Texas, 24 out of 45 community have children who are not meeting their developmental stages, potentially due to trauma exposure or ACEs. In response to that community concern, the ECC (2018a) identified the need to develop trauma-informed capacity-building for agencies who serve those children. The development of a trauma-informed, capacity-building program may help local agencies increase their effectiveness of child and family care services, including resiliency building. In Section 2, the researcher discusses the design and data collection used for this action research study. Methodology, participants, instrumentation, data analysis, and ethical procedures utilized are also discussed.

Research Design

The social work practice problem is that Wichita County, Texas has high rates of children who experienced or are experiencing trauma. An action research methodology was used as an approach to empower the ECC's social work action committee to identify and evaluate the challenges social service providers have when serving trauma exposed children in Wichita County, Texas. These children were identified with traumatic experiences that increased children's risk of not meeting developmental benchmarks across the life stages (ECC, 2018). Action research aligns with the purpose of this study. The purpose of this capstone project was to support the development of a trauma-informed capacity-building program to assist service providers.

This writer utilized a focus group and a questionnaire to collect data. The focus

group gathered valuable data to identify trauma-informed program building content. Exploring the Wichita County community service provision challenges and successes identified by the social work action committee helped study participants to create their own trauma-informed capacity-building program, which was the purpose of this study. Pseudonyms were used to mask the identities of the research project participants. The practice focused research questions were the following:

Q1: What capacity-building program content will help assess and improve an agency's policy and procedures for entire system readiness in delivering effective TIC and help improve a client's ability to develop resiliency?

Q2: What are the challenges or barriers to creating a trauma-informed capacity-building program and how may those challenges be overcome?

I used action research for this study and conducted a focus group with local social workers to explore nine protective factors of the Resiliency Theory (see Figure 1) that could reduce or eliminate the effects trauma has on children (Ungar, 2015). Along with having Ungar's nine protective factors as a foundation for the understanding in building resilience, the focus group explored the Trauma Informed Assessment model from Brown et al. (2013) to develop their own trauma-informed capacity-building program. This understanding of resilience building directly informed the development of a capacity-building program to help local agencies improve TIC services. This trauma-informed, capacity-building program can help agencies prevent or intervene with trauma among children in their community. Local social workers want to effectively reduce the effect of trauma on children and their families in Wichita County. The purpose of this capstone

project was to support the development of a trauma-informed, capacity-building program to assist service providers. Understanding how agencies promote resilience in their direct practice with at-risk children laid the foundation to improve or increase trauma-informed services to reduce symptoms that trauma-exposed children have. The following sections clarify operational definitions and key aspects of the study's participants, as well as validation procedures including rigor, instrumentation, data analysis, and ethical procedures.

Methodology

Prospective Data

Due to recent COVID pandemic protocol, the researcher proposed to collect data using a focus group conducted virtually. The researcher used the focus group questions to obtain data from Wichita County social workers (see Appendix C). The data detailed professional experiences with local trauma services and subsequently helped them develop a program to help those services build trauma-informed capacity-building. To help the social worker study participants answer and align with the practice focused research question, the researcher developed six focus group questions based on the fundamental concepts from Ungar's Resiliency Theory and key components of Ungar's work with varied families who have identified resilience building within their own communities (Jefferies et al., 2018; Ungar, 2015).

The focus group questions encouraged the focus group to review components of a valid and reliable trauma-informed agency assessment, such as the trauma-informed walkthrough. The social work action committee was engaged in the early stage of

identifying the need to develop their own capacity-building program already. The social work action committee previously reviewed and selected this capacity-building model as a tool to assist them. The Trauma-informed Walkthrough was a collaborative agency assessment that was explored by the focus group as a building block for their own capacity-building program. This model was created by Brown et al. (2013) to identify trauma triggers and to implement developed strategies that mitigate retraumatization to clients during service. The action research focus group explored barriers and challenges that agencies and their clients encountered in order to develop a trauma-informed, capacity-building program.

Participants

Social workers were recruited from the ECC. A convenience sample is a nonprobabilistic sampling technique that is used in quantitative studies because participants are readily accessible to the researcher and are selected in an ad hoc fashion based on their proximity to the researcher (Jager et al., 2017; Suen et al., 2014). The ECC has a social work action committee that was formed by community social workers and active since the coalition began. This committee provided primary stakeholders for a readily available convenience sampling. Acting as a member of the social work action committee was a primary eligibility criterion for this community base action research study. Social workers from all backgrounds, education levels, and areas of expertise were welcome to participate in the study. The participants should have a degree in social work, have practiced social work, or have been grandfathered into social work by the state board of social work examiners. Due to the nature of an action research project having a

researcher aligning with an agency that has direct connection or is invested into resolving a problem: the social work action committee was formed and actively addressed the community research problem. Some of the members may not be formerly trained or currently practicing as social workers. The concern of including informally trained social workers did not negate the participants' understanding of the community problem at hand and the value of their input.

After IRB approval, the researcher reached out? to the social work action committee of the ECC via email and in-person to provide more information about the study. There was currently an average total of 10 agency-based social workers from multiple agencies who were volunteers and participants in the ECC's social work action committee. Although fluctuating, there could be up to 90 total individuals that volunteer in the ECC. The stakeholders resided and worked in different regions and agencies across Wichita County. Creswell (2013) identified that elucidation was the goal for qualitative research, and that three to 10 participants in a focus group could accomplish that intent. The social work action committee, as part of a community established consortium, was designed to address TIC. The researcher worked alongside participants who already systematically addressed a complex issue.

This group of social workers automatically met the criteria of action research facilitators with a stake in engaging in the systematic inquiry into trauma that historically affected the community (Stringer, 2007). The 10 potential participants and the researcher used email to arrange an agreed-upon time and conducted one virtual focus group meeting. The meeting was approximately 90 minutes and was conducted using a virtual

platform called Zoom. That initial meeting was announced in the ECC monthly email letter. The individuals interested in participating in the study received a second email with the focus group questions along with information about the relevant Resilience Theory and Walkthrough model. In that email, an attached Recruitment Letter and Informed Consent letter found in Appendix A and Appendix B provided the purpose of the study, including risks and rewards of participation.

In the following up emails, the details of meeting place and time were determined. Each stakeholder reviewed the informed consent document and provided acknowledgement and participation agreement by returning an email with the response "I, PARTICIPANT'S NAME, have read and understand the Informed Consent document. I do consent to participate in a virtual focus group." An anonymous electronic demographic survey (see Appendix E) was required to be completed prior to participation. The social workers provided varied services for adults and children in Wichita County. The social work participants were from diverse backgrounds in social work practice. They collaborated to address the effects that trauma has on the developmental stages of children in their county. The participants were asked to share their experiences and perspectives in building resiliency to develop a capacity-building program for TIC service agencies. Pseudonyms were used to mask the identities of the research project participants.

Instrumentation

A single focus group was performed virtually with volunteer members of the ECC's social work action committee. This forum utilized a semistructured interview

process and standardized questions (see Appendix C) to elicit the social workers' insight and experience in trauma-informed services. The questions developed for the focus group were based on Ungar's writings on the Resilience Theory and the Trauma-Informed Walkthrough model by Brown et al. (Brown et al., 2013; Ungar, 2013). Open-ended questions were formulated to assist the researcher and focus group in identifying and gathering valuable data to identify trauma-informed program building content.

The focus group questions helped identify potential barriers in creating and implementing a trauma-informed, capacity-building program. Detailed and rich descriptions can arise from open-ended questions and build a healthy and robust qualitative report writing (Creswell, 2016). This data described the participants' experiences with the most common challenges identified when clients received help from local social service agencies.

The researcher facilitated the focus group. All data were recorded with audio recording and hand journaling procedures. The focus group was performed using Zoom, a private virtual forum. The Letter of Cooperation (see Appendix D) granted permission to use a private virtual setting.

Data Analysis

In this qualitative study, content analysis was useful to explore responses to interview questions and organizing the data (Hill, 2012). The focus group was conducted using the platform Zoom and was recorded and transcribed. The transcript of the focus group was analyzed, sorting the data into domains to identify themes for each domain for a reporting framework (Creswell, 2013; Herr & Anderson, 2015). Content analysis was

identified as being used in research that has used the same set of questions for each participant (Shannon et al., 2014). The general process for this analysis was to prepare and organize transcript text data to classify and present the data (Creswell, 2013). The contents were reviewed for the researcher's familiarization and comprehension of exploratory viewpoints that were expressed by the participants during the focus group. Related groups or categories of data were created after participants' statements provide a unit of measure (Stringer, 2007).

Validation Procedures

Stringer (2007) identified that action research has a different method than traditional research to establish rigor. This action research focused on establishing trustworthiness through credibility, transferability, dependability, and confirmability. This study cannot be generalizable to the entire population as the data only applied to the specific type of population addressed in the research question and is not applicable to a range of circumstances (Stringer, 2007). These findings contributed to conversations of TIC in research and practical application.

The practice of providing an auditable record of what took place in the research study supports the tenet of confirmability (Stringer, 2007). Throughout the process, the researcher maintained a journal and field notes. Handwritten notes and printed documents were kept in a locked box in the researcher's home office. All other computer-generated notes and data collection were kept on a password-protected computer and memory cards. Transcripts from audio recordings further established an audit trail to achieve confirmability (Stringer, 2007). This audit trail created a detailed transparent process that

was trackable and documentable, therefore becoming dependable (Stringer, 2007). An audit trail was essential so readers could follow the source of the data to ensure any interpretations or conclusions are logical and further supporting confirmability (McKay & Marshall, 2000).

Avoiding the usage of a single source of data by accessing multiple perspectives of study participants supported the overall tenant of credibility (Stringer, 2007). The ECC's organization design in being a consortium naturally included numerous views of varied study participants and agencies represented. This structure protected a study against a single source of data that could be self-serving and honored the principle that social workers behave in a manner that is trustworthy (Herr & Anderson, 2015). For a collaborative project to work and provide substance for the community to use, the participating members must ensure their input is accurately represented (Stringer, 2007). Participants' explored experiences and expressed perspectives were reviewed and confirmed by the very members who participated. This is called member checking and was accomplished by having participants review the transcripts to ensure data accuracy for credibility in the study (Stringer, 2007). Member checking allowed the participants to clarify or correct any interpretations of their presentation.

Using a validation group confirmed the truthfulness of the information and analysis and further strengthened the rigor of this action research study to achieve those goals (Stringer, 2007). The researcher used a validation group made up of the researcher, chairperson, and committee member in different stages throughout the action research study. For example, the group reviewed transcripts to provide observations and

perceptions from each participant's data in the focus group. They offered feedback after coding and the development of themes during data analysis. Mainly, the validation group helped provide insight and clarity on the study participants' responses in the transcript summary and supported thoroughness or rigor (McNiff & Whitehead, 2011).

Ethical Procedures

This researcher obtained approval from Walden University Institutional Review Board (IRB), (IRB approval number 11-12-20-0248400) to involve participants in the study. The researcher did not participate in any research activities with participants before receiving IRB approval. The Recruitment and Informed Consent letters emailed to participants detailed the purpose of the action research project and included risks and rewards that were involved (see Appendices A & B). Ethical research practices and standards were identified and reviewed. Confidentiality and anonymity were maintained throughout the research process to protect the identity of each participant, their clients, and the agency(ies) they worked with. Any revealed information that was determined to be possibly damaging to the image of any agency or professional image of an individual was not published or was masked to eliminate direct identification, including the role of each participant.

The researcher reviewed the informed consent and disclosed study participants' rights and risks of harm at the beginning of the focus group. The focus group was conducted virtually and was recorded and transcribed. All collected data were kept secure and private. The confidentiality of each stakeholder was maintained throughout the action research project. Pseudonyms were utilized throughout the project. The identities of each

participant and all identified agencies were masked. The gender, race, name, and workplace of each participant was not identified and any reference that could disclose the identity of a participant was not included. Handwritten notes and printed documents were kept in a locked box. All other notes and data collection were kept on a password protected computer and memory cards. All identities were kept confidential by assigning a pseudonym to each participant. All data were maintained and kept secure for 5 years following the study's completion.

Summary

In summary, the researcher utilized a focus group conducted virtually to collect data from Wichita County social workers about their experiences with community social services to inform the development of a trauma-informed, capacity-building program. The program was designed to help local agencies increase their effectiveness of child and family care services including resiliency building. After IRB approval, the researcher reached out to potential participants who met the study criteria to select the social work action committee from the ECC. This committee provided social workers from varied fields across the county. Ethical considerations and practices in the research were honored and adhered to as data and participant protections were utilized, including masking identities and workplaces. The researcher used content analysis to process the collected data from the focus group. Research validation procedures and ethical practices were consistently employed. A summary of findings was created after the completion of the content analysis. A final project report was made available to the ECC stakeholders. In Section 3, the researcher outlines the presentation of findings from this study.

Section 3: Presentation of the Findings

The purpose of this capstone project was to support the development of a trauma-informed capacity-building program to assist service providers. Data were identified and collected to support that development of a trauma-informed capacity building program during a research focus group. Seven individuals responded to the invitation to participate in the focus group portion of this study. Pseudonyms were used to mask the identities of the research project participants. In Wichita County, Texas, 24 out of 45 communities were within the range of 51%-80% children developmentally not on track on one or more domains identified in the Early Development Instrument (ECC, 2018b). The ECC identified trauma as the primary cause of developmental delays in children. In response to their own professional experiences in this region, they voted to create a trauma-informed capacity-building program due to a lack of substantial, relevant, and effective TIC across Wichita County. Therefore, it was naturally and easily identifiable that the social work practice problem is that Wichita County, Texas, has high rates of children who experienced or are experiencing trauma (ECC, 2018).

Higher incidences of trauma exposure have been associated with a substantial risk of repeating a grade, absenteeism, and decreased academic participation (Bethell et al., 2014). A trauma-informed capacity-building program can help improve an agency's system readiness and ability to deliver effective TIC that reduces the rate of trauma and directly addresses the imprint that trauma leaves on children. The researcher addressed the following questions:

Q1: What capacity-building program content will help assess and improve an

agency's policy and procedures for entire system readiness in delivering effective TIC and help improve a client's ability to develop resiliency?

Q2: What are the challenges or barriers to creating a trauma-informed capacity-building program and how may those challenges be overcome?

In Section 3 of this study, the researcher details data analysis and subsequent findings. In the data analysis techniques section, the researcher provided the time frame for data collections, data analysis process, validation procedures, and study limitations or problems. The findings document the characteristics of the sample population, an analysis of the finding and how they answer the research questions. A discussion of how the findings impact the social work practice problem include any unexpected discoveries.

Data Analysis Technique

Time Frame for Data Collection and Recruitment

Recruitment for this project began in December 2020 after the researcher received Walden University Internal Review Board (IRB) approval to conduct the study. The researcher contacted the executive director of the local United Way nonprofit organization. Concurrently, as the ECC Board of Director, the United Way executive director was the point of contact regarding any formal research activities with the ECC and authorized to have signed a Letter of Cooperation for the project. In turn, the executive director contacted all potential volunteers, approximately 100 individuals, via email.

Seven individuals responded to the executive director's invitation to participate in the focus group portion of this study. A copy of the consent form and sample interview

questions was sent to each participant by email. Each participant received adequate time to determine if the questions were within their capacity and comfort to answer. Within the initial email, several suggested days were given to determine the meeting arrangement. Within a few days, each member identified and agreed upon the best day and time to participate in a focus group setting a date rather quickly. Prior to the actual group discussion, the meeting time was finalized and confirmed with the participants via email. The data for this study were collected within a 90-minute focus group session. The focus group was performed and completed on December 9th, 2020. Within 1 week after the study, all seven of the participants completed an anonymous online demographic survey.

Data Analysis Procedures

For this study, the researcher used content analysis for coding techniques. The purpose of content analysis was to allow the researcher to simply explore and organize the documented data arising from responses to interview questions (Hill, 2012). This was especially effective and simplistic approach when the researcher used the same set of questions for each focus group participant (Shannon et al., 2014). Content analysis was a straight-forward method to identify trends and patterns by assigning codes to the data that helped answer the research questions (McNiff, 2016).

Upon completion of the focus group meeting, the researcher transcribed the recording word for word. Once the transcription was completed within 2 weeks, it was emailed to each participant for review. Each participant reviewed the transcription for accuracy. Each participant confirmed the accuracy of the transcription by email. From

there, the researcher reviewed the entire transcription.

While reviewing the data, the researcher used colored highlighting markers to identify word and phrases, on the hard copy transcript, that were relevant to the two research questions. Those highlighted phrases and impactful words were the codes that illuminate the primary ideas of the focus group session while maintaining the original context and meaning of the transcript. These codes created or identified permeating themes from the focus group. Five primary themes arose from the transcribed data.

Validation Procedures

Validation procedures was the process that demonstrated the ability to test and establish the truthfulness of the claims set forth in the action research report (McNiff & Whitehead, 2011). The researcher utilized credibility, dependability, and confirmability for validation procedures. Credibility was the reasonability and truthfulness of the study (Stangor, 2011). Prolonged engagement between the researcher and the participants established credibility because trust and understanding was developed. Member checking added to credibility. Stangor (2011) further stipulated that confirmability is the documentation that illustrates the research steps have been taken. Having an auditable record for anyone to review established confirmability. Dependability focused on the systematic approach to research that must be transparent and can be criticized (McNiff, 2016). The transcripts, field notes, and journaling kept by the researcher established dependability and an audit trail that further provided practical confirmability. Validation procedures were imperative to ensure truthfulness or validity was maintained during this research project.

Validation Group. Using a validation group checked the truthfulness of the information and analysis and further strengthened the rigor of the action research study to achieve those goals (Stringer, 2007). The researcher's validation group provided insight and clarity about the study participants responses in the transcript summary which supported thoroughness or rigor. The validation group was composed of a Walden University's doctoral chair and two peer reviewers (one current doctoral student and one Walden University doctoral graduate). For example, the validation group provided clarity on establishing coding themes from the transcript summary. The transcription and coding categories were also reviewed, and feedback was provided through member checking.

Audit Trail. Due to the fast-paced nature of action research, the process is captured through varied methods that can be audited later. That audit trail described the thinking, decisions, and actions of the researcher and action research participants (Herr & Anderson, 2015). The researcher utilized an audit trail throughout the study's collection process. Confirmability was achieved when varied methods of data collection could be reviewed. Audio recordings, transcripts, emails, and written notes or journaling of interactions with the participants were used. Concurrently in this study, dependability in research was accomplished by identifying that research study activities and processes took place. A password protected computer and memory card was used to maintain ethical procedures in protecting the participants privacy. All notes were secured in a locked cabinet.

Member Checking. Member checking was defined as utilizing the focus group participants to check the researcher's documentation and data (Creswell, 2016). Focus

group participants were asked to review the transcription for accurate interpretation, missing data, and to ensure their topical opinion was appropriately documented. The focus group participants communicated through email. The participants immediately provided feedback through those emailed exchanges. No changes or concerns were identified by the focus group participants. All participants were provided the opportunity to review their recorded statements and to provide clarity as needed. Member checking ensured that the researched data accurately reflects a participant's statement and viewpoint (Stringer, 2007). Credibility was established through data collection that presented as plausible.

Transferability. Transferability was when findings were not generalizable and had the potential to be transferred from one specific context to another specific context (Herr & Anderson, 2015). Due to the utilization of a convenience sampling, the outcomes of the study were not generalizable. The findings were not applicable to all individuals other than the focus group participants due to the methodology being nonprobable in nature (DeVellis, 2012). The study findings could be utilized in other communities although they cannot be applicable to every community setting like Wichita County, Texas. The transferability can be accurately identified by other sites that identify that the data provides contextual similarity to their own situation (Herr & Anderson, 2015). This action research project could inform other research studies.

Limitations and Problems During Data Collection. An action research project heavily relied on the dynamics with a researcher joining a group of people or an agency who already identified a community problem. The researcher facilitated the research

direction and ensured the action group followed established research values and practices. The participants identified the heart of the problem with varied subissues, subsequent barriers, and solutions or actions needed to address such concerns. A convenience sampling has naturally emerged for utilization in this study. Convenience sampling was defined as a selection of individuals who were available to participate and easily accessible such as the ECC members.

The very nature of this action research project depended on acquiring volunteers who worked with the ECC and have helped identify a community problem. Accessing a sample solely based on social work training and licensure characteristics was limited due to ECC association and sampling a resource limited rural community setting. The emailed contacts had a history of volunteering in the ECC or were interested in the ECC's mission with TIC. Due to complex and odd state practices of grandfathering professionals into social work licensure, the primary requirement for participants was to be a member of the ECC and/or to have experience in social work. Six of the seven participants were licensed with either a master's or bachelor's degree in social work, or directly worked in social work. The seventh participant was a master level licensed professional counselor who oversaw mental health clinicians with varied fields of education and licensure including social work. Each participant had extensive and rich history in the field of social work and/or social services, and all gave valued input and insight to an extensive community problem.

Findings

Characteristics of the Sample

Recruitment for study participation was focused on participants in the ECC due to the design of an action research project. The initial goal was to solely recruit participants who were licensed in social work, working in social work, and a member of the social work action committee in the ECC. The ECC was encompassed of varied professionals from all professions. All the members of the social work action committee were not all licensed nor formally educated social workers. The region is primarily rural, and resources are fairly limited to accessing social work professionals. The state of Texas has a history of grandfathering individuals into social work who were not formally educated as social workers. A total of seven individuals from the ECC responded to the call to research. Pseudonyms were used to protect the identity of the participants. The following section provides a self-reported and anonymous demographic overview of the participants.

Demographics of the Participants

Subject 1 was a social worker. They had a master's degree in social work. They had training and expertise in TIC and Trust-Based Relational Intervention. At the time of this study, they worked at a public school district.

Subject 2 was a program supervisor in mental health. They had a Master of Arts degree and a Bachelor of Arts degree in Social Work. They had training and expertise in mental health. At the time of this study, they worked at a private agency with a public contract.

Subject 3 was a Substance Abuse Counselor. They had a bachelor's degree in social work and worked as a licensed chemical dependence counselor. They had training and expertise in outpatient chemical recovering and protective services for women. At the time of this study, they worked at an outpatient care program for substance abuse.

Subject 4 was a licensed chemical dependence counselor. They had a bachelor's degree in social work and was a licensed chemical dependence counselor. They had training and expertise in substance abuse services. At the time of this study, they also worked at an outpatient care program for substance abuse.

Subject 5 was a licensed professional counselor. They had a Bachelor of Science degree in Psychology and a Master of Science degree in social work. They had training and expertise in adoption, foster care, trauma, resources, early childhood development, education, and mental health. At the time of this study, they was a volunteer for supporting at risk families.

Subject 6 was a licensed professional counselor and team supervisor. They had a Bachelor of Arts degree in Psychology and a Master of Education in Counseling. They had training and expertise in mental health services and clinical supervision. At the time of this study, they worked at and supervised an outpatient mental health program.

Subject 7 was a care coordinator. They had an associate's degree in sociology and a Bachelor of Science degree in psychology. They had expertise in mental health case management, family violence, and substance abuse treatment. At the time of this study, they worked at a nonprofit community outreach agency.

How the Findings Answer the Research Questions

In Wichita County, Texas, there is a consistent rate of children who are developmentally not on track in their stages of life that continued to increase (ECC, 2018). The ECC identified trauma as the primary cause of developmental delays in those children. In response to the community problem, the social work action committee voted to create a trauma-informed capacity-building program due to a lack of substantial, relevant, and effective TIC across the county. The study's research questions were the following: (a) What capacity-building program content will help assess and improve an agency's policy and procedures for entire system readiness in delivering effective TIC and help improve a client's ability to develop resiliency? (b) What are the challenges or barriers to creating a trauma-informed capacity-building program and how may those challenges be overcome?

After a systematic review of the focus group data, a total of five primary themes and 23 subthemes emerged. These themes were indicative of barriers faced by families and service providers in the community, and what capacity-building content was needed for delivering effective TIC. The primary themes included the following: the need to expose all community agencies to TIC; use of a universally accepted trauma informed language, preventing retraumatization of service recipients, use of Person-Centered Treatment; and encouraging complete agency buy-in with follow through. An outline of the study themes and subthemes are found in Table 1.

Table 1

Primary Themes and Subthemes

Primary Themes	Theme 1 Trauma-informed Care	Theme 2 Prevent retraumatization	Theme 3 Universally accepted trauma-informed language	Theme 4 Person-Centered Treatment	Theme 5 Agency buy-in and follow through
Subthemes	Exposure to Adverse Childhood Experiences	Multidimensional trauma informed care	Definition for trauma	Identifying bad vs. trauma induced behavior	Uninformed agency leadership
	Determines what comes next after ACES exposure	Unified and informed treatment team		Identifying the need for discipline vs. trauma-informed treatment	Leadership Apathy, Disconnect or Stagnation
	Improve community knowledge of violence and abuse	Safety and security while receiving services as perceived by client		Client choices, self-determination, empowerment	Trauma-informed training for front line workers with access to trauma-informed trainers.
	Access to trauma-informed trainers	Customer service given through trauma-informed lens		Trust Based Relational Intervention	Staff Safety, Debriefing, and Trauma informed Follow Through Protocols
	Improve reading, writing, and motor skills in children	Service provider knowledge of poor community transportation		Resource Mapping	Consistent funding
					Provider self-care and health assessment
					Policies and protocols with clear directions reflecting trauma informed care

Primary Theme 1: Trauma-Informed Care

In addressing Research Question 2, the focus group participants identified a barrier to creating a trauma-informed capacity-building program. The participants identified how the community and many social service agencies did not know what trauma was and identified the need for evidence based and relevant training. They identified how little access families had to trauma-informed care and why this was common in Wichita County. The participants shared their experiences in local research and training in trauma-informed care as an action committee member of the Early Childhood Coalition. The focus group participants emphasized the continued importance of educating the community on trauma and TIC.

Adverse Childhood Experiences

Most participants discussed their support and continued promotion of training with the ACE survey as its foundation but desired to move deeper into TIC.
Paula stated the following:

> I've not been that active the past year but prior to ACE trainer, the ECC was really trying hard to help kids reading skills up, to fine motors skills up, and help has all network and know each other so that we could serve the families and refer families. A lot of people that are involved with the ECC administration have an education background and worked in the school system. So, it was a big eye opener to be exposed to trauma-informed care and ACES. They became very passionate about it and oh my gosh this would totally change a Childs experience in school and the relationship between the teach and the child. Oh my gosh, this is gold. It's really an evolution and wake up, I think.

Sara stated the following:

> I think that part of this would be to learn to identify [trauma] using the ACES. Getting that more well known to healthcare providers and to educators, administrators, the community, other community resources, and then to minimize the effect of trauma through early intervention, counseling services, social services, and community cooperation.

The participants heavily identified the need for community wide education on trauma and the justification for trauma-informed care. They affirmed the effectiveness of ACE training. The participants identified their own experience of needing training in trauma both personally and professionally. Their passionate desire to share their experience and discovery with others was evident throughout the focus group. Most of the participants have participated in county wide education on ACES and expressed eagerness for the next step.

After Community Wide Exposure to ACEs, What Comes Next?

All of the participants agreed that learning about ACEs was a revelation in regard to understanding the correlation of trauma with poor academic performances in their county. No one was satisfied with just educating the public on traumatic experiences. Sissy stated the following:

> I will say that I seen a lot of community awareness part of campaigns in regard to ACES and things like that which I think is phenomenal. I think the primary things that I might add. Maybe a gap that I see is maybe what comes next… I think that to me is a pretty big area that could be served, is the what comes next one I'm

> able to identify a child with trauma, once I know why their behavior looks like they do and how could I address it in a way that's appropriate for my setting and for my education and things like that.

In agreement, the participants were concerned that their action committee was not performing much action. They were satisfied with progress in educating the varied communities on trauma. Unfortunately, they could not identify action items or plans that were being implemented to reduce the amount of trauma being experienced in Wichita County. One of the actionable steps they identified was increasing access to trauma-informed trainers.

Access to Trainers

From agency to agency, there was no identified equality of trauma-informed services. Sara stated the following:

> I guess it depends on the agency you're talking about. For instance, I've been talking with the school district and them being trauma-informed has been a challenge because the teachers don't have the capacity to get all the trainers, the social workers or counselors yet.

Throughout the recent years multiple ACE training sessions have been given in varied forums from ECC. The focus group volunteers identified the continued need for training. They identified the need for agencies to have their own trauma-informed care trainers and specialists in order to maintain relevant and evidence based practices. They felt that

successfully addressing trauma for the long term will only come from within each agency.

Knowledge on Violence and Abuse

Participants continued to emphasize the importance of educating the general public on traumatic experiences that are occurring in the county. Rosie stated:

> To me, we need to improve the knowledge in the community about violence and abuse, and how to ID these children. Like somebody said, instead of it being just a problem child. What trauma is there.

Since the Early Childhood Coalitions primarily addressed local school district leadership, it was natural to see quick progress of trauma-informed education within the education districts. Unfortunately, the movement stalled when training did not continue within the agencies themselves. The focus group participants identified the need for long term investment in agencies for trauma-informed care.

Primary Theme 2: Prevent Retraumatization

The focus group addressed Research Question 1 in identifying how to improve an agency's policy and procedures for entire system readiness in delivering effective TIC and improving a client's ability to develop resiliency. Receiving help is challenging for most adults in any given situation. It is particularly challenging when adults feel vulnerable and insecure. Receiving help can even be harmful if the client has historically endured poor experiences with any form of social services. The group identified practical solutions in answering Research Question 1. Nancy stated:

> I know for the Social Work Committee, it's to prevent the retraumatization of

> adults so that it doesn't trickle down to their children. To stop that cycle of ACES and trauma.

As professionals currently working in the field the focus group participants were quick to identify the need for companies to improve, evolve or even completely change their policies and practices to address trauma.

Unified and Informed Treatment Team

In response to reviewing the trauma-informed, walk-through assessment within the same topic, Rosie stated:

> The one that caught my eye was the service policies and specifically number three and it touched on about the retraumatization [of clients]. How can we get from point A to point B and not retraumatize? Making sure that everybody on the treatment team is on the same page on how we are to do that.

Every person responds different to an identical life experience. The participants highlighted how a client may be specifically retraumatized by their experience in receiving services. Their response was that services must be individually tailored or person centered and meeting them at where they are at. So you must get to know your client as the focus group participant identified in the next subsections.

Service Provider Knowledge of Public Transportation

Although the main town in the county was a metropolitan due to population census, most of the communities within this county were rural farmland. Resources were extremely limited, even in the main town. Paula identified a significant concern for the vulnerable and impoverished clients:

> [It] definitely affects all of the different agencies to be aware of the lack of [public access to] transportation to receive services. I think a lot of the agencies are insensitive to that and their delivery of services. Even preCOVID, people weren't getting help that needed help and there were agencies that were unwilling to be flexible and modify when they could. That stood out.

Customer Service Given Through Trauma-Informed Lens

A cornerstone concern throughout social work literature focused on how both clients and service providers may have a history of traumatic experiences. Retraumatizing the clients and providers was a sincere concern during provisions of service.

In regard to the client's perspective, Nancy stated:

> …focus on customer service that's being given through these agencies so that people have access to what they need in a way that is kind. To put it simply, that realizes where people are coming from and give them what they need so that they are not threatened, or they don't avoid getting help.

Multidimensional Trauma-Informed Care

In Wichita County, the primary approach to bringing trauma-informed care has solely been academic or informational. TIC has been presented through the educational system but not implemented in varied agencies across the county. The participants desired to see TIC as a foundational element in all aspects of community helping services.

Sissy stated:

> I also think that there's an element of recognition that trauma-informed care and

> practice is multidimensional. It really has to trickle down in all of those different areas because just integrating trauma-informed care into a school when it's not being integrated into other aspects of the community isn't enough.

Safety and Security While Receiving Services

Not all fields of practice in the helping services have the same ethics and principles guiding their work. Often, safety comes through protocol response. Paula stated:

> Okay, right now I work for a social service agency run by a social worker. Self-determination, confidentiality, all those values are there. However, we partner or have to work with other agencies that aren't like that but we share clients and customers. Just somehow, I don't always see that same respect for confidentiality at the other social service agencies because they are not social workers. They don't have those values and ethics.

The participants identified the need for service providers to understand that a traumatic experience can influence all perspectives of a clients life. Therefore, they believe it was imperative to approach each client looking through the lens of trauma. They identified the need for all agency's policies and practices to reflect that understanding. Most importantly, they identified the need to meet each client where they were at in their life. The study participants identified the need for this type of trauma-informed care to be uniformly practiced throughout Wichita County in order to prevent retraumatization of clients. Part of that uniformity is a common language.

Primary Theme 3: Universally Accepted Trauma-informed Language

To expect the same results across the community there must be a unifying bond through communication. The participants agreed that each agency must have the same understanding in trauma-informed language. The group addressed a common concern for both question one and two in identifying the barriers to creating a trauma-informed program and what content it needs. They identified the concern of needing a universal language within TIC. Sissy stated:

> Education for the families being coupled with that and everyone speaking the same language, I think is a really big barrier that I see but across the board in different agencies and that multidimensional kind of arena.

Rosie stated:

> Something that I have seen over the years is a stumbling block for trauma-informed care, the definition of the word trauma across the board in all the facilities, instead of having in the one facility as this is what it means and different over here in the other facility, just have one [definition] cross the board for trauma.

Since each participant comes from varied work field sites they were easily able to identify the differences and challenges that arises from those fields of practicce. Communication was a major concern that was brought up. The participants identified a need for a unified definition of trauma and trauma-informed language in order for each client to receive the appropriate and evidence-based treatment as needed. They felt that ACES laid that educational foundation. The participants desired for that unified trauma-informed

language to reflect in policies and best practices for clients and patients. Another uni-formed approach to trauma-informed care was person centered treatment.

Primary Theme 4: Person-Centered Treatment

The participants focused on social work characteristics and modality practices as in Person-Centered Treatment that considers strengths and weakness in treatment. The focus group identified common issues that touched both research questions. The focus group identified that not having a Person-Centered Treatment approach created not only a barrier in TIC but should be a foundational perspective in creating trauma-formed policies and procedures. The group identified the importance of understanding the client's entire perspective of receiving services and why as described in the following subsections.

Identifying Bad Behavior vs. Trauma Induced Behavior

Sara identified an important concern that school district teachers did not having the resources, capacity, or training:

> Getting everyone the education they need. Recognizing the symptoms of trauma and knowing what is just bad behavior. And what is a behavior as a result of trauma and how to discipline it appropriately.

Resource Mapping

Similar to empowering their clients in a person-centered treatment modality was helping clients successfully access resources themselves. Sissy stated:

> Another thing that we had talked about was trying to get an [application] that has a list of resources that are very easily accessible. If you think about computer

> programming, we would gather from each agency. If you're pregnant and this is your first child and you're within so many weeks, the best resource is probably going to be the nurse family partnership. If you're beyond those weeks or this is not your first pregnancy we might look to adoption, kind of knowing so that we can best use our resources and send people to the best place for their current situation. It would be almost like a cascading list. It sounds complicated but it can get that way I guess. The way professionals know. We all know where to send people and we all know what the rules are for the other agencies because if somebody has to have a picture ID to go somewhere, we can work with them. If they don't, we're not going to send them there because we know they have to get it before they go to that door.

Sara stated:

> The term resource mapping can be a little confusing because it doesn't literally involve a map. It just involves conducting and consolidating a list and a referral process like you mentioned details that a family would need to know in order to get their services. It's a lot of community collaboration. Social work traditionally encourages a Person-Centered Treatment. Literature illustrates the long-term effectiveness of treatment when the power to change is within the hands of the client themselves. When reviewing the trauma-informed walk-through assessment the participants mentioned the components that they desired to focus on.

Sissy stated:

> I really was drawn towards the section about choices simply because I find it so

> integral in trauma-informed care and working specifically with children. We utilize choices a lot in the work that I do to provide a level of self-determination to allow our kids to get out of that amygdala and up to that prefrontal cortex. For me, I think that the more that is integrated in any kind of environment that is going to claim to be trauma-informed the better. From the moment that someone makes that initial call or has a first contact, I think that there needs to be just an influx of that because so many of the families that I work with, and I know that probably most of work with, have lived a life where choices really weren't afforded to them. Teaching them that their voice matters, that their determination for their goals and their treatment, all the way from our little kitties to our adults that have lived this for years and years, I think is very important.

Sometimes what is the obvious answer to the social worker is not the actual solution that the client really needs. For example a child does not always act negatively because they are bad. Maybe they are simply scared of walking home. The focus group identified that the client is the one who really knows themselves the best and at times simply needs a hand. The group identified community wide needs that if resolved could have a profound affect. In order for a social worker to encourage the client to reveal personal needs—trust needs to be developed. The next subsection addresses provider to client interaction.

Trust Based Relational Interventions with Trauma-Informed Care

Only one participant was certified in Trust Based Relational Interventions (TBRI). In an effort to answer Research Question 1, she identified the TBRI model's principals of connecting, empowering, and correcting, which were supported by all

participants. TBRI addresses complex developmental trauma that has a lasting effect in children. The focus group participant desired to ensure that policies and procedures create staff competency in treating clients as if they have endured life changing trauma.

Nancy stated:

> I know when I worked at the state hospital when they rolled out their trauma-informed care [program], what they called Healing Today Hope for Tomorrow. I worked on the admission team. I can admit that when I went to that training and they were like, "What are you going to do when somebody grabs your wrist." I was like "I'm going to twist out of it and tell them to step away." My safety was first and that was my thought but that training they did a good job to say well, "While they do it it may not always be a violent grab." To help us [as providers] to respond less rash and less always on the defensive. Over the years, after that training I really saw a different way to direct your staff even dealt with the client. Think about what did they experience before they got to our doors. That might be the reason they're acting this way and we need to handle people differently. I think something too when I worked at [another local community agency] the training was person-centered planning. That's part of it too is to look at the person and where they came from and the plan for them. That, of course is going to be trauma-informed care. We were informed of their history we're going to plan to them personally. I think there can be buy-in in these big agencies… People getting better, faster, staff were happier That's what the administration has to see those number from places that it worked and to say this is going to be better all

the way around.

Social workers naturally lean towards ethics and principles that guide their field of practice. The focus group participants were no different. They highly emphasized the need for self-determination. The participants emphasized and highlighted the need to look through the client's perspective in order to understand the choices or lack of choices they have due to limited community resources. In turn, the social worker may effectively assist the client to empower themselves.

Primary Theme 5: Agency Buy-In and Follow-Through

The participants respectfully identified their experiences with local agencies that were owned regionally and abroad. This was another theme that addressed both research questions. Not only did the focus group identify what capacity-building program content would help assess and improve an agencies readiness to deliver TIC, they also identified the local systematic challenges or barriers to creating that trauma-informed, capacity-building program. Some of the concerns were emotionally charged to the participants as they tried not to express their frustrations with systemic problems.

Exposing Leadership to Trauma-Informed Care

Often leaders invest into what they are passionate about or trained for. The focus group participants identified a common concern that they experience with policy makers and leadership in companies. Problems that are not made known to leadership may never get addressed.

Paula stated the following regarding the exposure to TIC:

The one that would be in charge of training and policy making do not necessarily

> have a social work or psychology or human service background and so they have not bought into the entire idea of being traumatized and the population that crosses their door.

Front Line Workers Being Trained

If the leadership is not invested into trauma-informed care there is a possibility that the front line staff will not be concerned about trauma-informed care. Furthermore, even if the staff is concerned about trauma they may not be educated in trauma-informed care. A situation involving may be identified but not properly addressed.

Nancy stated:

> Speaking to that one of the barriers is that one, the frontline workers at that job don't have any education. Well, it doesn't require education. From the state down, the idea is just almost like a call center and their regulations come from [the state capital]. I think that's the barrier to those big agencies is that they don't have control locally. It's not even local people that is interviewing our clients here in Wichita. That's another issue with those big agencies is that they've gone statewide with how they pull cases. They don't know our local people, they don't know our local businesses, and I've seen that to be a barrier to clients.

Funding Challenges

There is an old adage that if you follow the money you will follow what a person is passionate about. Many agencies rely on grants and government funding. Both of those money sources are short term and need to be reapplied for. Often times the funding

source depletes depending on the current political administration's humanitarian focus. There is a roller coaster like experience with fiscal support. The focus group addressed this concern.

Rosie stated:

> Another thing I was thinking about also is the funding. Getting funding that will not just fund it for 1 year or 2 years, or 5 years, but funding across the board indefinitely, about what we need to get going, instead of losing the funding, and then trying to start it up again in 6 months, or 1 year, or whatever. Just keep it consistent with funding.

Environment that Encourages Provider Self-Care and Health Assessment

An area that the participants identified in the helping profession was that the health and welfare of its providers and practitioners is often overlooked. An unhealthy social worker can be a harmful social worker. An unidentified focus group participant spoke on the very fact that many staff get into the field to help others because at one time they received services or wish they had received services when they needed it. An agency administration needs to be aware of practices that retraumatize their own staff. All of these concerns are reflected in the following subsections.

Sara stated:

> I work for an agency. They're very good about this and making sure that we care for ourselves. They make sure that we make family and self-care a priority, especially admits COVID, but they also educate on the effects of retraumatization and the signs of it and knowing when you need a break and if something is

triggering to you when providing services to another family. There's always supervision available to each clinician and then the possibility of transfer of supervision if that isn't enough. I don't know if that can be applied to every agency but that's how we try to prevent it. I think the [trauma-informed walk through] assessment is pretty thorough. It looks excellent and that it could be overwhelming but maybe a chunk at a time on tackling each of the issues because there's a lot of detail on it but it sounds great and beneficial, yes.

Staff Safety, Debriefing, and Trauma-informed Follow Through Protocols

The focus group identified the need for agencies to have practices and policies that protect the staff. Concerns for physical and mental health wellbeing of social workers were identified in daily work activities. They also identified practical solutions to those concerns. As they mentioned, a healthy staff an healthily serve their clients.

Paula described multiple safety concerns and stated:

Another thing is security. None of my clients have never mentioned it as an issue or seemed a concerned and I guess I just took it for granted doing street social work that safety is an issue. You go to hotels in the middle of the night, there's not enough of staff to have somebody with you. Oh there's something we an do about that and be aware of that. Wow what would that look like… I used to tell my students, before you start helping, make sure you've healed because your broken parts are going to hurt others and you're not going to be objective. If you were in an abusive relationship, you're going to project what went wrong with that relationship onto the client at the shelter when their situation could be

> different. I think everybody needs to take a self-assessment and I think the supervisors at all agencies need to be very aware of that. Then also, I've just worked for a lot of agencies where maybe you are the only social worker there. You're hearing heavy, heavy stuff from clients and there's no case team, no debriefing. Some way to get that need met of debriefing and someone to talk to you to help you. I have formed an informal relationship and partnership with some people at that different agencies just because of that need.

Blanca supported the need for leadership support. She suggested the need for agency leadership to be invested in comprehending trauma. More specifically she desired leadership to address trauma in all phases of their business practices:

> When you were talking about barriers in the implementation everybody said things that I was going to say, so it wasn't that but for us we had the buy-in from leadership in words but it wasn't in the action. It really for us, that was our barrier and again, obviously we had no money but we had people who had no problem asking for money. We figured out as we went but it really was a grassroots effort for us. We started at the grassroots level. We got our case managers and the people doing the direct care every day to understand what it was for, the education, why it's important and to see that it's working. Then when leadership saw that we got policies and procedures and contracts and things like that added with the language. There was [follow through]. When I saw it in action and they saw improved outcomes for people that we served and they saw deeper

connections, then there's a little bit more action behind it because it was working.

In support of Blanca's statement regarding leadership, Paula encouraged the utilization of internal assessments within an agency. She also gave insight into how an assessment could be successfully implemented:

> I think the [trauma-informed walkthrough assessment is] a useful tool. I just think it needs to maybe come in sideways, the backdoor or after a relationship and rapport.

Leadership Apathy, Disconnect, or Stagnation

Nancy and Blanca had addressed a very challenging topic in identifying some willful opposition to changing the way agencies assist their clients. Not only were barriers identified but they included ways to address those concerns in a humble fashion.

Nancy stated:

> Maybe if we developed the training first and we just started offering that for free and then in that training, when we talked about these are the benefits, this is a black and white on paper benefit to having this assessment and having deeper training with your staff in your specific agency to what you do. The fact is we know what agencies in town have these barriers. Those of us who have been working in the field for so long and living in this town we know. We could probably fill out the walkthrough for some places. We know they need the training and they could get it for free and then maybe they would buy-in and say well let's see exactly where we need more training on.

Blanca stated:

> …The people that need it are not receptive to it. We've had some things that have been mandated by the government and people still aren't doing it.

Policies and Protocols with Clear Directions Reflecting Trauma-Informed Care

Blanca succinctly summarized her perception of barriers seen in many local agency's policies and protocols in serving clients. Her concerns not only addressed the clients trauma or retraumatization but the health and well-being of the staff serving them. She ended with a very simple yet poignant question.

Blanca added:

> Again, everybody seems to talk about that safety and security piece but for me it goes deeper than that. It's not just the physical safety. It's also the emotional safety of both the people that we're serving and the people that are serving. For both. My thoughts are some clear expectations and policies and procedures and things like that. These are the expectations. Then some education. if you are having a hard time. This is what you are doing. If you're having problems give a protocol for that because sometimes it's not always about the physical safety, sometimes it's about the retraumatization as we talked about previously. Having very clear direction on what these things are going to happen and that's okay. What are we going to do?

Impact on the Social Work Practice Problem

In the current section, the researcher reviewed the social work practice problem for primary and subthemes that were identified from the analyzed data provided by the

focus group participants. The study's practice problem involved the issues that service providers have in addressing the high rates of children who experienced or are experiencing trauma in Wichita County, Texas. The two research questions are Q1: What capacity-building program content will help assess and improve an agency's policy and procedures for entire system readiness in delivering effective trauma-informed care and help improve a client's ability to develop resiliency?Q2: What are the challenges or barriers to creating a trauma-informed capacity-building program and how can those challenges be overcome? This section describes the impact that the aforementioned social work practice problem on Wichita County from the perspective of the focus group participants as they answered the two research questions.

In Primary Theme One, Trauma-Informed Exposure, the study findings aligned with the practice problem because exposure to traumatic experiences was the common component with children who displayed low academic and poor life stage milestone development. The participants were able to present answers to both research Q1 and Q2 in identifying barriers in creating a trauma-informed program and what is needed in that capacity building program. According to the focus group participants, it was imperative for all service providers and families to become familiar with the concepts behind the ACEs psycho-education and become trauma-informed. More importantly, the participants identified the need to examine creating service provisions designed through the lens and understanding that every person potentially had or experienced a trauma.

Sissy perfectly illustrated a social worker's micro, mezzo, and macro mindset in asking what is next: addressing the larger picture. Sissy explained, "…how could I

address it in a way that's appropriate for my setting and for my education and things like that?" The focus group identified the importance of moving on to the natural next step in providing interventions.

The concern for follow through naturally led to topics identified within theme two of Preventing Retraumatization. Again, the participants were able to present answers to both research questions in identifying barriers in creating a trauma-informed program and what is needed in that capacity building program. Nancy quickly identified that clients often become retraumatized while receiving services that were intended to help them. A simple concern that often was not considered by many practitioners was the demographics of the vulnerable and impoverished clients. Paula stated that a lot of agencies are insensitive to the fact that clients may not have transportation to get to an appointment. Wichita County has very little and limited public transportation, increasing travel difficulties. Many of the service hours for public transportation do not coincide with social service hours for a client to make it on time to an appointment or even return to their residence.

A section of the explored trauma-informed walk-through assessments involved safety and security. Both Sissy and Nancy remarked on the need for multidimensional TIC. To avoid retraumatizing any patient, all practices by service providers should reflect the understanding that every patient has the potential to have been exposed to trauma. Rosie aptly identified this requirement to make "sure everybody on the treatment team is on the same page on how we are are to do that."

In connection to retraumatization, language was discussed with the participants.

Theme three emerged with discussing the need for a Universally Accepted Trauma-Informed Language. Sissy identified the need for everyone to use the same terms and definitions when it comes to trauma-informed care. Sissy explained that in order for trauma-informed care to permeate all services, there must be usage of the same trauma-informed language. Rosie simplified the concept through her idea of having a commonly accepted definition of what trauma is. Both participants identified foundational concepts in addressing both research Q1 and Q2 with identifying barriers in creating a trauma-informed program and what is needed in that capacity building program.

Again, research Q2 was addressed in identifying what is needed in their proposed capacity building program in theme four. Theme four identified the need to return to a foundational component of social work found in Person-Centered Treatment. Sara identified the importance of treating each individual as individuals. She identified the need to create resources, capacity, and training so service providers can recognize if a child's behavior is simply a concern of youthful indiscretions, or a direct result of traumatic exposure symptoms. After, appropriate actions or referrals can be immediately and directly completed, no matter their position. That is personalize treatment intervention.

In the discussion about Person-Centered Treatment, social work concepts of empowerment, choices, and self-determination were discussed. Sissy explained a concept that the social work action committee has been working on: Resource Mapping. Resource mapping is a way to condense and identify all social services within a community. This can only be accomplished through community collaboration of agencies who share their

service provisions and incremental requirements for access. Resource mapping created a short but comprehensive list. This map enabled a client to identify their needs and how to meet them without losing time and resources by going to the wrong services.

Theme five was Agency Buy-in and Follow Through, and was a challenging topic to discuss research Q1 as it addressed grassroot barriers to creating a trauma-informed capacity-building program and how can those challenges can be overcome. This involved interest from all members of the community concerned with the social work practice problem. Paula began by explaining how if one wants change, they must start at the top of an organization. Paula noted that leadership must be exposed to trauma-informed care for results to be successful in a community.

Participants identified that upper management in several local agencies know of the changes that need to occur, but are not willing to make structural changes to their company. There was general insight given by participants who know of local agencies who do not following statewide changes in laws regarding client services. That same kind of leadership apathy or defiance may be the reason why agencies are not trauma-informed and rely on outdated modalities of treatment.

Fortunately, Blanca identified an agency that started at the grassroots level, made changes, and had healthy results for performance outcomes for staff and clients served. The changes were seen as beneficial for clinical treatment, but also for their business model's bottom line. It was identified that when the business bottom line is financially successful, the fear of financially investing back in your staff and organization decreases. An example of poor investment in an agency was given by Nancy who explained that not

all frontline workers have an advanced education and may need further training.

Sara further addressed that staff who are clinically trained may experience burn out, compassion fatigue, or vicarious trauma, due to their workload or type of workload. She identified that her company's priority was in the health and welfare of their providers. Sara identified how her administration and management ensured that practices were in place to check the health of each practitioner. In support, Paula bought up concerns of staff and patient wellbeing due to the forgotten practice of caseload debriefing.

The next section will address unexpected finding from the focus group data.

Unexpected Findings

The ECC was primarily founded and organized by professionals in the education field. The original mission was to improve academic and life stage milestones for children. Therefore, there was a natural expectation for the researcher to see the field of education to lead the local community with trauma-informed interventions. Within theme five, Agency Buy-in and Follow Through, was a subtheme called trauma-informed training for front line workers with access to trauma-informed trainers. This concern was identified within the school districts. The individuals with the most exposure time to children reportedly had the least amount of trauma-informed training and least amount of access to trauma-informed trainers. The focus group participants were very passionate in identifying the need for continued training for sustaining long term trauma-informed care.

Summary

Section 3 of this action research project gave an overview of the study's findings.

The chapter included a review of data analysis techniques, the study findings, and a summary of the results. The research questions were the following: Q1 What capacity-building program content will help assess and improve an agency's policy and procedures for entire system readiness in delivering effective TIC and help improve a client's ability to develop resiliency? Q2 What are the challenges or barriers to creating a trauma-informed capacity-building program and how may those challenges be overcome? The social work practice problem involved the development of a capacity-building program to implement trauma-informed care throughout the community to address trauma with local children, their families, and the social work agencies that serve them.

The study participants provided insight and practical application towards unifying the community to successfully reduce or prevent the effect that trauma has on children. The participants identified primary themes: the need to expose all community agencies to trauma-informed care; use of a universally accepted trauma informed language, preventing re-traumatization of service recipients, use of Person-Centered Treatment; and encouraging complete agency buy-in with follow through. In the study findings, there was identification of unexpected findings, particularly that trauma-informed training for secondary school frontline workers was minimal, and access to trauma-informed trainers was nonexistent.

The purpose of this capstone project was to support the development of a trauma-informed capacity-building program to assist service providers. In Section 4, the researcher provides a robust discussion of the practical application of the study's findings to social work ethics, recommendations for social work practice, and implications for

social change. The section includes recommendations for future research as indicated by this study's findings. Recommendations can aid in the exploration of connected practice problems and their potential solutions.

Project Section 4: Application to Professional Practice and Implications for Social Change

The practice focus research questions of this project were: Q1 What capacity building program content will help assess and improve an agency's policy and procedures for entire system readiness in delivering effective trauma-informed care and help improve a client's ability to develop resiliency? Q2 What are the challenges or barriers to creating a trauma-informed capacity building program and how may those challenges be overcome? The purpose of this capstone research project is to support the development of a trauma-informed capacity building program to assist service providers. The social work long-term practice problem focuses on the Early Childhood Coalition helping social service agencies reduce or prevent the affect the trauma has on children. This writer used an action research design to discover the factors that impede trauma informed-care in Wichita County. This writer conducted a study and identified what program content will improve an agency's trauma-informed services in Wichita County.

Key Findings and How They Inform Social Work Practice

This writer worked with seven members of the Early Childhood Coalition's social work action committee. They were interviewed in a focus group to learn about their perspectives on trauma-informed care given by community agencies and creating capacity building content to improve those services. During the focus group, the participants identified multiple themes that were consistent with literature on trauma-informed care. These themes were indicative of barriers faced by families and service providers in the community and identified what capacity building content is needed for

delivering effective trauma-informed care. A summary of the themes were: trauma-informed care, prevent re-traumatization, universally accepted trauma-informed language, Person Centered Treatment, and agency buy-in and follow through. The social work action committee members revealed the unexpected challenge that workers exposed to children the most have the least amount of trauma-informed care training. The key findings of the study informed social work practice by recognizing existing barriers to implementing trauma-informed care. The findings also identified what capacity building program content will help assess and improve an agency's policy and procedures for entire system readiness in delivering effective trauma-informed care.

Findings and Knowledge in the Discipline

Due to lack of generalizability, the current research project findings has limitations when it comes to extensive application of knowledge in the field of social work. Fortunately, if there are similar regions like Wichita County, this study may have effective inferences for social work practice in the state of Texas. A recent study of two hundred and twenty-six participants identified that creating effective community based interventions is key to the construction of personal resilience in order to mitigate the effects of trauma (Ross et al., 2020). Despite the vast body of research on trauma, in the last two decades, Ross et al., (2020) identified the lack of trauma assessing and subsequent assignment of trauma-informed intervention programs. Creating a trauma-informed assessment and providing capacity building for interventions program is exactly what the focus group addressed.

Need for Trauma-informed Care

1,649 students completed the Early Development Instrument (EDI) surveys in Wichita County (ECC, 2018b). The EDI results identified where children are vulnerable, at risk, or lacking in healthy development. Without being physically and mentally healthy, children will not attain elevated measures of skill in the EDI domains (Webb et al., 2017). All of the categories find these children are either vulnerable or at risk and are not on track for healthy development. More specifically, 24 out of 45 communities were within the range of 51%-80% in the proportion of children developmentally not on track on one or more domains. More than 2000 studies in this last decade have identified that traumatic experiences in a child's life is a permeating concern that effects every milestone (Ross et al., 2020). All of these challenges to healthy childhood development have been connected to traumatic events in a child's life and justify trauma-informed care provisions (Early Childhood Coalition of Greater Wichita County Area, 2018b).

The focus group overwhelmingly voiced the need for effective interventions that addresses trauma-informed care. Even with the common usage of the Adverse Childhood Experience survey in primary care facilities: trauma-informed care interventions are rarely being utilized (Poole, Dobson & Pusch, 2018). The Early Childhood Coalition would extensively benefit from understanding what the social work action committee identifies as the greatest need in reducing the effect of trauma on children and their families. That knowledge would be directly applied by the Early Childhood Coalition to develop a trauma-informed capacity building program to assist social services. Ungar (2015) believes that a child's resiliency is a direct reflection of the community that they

live in. Unfortunately, across Wichita County, social services do not universally reflect the urgency that 24 out of 45 communities have substantial amounts of children who are not meeting their developmental stages as directly influenced by trauma.

Re-iterating what Sissy stated:

> I will say that I seen a lot of community awareness part of campaigns in regard to ACES and things like that which I think is phenomenal. I think the primary things that I might add. Maybe a gap that I see is maybe what comes next… I think that to me is a pretty big area that could be served, is the what comes next one I'm able to identify a child with trauma, once I know why their behavior looks like they do and how could I address it in a way that's appropriate for my setting and for my education and things like that.

The focus group participants agreed on the urgent need to have tangible grassroots implementation of trauma-focused care programing.

Prevent re-traumatization

Trauma-informed care has unique characteristics that are intentional in design: to recognize the commonality of trauma and to prevent re-traumatization while providing services (SAMHSA, 2014). The Substance Abuse and Mental Health Services Administration in the United States identified that it is essential to have intentional trauma-informed practices (Bent-Goodley, 2018). The principals behind the development of trauma-informed practices will not focus just on clinical treatment but that the entire organizational services are performed in a way that avoids further harm to a patient.

Therefore, service strategies, clinical treatment, and delivery must look through the conceptualization that all clients may have experience trauma. So the goal is to avoid re-traumatization or the reinforcement of vulnerability and disempowerment felt by the client (Levenson, 2020). Trauma-Informed care understands that a child's experience with trauma is very the foundation in understanding their current presenting challenges. For over decades the Adverse Childhood Experiences continues to support this ascertain that looking through the lens of trauma is imperative to avoid re-traumatization and to address current effects that trauma creates (Larkin , Felitti, & Anda, 2014). The focus group heavily emphasized the importance of assisting local agencies with capacity building services to create or improve county wide trauma-informed care.

Universally accepted trauma-informed language

Without an universal trauma-informed language, there is a risk of diluting meaningful trauma-informed care interventions for clients of social services (Darroch et al., 2020). The focus group participants identified the need for consistent language in order to provide adequate trauma-informed practices. Specific trauma-informed language will reduce barriers and provide a equity-oriented approach therefore services will address the clients who are most effected by trauma. A common language is a component of creating safety and trustworthiness within trauma-informed care services (Poole and Greaves, 2012).

For example, the department of justice in Canada recognized that having a trauma-informed approach supported by a trauma-informed language will create an environment that responds to victims in safe, compassionate, and respectful ways (Ponic

et al., 2018). They stipulated that this form of communication will have a more positive impact on the lives of clients and staff. Communication strategies were cited, in well over fifty studies, as an important aspect of trauma-informed care (Darroch et al., 2020). A trauma-informed language can find itself deeply embedded in the culture, policy, and practices of each organization which reflects the communities needs in Wichita County

Person Centered Treatment

Considerable research studies have identified that childhood trauma has significant effect on various adulthood outcomes (Frewen et al., 2019). Keeping that in mind, it is not a surprise that treating an entire family may bring challenges from every stage of life that is represented. Empowerment through person-centered language, neutralizing power struggles and sharing strengths, giving choices, understanding and reframing resistance, and collaborating are all characteristics of person-centered treatment that create a safe environment (Leverson, 2020).It is through safety that trustworthiness is established (Ferentz, 2015) The focus group identified that a person-centered environment is imperative in implementing trauma-centered care. The focus group wanted to rely on the social workers roots in utilizing person-centered treatment.

Agency Buy-In and Follow Through

Extensive research continues to identify the need for family-wide interventions against the effect of adverse childhood experiences or trauma (Ortiz, 2019). Well over thirty years of research, across the globe, identifies the intergenerational effects that trauma has on behavior and physiological mechanisms of the individual and family unit. The Center for Disease Control (2020) identified the greatest protective factor against the

lifelong effect of traumatic experiences are safe, stable, nuturing relationships and environments. Part of the environment is social service agencies. The focus group identified the need for local agencies throughout Wichita County to truly buy into the research and address the wide effects that trauma has on the county. The focus group identified that community services need to reflect evidence based trauma-informed care practices.

In conclusion, knowledge can be extended to the discipline of social work practice through the immediate review and possible evaluation of social work and social services throughout each agency that serves in Wichita County. The organization of section 4 included Application to Social Work Ethics, and Recommendation for Social Work Practice: Action Steps, Impact to the Researcher's Social Work Practice, Practice Research and Policy Considerations, Study Limitations, Study Recommendations, Disseminate the Findings, Implications for Social Change, and Final Thoughts.

Application for Professional Ethics in Social Work Practice

According to the National Association of Social Workers (NASW, 2021), three social work ethical principles that underlie the current action research project are that social workers respect the dignity and worth or the person, social workers practice within their areas of competence, develop, and enhance their professional expertise, and the social worker's primary goal is to help people in need while addressing social problems. The results of this study support the social work values of dignity and worth of the person, competence, and service. This study involves exploring the processes needed to develop and maintain resilience through trauma-informed practices in social services.

The following sections explored the application of social work ethics to the current action research project.

Service

The social work value of service compels the primary goal in social work with the ethic of helping people in need and to address social problems. The profound effect that trauma has in Wichita County covers micro, mezzo, and macro perspective of this region. The social work long-term practice problem focuses on the ECC helping social service agencies to reduce or prevent the affect trauma has on children. The focus group participants recognized this concern therefore continue to volunteer their time and professional skills in efforts to address the county wide problem. The study provides practical application in addressing the purpose of this capstone project. The focus group findings support the development of a trauma-informed capacity-building program to assist service providers overcome barriers to trauma-informed care.

Competence

Social workers are known for their high value of professional standards of proficiency. It is reflected in the ethical standards that social workers practice within their areas of competence, develop, and enhance their professional expertise (NASW, 2021). The focus group identified the need for local practitioners to develop and enhance their professional expertise in trauma-informed care so the services to clients are reflected in competent work. The focus group participants identified real time barriers to serving individuals who have been traumatized. The focus group participants identified substantial solutions to those barriers of trauma-informed care services. Social work

ethical standards of competence, private conduct, and possible impairment also include professional and personal development through continued assessments of current well-being (Cox & Steiner, 2013).

Dignity and Worth of the Person

The final NASW (2021) ethical principle overwhelmingly indicated in the current action research project was related to the inherent dignity and worth of clients. This ethical principal and value should guide social work practice and social services into community action. Research continues to identify the commonality and potential that individuals have with experiencing trauma. Almost all of the focus group findings identified the need to uniquely view each client specifically through the lens of trauma.

Unfortunately, local services and agency practices do not consistently address or reflect the concern that trauma has on families in multiple communities. This was identified by the extensive effect that trauma has on the children across Wichita County, Texas as measured by their poor academic and stages of development performances. The focus group identified the need for social services to enhance or change their approach to trauma-informed care. The focus group participants were driven by the inherent dignity and worth of every citizen of Wichita county and desired to put evidence based measures into practice. They were very cognizant of the over all health and future of their communities if trauma was not addressed. The focus group identified the need for raising the standard of professional and ethical obligations to clients through capacity building in trauma-informed care. The findings of the present study will more clearly define the barriers to creating a trauma-informed capacity-building program. The findings will also

define what capacity-building program content will help assess and improve an agency's policy and procedures for entire system readiness in delivering effective TIC. These findings will regionally impact social work by meeting and superseding the expectations set forth in social work ethics and values in treating trauma exposed children through evidence based practices in trauma-informed care.

Recommendations for Social Work Practice: Action Steps

Based on the action research project findings there are two action steps for social work practitioners to work on. The first step would be to further increase support and alliances with forces that are vested or will take ownership in advocacy for the long term in trauma-informed care throughout the region. A second step would be to form a trauma-informed capacity-building program team to fully develop and implement the trauma assessment and walk-through protocol model throughout Wichita County. This team would be the boots on the ground to get measurable traction on the local trauma-informed care movement. Additional research may build upon this current study to accomplish more generalized results. This would be especially important as the effects of trauma are being identified across cultures and communities throughout the world.

Support and Alliance

The Early Childhood Coalition has multiple community stakeholders who are fully committed to social change. Social workers are used throughout the county in varied agencies and fields. Finding those social workers to create an alliance in trauma-informed care would be powerful. Unfortunately, social workers alone can not make the immense changes themselves in such a vast geographic region. They could expand and recruit for

individuals in agencies who are passionate about trauma-informed care and are willing to build on their knowledge and practices. Identifying individuals with authority in private or nonprofit agencies who have the innate ethical ideology or experience that aligns with trauma-informed care will be a powerful ally. To be effective and dedicated to change, ultimately, Wichita County will need to align their ideologies and business practices to improve the community's current trauma problem.

Action Team

The Early Childhood Coalition has performed years of research and intense community outreach to bring awareness to the imprint that trauma leaves through Adverse Childhood Experiences. They are the model of advocacy in education for relevant and evidence based trauma-information. The focus group members identified the need to take this advocacy one step further. They identified the current concerns in local client treatment and how patients need interventions that specifically target trauma-informed care. The focus group members revealed their desire to put plans into actionable steps. The barriers and solutions they identified in providing trauma-informed care is a practical and proven trauma specific approach (Keesler, Green, & Nochajski, 2017).. Although still not widely implemented worldwide, trauma focused interventions the focus group identified continue to present promising results, indicating that traumatized individuals do benefit from a more integrative approach (Karsberg et al., 20).

Impact to the Researcher's Social Work Practice

As a result of this action research project, this writer will make improved efforts to work with the Early Childhood Coalition to bring about social change. This writer will

volunteer time to assist in developing the social work action team's approach to directly advocating for the improvement of community wide social services. They goal is not just to create trauma-informed communities but implement agency policies that reflect such understandings that reflect the needs in Wichita County.

As a newly appointed director of inpatient mental health clinical services, of the only psychiatric hospital in a large geographical region, this writer will have profound opportunities to build bridges and interconnect agencies for a unified front against the effects of trauma. Mental and physical health must be equally addressed within the lens of trauma-informed care (CDC, 2020). Therefore, this writer’s personal practice and administrative foundation will reflect trauma-informed care as time proceeds and this writer’s influence grows.

Transferability of the Findings

The participants in the study on medical social workers with Undo et., al (2019) highlighted the relevance of research findings to their clinical practice but emphasized the imperative for support in translating research into policy and practice. With the social work imperative of to do more good than harm, it is important to rely on practice that is rooted in evidence-based guidelines. Those guidelines will identify what clients actually need. Thus, from a client safety perspective, the social work action committee needs to apply evidence-based practices. Trauma-informed care fulfills that exigency.

Practice

Disseminating the report for the current action research project can have an immediate impact on the Early Childhood Coalitions advocacy in Wichita County. The

action research project will give the ECC a report that represents a plethora of applicable data, literature, and an organized outline of problems facing Wichita County's social service provisions. More importantly, the action research project will give the ECC a usable tool that can be applied in grass roots efforts that brings about social change.

Research

The current action research project perfectly aligns with the current movement in Wichita County that addresses the effect that trauma experiences have on children and their family. The action research project cannot be generalizable beyond the local study participants. Themes in the study such as trauma-informed care, prevent re-traumatization, universally accepted trauma-informed language, Person Centered Treatment, and agency buy-in and follow through may be further studied. Future studies can strengthen the justification for policy and practice revisions in social services that address trauma.

Policy Considerations

The findings of the action research project will address long standing and difficult barriers to treating trauma in children and families in Wichita County. Addressing systemic needs for change can present as initially expensive and difficult when admitting that the services we provide may not be effective. More importantly, creating bridges across competing agencies can be most challenging. Each study participant reported policy and procedures in place that reflected the principles of TIC, but very few individuals reported consistent experiences of those principles.

Limitations of the Study

Both a strength and a limitation was using a convenience sample. The strength was having a focus group that already had identified a community wide problem. The other benefit was being able to tap into local experts who were already familiar with the problems that trauma has incurred into the community. The weakness was having minimal participants that were licensed social workers and a comparatively small community action group that was part of the ECC. A bigger sample size may have provided more perspectives and further exploration in trauma-informed care. A significant factor was the continual turn over rate of volunteers in the ECC. Therefore some participants not fully familiar with all perspectives and history of the ECC's work on trauma in Wichita County. Although multiple demographics were represented, all participants were locally raised and oriented as female. Subsequently with limited diversity in gender and race represented there was a potential for inhibiting alternative perspectives. The current action research project cannot achieve transferability or be generalized. Even with those limitations, this writer believes that valuable insight into issues facing social services in Wichita County has been provided. The action research project may be used to develop future research and be a springboard into grass roots social change that directly addresses trauma-informed care.

Study Recommendations

Study recommendations can aid in the exploration of connected practice problems and their potential solutions. A limitation of the study illustrated the lack of licensed social workers participating in research. A recommendation grounded in that weakness

would be to identify how to engage more social workers in the county regarding trauma-informed care. This would be significant, as social workers are on the front line in addressing the effects of trauma in the field.

The social work practice problem is that Wichita County, Texas, has high rates of children who experienced or are experiencing trauma (ECC, 2018). The social work long-term practice problem focuses on the ECC helping social service agencies to reduce or prevent the affect trauma has on children. Recommendations for future research would be to explore the application of the solutions the focus group recommended in addressing the barriers in creating a trauma-informed capacity building program. Extensive research can be further performed in identifying what program content actually helped the ECC assess and improve an agency's policy and procedures for entire system readiness in delivering effective trauma-informed care. Research can be continually performed in identifying what program content did help improve a client's ability to develop resiliency too. The foundational strength of the Early Childhood Coalition is that it is a collaborative effort of many organizations and the final recommendation is to explore more ways to collaborate *boots on the ground* type of services instead of just educational advocacy.

Disseminate the Findings

Community stakeholders and participants of the Early Childhood Coalition are consistently looking for ways to educate the public and service providers throughout Wichita County. This action research project can be a vital tool in their efforts to combat the effects that trauma has on children and their families. A final plan for disseminating

the findings is having a formal educational presentation with the Early Childhood Coalition's executive leadership and then with their extensive membership. This writer's goal is to serve as a guest presenter to report this action research projects findings on a panel of stakeholders. This writer's goal would be to educate the ECC about their own social work action committee's findings from the focus group participants. This writer's hope is that they use the results as a springboard to engage community agencies with real world solutions to provide effective trauma-informed care. It is this writer's goal to work collaboratively as an advisor with all Wichita County communities in addressing the development of social service work in reducing the effects of trauma on our county.

Implication for Social Change

Micro

This topic of research has been such an intense emotionally driven force. This writer cannot remove the bias and motivation for such an action research project topic. For this writer, as a third generation survivor of the sex slave trade, it was impossible not to think of the micro level ramification of social change. The immensely overwhelming data that the Early Childhood Coalition has identified regarding the traumatic effect that children across the Wichita County region bear is in itself the call for social change for the individual client. With so many children experiencing trauma on a personal level, there must be a call to action.

Mezzo

The strength in a coalition grass root effort is substantial. On the mezzo level, agencies can benefit by using a shared capacity-building program for strengthening their

ability to fulfill their mission and impact clients' lives. Members of the focus group came from varied agencies throughout the county. They represented varied perspectives of social work in the field. Their unified identification of universal social service concerns will bring improvement upon existing policies and services. A coalition can share successes, failures, and resources amongst themselves: by building bridges to improve services, those agencies can create positive social change across Wichita County together and reduce the effect that trauma has.

Macro

On the macro level, there is a need for policy revision to include trauma-informed care throughout state sponsored or funded agencies and programs. On the federal level, trauma-informed care continues to be recognized as a grave need but has not trickled down to the varied state levels (CDC, 2020). Throughout the action research project, the literature review and focus group members identified the lack of funding and priority of actual trauma-informed services. There is plenty of education but very little application. As always, the direction of funding will identify the priorities given in services. Trauma-informed care services needs to be a priority.

Summary

In conclusion, this action research project has served to identify the need for services that provide trauma-informed care throughout Wichita County, Texas. This county is experiencing an epidemic of trauma exposure to children and families. Social workers continue to provide a valuable role to help individual children, their families, and their community create protective processes to navigate trauma by growing or maturing

the capacity for resiliency. With ease, the focus group participants were able to identify the challenges or barriers to creating a trauma-informed capacity-building program and how can those challenges be overcome. They were also able to identify capacity-building program content that will help assess and improve an agency's policy and procedures for entire system readiness in delivering effective trauma-informed care and help. To accomplish social change, social workers cannot act alone but must align with the entire county in addressing the need for trauma-informed care. This current study affirms the valuable work that the Early Childhood Coalition has been doing to address trauma-informed care. This action research project can provide the tools to create empowerment, awareness, and a practical platform to initiate social change.

References

Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry, 76,* 103-108.

Adamson, C., Beddoe, L., & Davys, A. (2014). Building resilient practitioners: Definitions and practitioner understandings. *British Journal of Social Work, 44*(3), 522-541.

Adamowich, T., Kumsa, M. K., Rego, C., Stoddart, J., & Vito, R. (2014). Playing hide-and-seek: Searching for the use of self in reflective social work practice. *Reflective Practice, 15*(2).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Anda, R., & Porter, L. (2018). *About Page.* ACE Interface. https://www.aceinterface.com/About.html

Anderson-Carpenter, K. D., Watson-Thompson, J., Jones, M. D., & Chaney, L. (2017). Improving community readiness for change through coalition capacity building: Evidence from a multisite intervention. *Journal of Community Psychology, 45*(4), 486-499.

Antonovsky, A. (1979). *Health, stress, and coping.* Jossey-Bass.

Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45,* 239–263.

Arat, G., & Wong, P. W. C. (2019). Commentary on: How schools enhance the development of young people's resilience, by Ungar, Connelly, Liebenberg, and Theron, 2017. *Social Indicators Research, 143*(1), 319–324.

Ballenger-Browning, K., & Johnson, D. C. (2010). *Key facts on resilience*. http://psycnet.apa.org/record/717302011-001

Bartletta, J. M., Griffinb, J. L., Spinazzolac, J., Fraserd, J., Noroñad, C., Bodiane, R., Toddb, M., Montagna, C., & Barto, B. (2018). The impact of a statewide trauma-informed care initiative in child welfare on the well-being of children and youth with complex trauma. *Children and Youth Services Review, 84,* 110-117.

Ben-Porat, A., & Itzhaky, H. (2014). Burnout among trauma social workers: The contribution of personal and environmental resources. *Journal of Social Work, 15*(6), 606-620.

Bercier, M. L., & Maynard, B. R. (2015). Interventions for secondary traumatic stress with mental health workers. *Research on Social Work Practice, 25*(1), 81-89.

Beronia, K., Po, R., Skopec, L., & Glied, S. (2015). *ASPE issue brief: Affordable Care Act expands mental health and substance use disorder benefits and federal parity protections for 62 million Americans.* Office of the Assistant Secretary for Planning and Evaluation.

Berzoff, J., & Drisko, J. (2015). What clinical social workers need to know: Bio-psycho-social knowledge and skills for the twenty first century. *Clinical Social Work Journal, 43*(3), 263-273.

Bethell, C. D., Newacheck, P., Hawes, E., & Halfon, N. (2014). Changing epidemiology of children's health. Adverse childhood experiences: Assessing the impact on health and school engagement and the mitigating role of resilience. *Health Affairs, 33*(12), 2106- 2115.

Bettney, L. (2017). Reflecting on self-care practices during clinical psychology training and beyond. *Reflective Practice, 18*(3), 369.

Biglan, A., Van Ryzin, M. J., & Hawkins, J. D. (2017). Evolving a more nurturing society to prevent adverse childhood experiences. *Academic Pediatrics, 17*(7S), S150–S157.

Black, P. N., Jeffreys, D., & Hartley, E. K. (1993). Personal history of psychosocial trauma in the early life of social work and business students. *Journal of Social Work Education, 29*(2), 171-180.

Blodgett, C., & Lanigan, J. D. (2018). The association between adverse childhood experience (ACE) and school success in elementary school children. *School Psychology Quarterly, 33*(1), 137-146.

Brewer, M., & Flavell, H. (2018). Facilitating collaborative capabilities for future work: What can be learnt from interprofessional fieldwork in health. I*nternational Journal of Work-Integrated Learning, 19*(2), 169–180.

Briggs-Gowan, M. J., Ford, J. D., Fraleigh, L., McCarthy, K., & Carter, A. S. (2010). Prevalence of exposure to potentially traumatic events in a healthy birth cohort of very young children in the northeastern United States. *Journal of Traumatic Stress, 23.*

Brockhouse, R., Msetfi, R. M., Cohen, K., & Joseph, S. (2011). Vicarious exposure to trauma and growth in therapists: The moderating effects of sense of coherence, organizational support, and empathy. *Journal of Traumatic Stress, 24,* 735–742.

Brown, V. B., Harris, M., & Fallot, R. (2013). Moving toward trauma-informed practice in addiction treatment: A collaborative model of agency assessment. *Journal of Psychoactive Drugs, 45*(5), 386-393.

Brownson, R. C., Allen, P., Duggan, K., Stamatakis, K.A., & Erwin, P.C: (2012). Fostering more-effective public health by identifying administrative evidence-based practices: A review of the literature. *American Journal of Preventive Medicine, 43*(3).

Butler, L. D., Carello, J., & Maguin, E. (2016). Trauma, stress, and self-care in clinical training: Predictors of burnout, decline in health status, secondary traumatic stress symptoms, and compassion satisfaction. *Psychological Trauma: Theory, Research, Practice, and Policy, 9*(4).

Cabiati, E., & Raineri, M. L. (2016). Learning from service users' involvement: A research about changing stigmatizing attitudes in social work students. *Social Work Education*, *35*(8), 982-996.

Cadima, J., Enrico, M., Ferreira, T., Verschueren, K., Leal, T., & Matos, P. M. (2016). Self-regulation in early childhood: The interplay between family risk, temperament and teacher-child interactions. *European Journal of Developmental Psychology, 13*(3).

Calhoun, L., & Tedeschi, R. (2006). The foundations of posttraumatic growth: An expanded framework. In L. G. Calhoun & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research and practice* (pp. 3–23). Routledge.

Campbell, J. A., Walker, R. J., & Egede, L. E. (2016). Associations between adverse childhood experiences, high-risk behaviors, and morbidity in adulthood. *American Journal of Preventive Medicine, 50*(3), 344–352.

Carello, J., & Butler, L. D. (2015). Practicing what we teach: Trauma-informed educational practice. *Journal of Teaching in Social Work, 35*(3), 262-278.

Centers for Disease Control and Prevention. (2016). *Adverse Childhood Experiences (ACEs).* https://www.cdc.gov/violenceprevention/acestudy/index.html.

Centers for Disease Control and Prevention. (2020). *Adverse Childhood Experiences (ACEs).* https://www.cdc.gov/violenceprevention/acestudy/about.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fchildabuseandneglect%2Facestudy%2Fabout.html

Chi, G. C., Williams, M., Chandra, A., Plough, A., & Eisenman, D. (2015). Partnerships for community resilience: Perspectives from the Los Angeles County Community Disaster Resilience project. *Public Health, 129*.

Child Welfare Committee National Child Traumatic Stress Network. (2008). *Child welfare trauma training toolkit: Comprehensive guide* (2nd ed.). National Center for Child Traumatic Stress.

Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A., & Benight, C. (2014). A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychological Services, 11*(1), 75-86.

Cieslak, R., Shoji, K., Luszczynska, A., Taylor, S., Rogala, A., & Benight, C. C. (2013). Secondary trauma self-efficacy: Concept and its measurement. *Psychological Assessment, 25*(3), 917-928.

Clark, E., & Corbett, B. (2018). *Social Work leadership - What is a leader? Are you one? Can you become one?* https://www.socialworker.com/feature-articles/practice/social-work-leadership-what-is-a-leader-are-you-one-can-you-become-one/

Cloitre, M. (2015). The "one size fits all" approach to trauma treatment: Should we be satisfied? *European Journal of Psychotraumatology, 6*, 27344.

Conchar, C., & Repper, J. (2014). "Walking wounded or wounded healer?" Does personal experience of mental health problems help or hinder mental health practice? A review of the literature. *Mental Health and Social Inclusion, 18*(1), 35-44.

Coulacoglou, C., & Saklofske, D. H. (2017). *Psychometrics and psychological assessment: Principles and applications.* Academic Press.

Courtois, C. A., & Gold, S. N. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(1), 3–23. https://doi.org/10.1037/a0015224

Cox, K., & Steiner, S. (2013). *Self-care in social work: A guide for practitioners, supervisors, and administrators.* https://www.naswpress.org/product/53634/self-care-in-social-work

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches*. SAGE.

Creswell, J. W. (2016). *30 essential skills for the qualitative researcher.* SAGE.

Cutuli, J. J., Alderfer, M. A., & Marsac, M. L. (2019). Introduction to the special issue: Trauma-informed care for children and families. *Psychological Services, 16*(1), 1-6.

Cvetovac, M. E., & Adame, A. L. (2017). The wounded therapist: Understanding the relationship between personal suffering and clinical practice. *The Humanistic Psychologist, 45*(4), 348-366.

Davies, S., Janus, M., Duku, E., & Gaskin, A. (2016). Using the early development instrument to examine cognitive and non-cognitive school readiness and elementary student achievement. *Early Childhood Research Quarterly, 35*, 63–75.

DeVellis, R. F. (2012). *Scale development: Theories and applications.* SAGE.

de Vries, G., & Olff, M. (2009). The lifetime prevalence of traumatic events and posttraumatic stress disorder in the Netherlands. *Journal of Traumatic Stress, 22*(4), 259–267.

De Young, A. C., Kenardy, J. A., & Cobham, V. E. (2011). Trauma in early childhood: A neglected population. *Clinical Child and Family Psychology Review, 14*, 231–250.

Despard, M. R. (2016). Strengthening evaluation in nonprofit human service organizations: Results of a capacity-building experiment. *Human Service Organizations: Management, Leadership and Governance, 40*(4), 352-368.

Dombo, E., & Gray, C. (2013). Engaging spirituality in addressing vicarious trauma in clinical social workers: A self-care model. *Social Work and Christianity, 40*(1), 89-104.

Durst, D., & Ives, N. (2012). Social work education Canada's north: Capacity building through social work. *Journal of Comparative Social Work, 7*(1), 7-17.

Early Childhood Coalition of Greater Wichita County Area. (2018a). *Fighting ACEs community empowerment summit.*

Early Childhood Coalition of Greater Wichita County Area. (2018b). *Strategic Plan 2018.*

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine, 14*(4), 245-258.

Forrest, S., Gervais, R., Lord, K. A., Sposato, A., Martin, L., Beserra, K., & Spinazzola, J. (2018). Building communities of care: A comprehensive model for trauma-informed youth capacity building and behavior management in residential services. *Residential Treatment for Children and Youth, 35*(4), 265-285.

Gilmer, S. D. (2012). *A description of nonprofit executive leaders' perceptions of human resource capacity building within their organizations* [Doctoral dissertation, University of Arkansas]. ProQuest Dissertations and Theses.

Gitterman, A., & Knight, C. (2016). Promoting resilience through social work practice with groups: Implications for the practice and field curricula. *Journal of Social Work Education, 52*(4), 448-461.

Glennon, A., Pruitt, D., & Rouland Polmanteer, R. (2019). Integrating self-care into clinical practice with trauma clients. *Journal of Human Behavior in the Social Environment, 29*(1), 48-56.

Goldberg, M., Hadas-Lidor, N., & Karnieli-Miller, O. (2014). From patient to therapatient. *Qualitative Health Research, 25*(7), 887-898.

Griffiths, A., & Royse, D. (2017). Unheard voices: Why former child welfare workers left their positions. *Journal of Public Child Welfare, 11*(1), 73.

Hales, T. W., Nochajski, T. H., Green, S. A., Hitzel, H. K., & Woike-Ganga, E. (2017). An association between implementing trauma-informed care and staff satisfaction. *Advances in Social Work*, (1), 300.

Hambsch, J., Georg, S., & De Bock, F. (2016). Validation of the early development instrument to identify vulnerable children in German preschools. *European Journal of Public Health, 26*(1).

Harris, M., & Fallot, R. (2001). *Using trauma theory to design service systems: New directions for mental health services.* Jossey-Bass.

Harvard School of Public Health. (2012). *Capacity building for trauma interventions in low resource settings: Models for development and implementation of evidence-based practice* [lecture].

Henry, J., Richardson, M., Black-Pond, C., Sloane, M., Atchinson, B., & Hyter, Y. (2011). A grassroots prototype for trauma-informed child welfare system change. *Child Welfare, 90*(6).

Herman, J. L. (1992). *Trauma and recovery.* BasicBooks.

Hernandez-Wolfe, P., Killian, K., Engstrom, D., & Gangsei, D. (2014). Vicarious resilience, vicarious trauma, and awareness of equity in trauma work. *Journal of Humanistic Psychology, 55*(2), 153-172.

Herr, K., & Anderson, G. L. (2015). *The action research dissertation: A guide for students and faculty.* SAGE.

Hill, C. E. (2012). *Consensual qualitative research: A practical resource for investigating social science phenomena.* American Psychological Association.

Holbrook, A. M., Tennille, J., & Buck, P. W. (2017). Building capacity for evidence-based practice together. *Social Work in Public Health, 32*(7), 421-431.

Hurlburt, M., Aarons, G. A., Fettes, D., Willging, C., Gunderson, L., & Chaffin, M. J. (2014). Interagency collaborative team model for capacity building to scale-up evidence-based practice. *Children and Youth Services Review, 39*, 160-168.

Hyatt, D. (2014). From healer to transformed healer: Relearning lessons in grief. *Reflections, 20*(2).

Jacobs, J. A., Duggan, K., Erwin, P., Smith, C., Borawski, E., Compton, J., & Brownson, R. C. (2014). Capacity building for evidence-based decision making in local health departments: Scaling up an effective training approach. *Implementation Science, 9*(1).

Jager, J., Putnick, D. L., & Bornstein, M. H. (2017). More than just convenient: The scientific merits of homogeneous convenience samples. *Monographs of the Society for Research in Child Development, 82*(2), 13–30.

Jefferies, P., McGarrigle, L., & Ungar, M. (2018). The CYRM-R: A Rasch-validated revision of the child and youth resilience measure. *Journal of Evidence-Informed Social Work*, 1-24.

Jirek, S. L. (2017). Narrative reconstruction and post-traumatic growth among trauma survivors: The importance of narrative in social work research and practice. *Qualitative Social Work, 16*(2), 166–188.

Jones, L. K., & Cureton, J. L. (2014). Trauma redefined in the DSM-5: Rationale and implications for counseling practice. *The Professional Counselor, 4*, 257–271.

Joseph, S., & Murphy, D. (2014). Trauma: A unifying concept for social work. *British Journal of Social Work, 44*(5), 1094-1109.

Joubert, L., Hocking, A., & Hampson, R. (2013). Social work in oncology—Managing vicarious trauma—The positive impact of professional supervision. *Social Work in Health Care, 52*(2-3), 296-310.

Kar, S. K., & Singh, N. (2020). Person centered approach to the diverse mental healthcare needs during COVID-19 pandemic. *SN Comprehensive Clinical Medicine*, 1-3. Advance online publication.

Kesten, J. M., Griffiths, P. L., & Cameron, N. (2014). A critical discussion of the Community Readiness Model using a case study of childhood obesity prevention in England. *Health & Social Care in the Community, 23*(3).

Knight, C. (2014). Trauma-informed social work practice: Practice consideration and challenges. *Clinical Social Work Journal, 43*(1), 25-37.

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., Brymer, M. J., & Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice, 39*(4).

Koo, D., & Miner, K. (2010). Outcome-based workforce development and education in public health. *Annual Review of Public Health, 31*, *253-269.*

Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research* (4th ed.). SAGE.

Landau, J., Mittal, M., & Wieling, Y. E. (2008). Linking human systems: Strengthening individuals, families, and communities in the wake of mass trauma. *Journal of Marital and Family Therapy, 34*(2).

Lang, J. M., Campbell, K., Shanley, P., Crusto, C. A., & Connell, C. M. (2016). Building capacity for trauma-informed care in the child welfare system. *Child Maltreatment, 21*(2), 113-124.

Larkin, H., Felitti, V. J., & Anda, R. F. (2014). Social work and Adverse Childhood Experiences Research: Implications for practice and health policy. *Social Work in Public Health, 29*(1), 1-16. https://doi.org/10.1080/19371918.2011.619433

Lawrence, L. S. (2016). The group, the photograph, the wound, and the writing: How a social worker uses narrative medicine to facilitate groups. *Smith College Studies in Social Work, 86*(1), 45-57.

Lee, J. J., Gottfried, R., & Bride, B. E. (2018). Exposure to client trauma, secondary traumatic stress, and the health of clinical social workers: A mediation analysis. *Clinical Social Work Journal, 46*(3), 228–235.

Levenson, J. (2017). Trauma-informed social work practice. *Social Work*, *62*(2), 105-113. https://doi.org/10.1093/sw/swx001

Liberato, S. C., Brimblecombe, J., Ritchie, J., Ferguson, M., & Coveney, J. (2011). Measuring capacity building in communities: A review of the literature. *BMC Public Health, 11*(850). https://doi.org/10.1186/1471-2458-11-850

Lieberman, A. F., & Knorr, K. (2007). The impact of trauma: A developmental framework for infancy and early childhood. *Pediatric Annals, 36*, 209.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*(3), 543–562.

Macke, C., & Tapp, K. (2012). Teaching research to MSW students: Effectiveness of the team-based learning pedagogy. *Journal of Teaching in Social Work, 32*.

Masten, A. S. (2014). Global perspectives on resilience in children and youth. *Child Development, 85*(1), 6-20.

McDermott, F., & Bawden, G. (2017). New ways of seeing: Health social work leadership and research capacity building. *Social Work in Health Care, 56*(10), 897–913.

McGavock, L., & Spratt, T. (2017). Children exposed to domestic violence: Using adverse childhood experience scores to inform service response. *British Journal of Social Work, 47*(4), 1128–1146.

McKay, J., & Marshall, P. (2000). Quality and rigor of action research in information systems. *European Conference of Information Systems 2000 Proceedings*. http://aisel.aisnet.org/ecis2000/38

McLaughlin, K. A., Koenen, K. C., Hill, E. D., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Traumatic event exposure and posttraumatic stress disorder in a national sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 52*, 780–783.

McNiff, J. (2016). *You and your action research project.* Routledge.

McNiff, J., & Whitehead, J. (2011). *Doing and writing action research*. SAGE.

Meyers, A. (2016). Trauma and recovery. *Family Journal, 24*(2), 147-156.

Michalopoulos, L. M., & Aparicio, E. (2012). Vicarious trauma in social workers: The role of trauma history, social support, and years of experience. *Journal of Aggression, Maltreatment & Trauma, 21*(6), 646-664.

Moffitt, T., Arseneault, L., Belsky, D., Dickson, N., Hancox, R., Harrington, H., & Caspi, A. (2011). A gradient of childhood self-control predicts health, wealth, and public safety. *Proceedings of the National Academy of Sciences of the United States of America, 108*(7).

National Association of Social Workers. (2017). *Code of ethics of the National Association of Social Workers.* https://www.socialworkers.org/LinkClick.aspx?fileticket=ms_ArtLqzeI%3d&portalid=0

National Association for Social Work. (2019). *Read the code of ethics.* https://www.socialworkers.org/about/ethics/code-of-ethics/code-of-ethics-english

National Center on Substance Abuse and Child Welfare. (2015). *Trauma informed-care walkthrough project report data and findings.* https://ncsacw.samhsa.gov/resources/trauma/default.aspx

Nederhof, E., Ormel, J., & Oldehinkel, A. J. (2014). Mismatch or cumulative stress. *Psychological Science, 25*(3), 684-692. https://doi.org/10.1177/0956797613513473

Newcomb, M. A. (2018). *Recognizing resilience: Understanding how childhood adversity impacts undergraduate social work and human services students* [Doctoral dissertation, Queensland University of Technology].

Newcomb, M., Burton, J., Edwards, N., & Hazelwood, Z. (2015). How Jung's concept of the wounded healer can guide learning and teaching in social work and human services. *Advances in Social Work and Welfare Education, 17*(2), 55-69.

Nilsson, P. (2014). Are empathy and compassion bad for the professional social worker? *Advances in Social Work, 1*(15).

Nyumba, O., Wilson, K., Derrick, C., & Mukherjee, N. (2018). The use of focus group discussion methodology: Insights from two decades of application in conservation. *Methods in Ecology and Evolution, 9*(1).

Ogińska-Bulik, N. (2013). Negative and positive effects of traumatic experiences in a group of emergency service workers: The role of personal and social resources. *Medycyna Pracy, 64*(4).

Pataky, M. G., Báez, J. C., & Renshaw, K. J. (2019). Making schools trauma informed: using the ACE study and implementation science to screen for trauma. *Social Work in Mental Health, 17*(6).

Paynter, S., & Berner, M. (2014). Organizational capacity of nonprofit social service agencies. *Journal Of Health and Human Services Administration, 37*(1), 111–145.

Pietrzak, R. H., & Southwick, S. M. (2011). Psychological resilience in OEF-OIF Veterans: Application of a novel classification approach and examination of demographic and psychosocial correlates. *Journal of Affect Disorders, 133*(3).

Popescu, M., Strand, V., Way, I., Williams-Hecksel, C., & Abramovitz, R. (2016). Building a trauma-informed workforce capacity and legacy. *Journal of Teaching in Social Work, 37*(1), 36-54.

Purvis, K. B., Cross, D. R., Dansereau, D. F., & Parris, S. R. (2013). Trust-based relational intervention (TBRI): A systemic approach to complex developmental trauma. *Child & Youth Services*, 34(4), 360-386. https://doi.org/10.1080/0145935x.2013.859906

Putnam, R. (2015). *Our kids: The American dream in crisis*. Simon & Schuster.

Resilience Research Centre. (2018). *CYRM and ARM user manual*. Resilience Research Centre, Dalhousie University. http://www.resilienceresearch.org/

Richard, A. (2012). The wounded healer: Can we do better than survive as therapist? International *Journal of Psychoanalytic Self Psychology, 7*(1), 131-138.

Salloum, A., Choi, M. J., & Stover, C. S. (2018). Development of a trauma-informed self-care measure with child welfare workers. *Children and Youth Services Review, 93,* 108-116.

Sacks, V., Murphey, D., & Moore, K. (2014). *Adverse childhood experiences: National and state level prevalence.* https://www.childtrends.org/publications/adverse-childhood-experiences-national-and-state-level-prevalence

Scheeringa, M. S., Zeanah, C. H., Myers, L., & Putnam, F. W. (2003). New findings on alternative criteria for PTSD in preschool children. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*, 561–570.

Shannon, P. J., Simmelink-McCleary, J., Im, H., Becher, E., & Crook-Lyon, R. E. (2014). Developing self-care practices in a trauma treatment course. *Journal of Social Work Education, 50*(3), 440-453.

Shannon, P. J., Simmelink-McCleary, J., Im, H., Becher, E., & Crook-Lyon, R. E. (2014). Experiences of stress in a trauma treatment course. *Journal of Social Work Education, 50*(4), 678-693.

Shean, M. (2015). Current theories relating to resilience and young people: A literature review. *Victorian Health Promotion Foundation*. https://www.vichealth.vic.gov.au/search/mental-wellbeing-strategy.

Schelbe, L., Radey, M., & Panisch, L. S. (2017). Satisfactions and stressors experienced by recently-hired frontline child welfare workers. *Children and Youth Services Review, 78,* 56–63.

Shoji, K., Bock, J., Cieslak, R., Zukowska, K., Luszczynska, A., & Benight, C. C. (2014). Cultivating secondary traumatic growth among healthcare workers: The role of social support and self-efficacy. *Journal of Clinical Psychology, 70*(9), 831-846.

Shoji, K., Lesnierowska, M., Smoktunowicz, E., Bock, J., Luszczynska, A., Benight, C. C., & Cieslak, R. (2015). What comes first, job burnout or secondary traumatic stress? Findings from two longitudinal studies from the U.S. and Poland. *PLOS One, 10*(8), e0136730.

Siebert, D. C. (2001). Work and well-being: A survey of distress and impairment among North Carolina social workers. *Humanities and Social Science, 62*(3–A), 1212.

Smith, J. (2012). The resilient survivor—A student social worker's journey. *Social Work Education, 33*(1), 3-14.

Smith-Osborne, A., & Whitehill Bolton, K. (2013). Assessing resilience: A review of measures across the life course. *Journal of Evidence-Based Social Work, 10*(2), 111-126.

Southwick, S., Bonanno, G., Masten, A., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: Interdisciplinary perspectives. *European Journal of Psychotraumatology, 5(1).*

Staempfli, A., Adshead, L., & Fletcher, J. (2015). Ready for qualified practice? A comparative study of capability for critical reflection and analysis of MA social work and MA step up to social work students at the end of second placement. *Social Work Education, 34*(8), 952-966.

Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.). Eastwoods, LLC.

Strand, V. C., Popescu, M., Way, I., & Jones, A. S. (2017). Building field agencies' capacity to prepare staff and social work students for evidence-based trauma treatments. *Families in Society: The Journal of Contemporary Social Services, 98*(1), 45-56.

Stangor, C. (2011). *Research Methods for the Behavioral Sciences.* Cengage Learning.

Straussner, S. L., Senreich, E., & Steen, J. T. (2018). Wounded healers: A multi-state study of licensed social workers' behavioral health problems. *Social Work, 63*(2), 125-133.

Stringer, E. T. (2007). *Action research* (Laureate Education, Inc., custom ed.). SAGE.

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-488.4. http://www.hmprg.org/wp-content/themes/HMPRG/backup/ACEs/Handouts_Merged%20Final.pdf

Substance Abuse and Mental Health Services Administration (2017). *Trauma-informed approach and trauma-specific interventions.*

Suen, L., Huang, H., & Lee, H. (2014). A comparison of convenience sampling and purposive sampling. *Journal of Nursing, 61*(3), 105–111.

Taylor, L. K., Weist, M. D., & Deloach, K. (2012). Exploring the use of the interactive systems framework to guide school mental health services in post-disaster contexts: Building community capacity for trauma-focused interventions. *American Journal of Community Psychology, 50*(3-4), 530–540.

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9,* 455–471.

Ungar, M. (2015). *I still love you: Nine things troubled kids need from their parents.* Dundurn Publication.

Ungar, M. (2013). Resilience, trauma, context, and culture. *Trauma, Violence, and Abuse, 14*(3).

Ungar, M. (2011). The social ecology of resilience: Addressing contextual and cultural ambiguity of a nascent construct. *American Journal of Orthopsychiatry, 81*(1).

Ungar, M. (2008). Resilience across cultures. *British Journal of Social Work, 38*(2), 218-235.

Ungar, M., Brown, M., Liebenberg, L., Othman, R., Kwong, W., Armstrong, M., & Gilgun, J. (2007). Unique pathways to resilience across cultures. *Adolescence, 42,* 287-310.

Van Breda, A. (2018). A critical review of resilience theory and its relevance for social work. *Social Work, 54*(1).

Van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma.* Viking.

Wagaman, M. A., Geiger, J. M., Shockley, C., & Segal, E. A. (2015). The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers. *Social Work, 60*(3), 201-209.

Walsh, J. (2014). *Theories for direct social work practice* (3rd ed.). Cengage Learning.

Watson-Thompson, J., Keene Woods, N., Schober, D. J., & Schultz, J. A. (2013). Enhancing the capacity of substance abuse prevention coalitions through training and technical assistance. *Journal of Prevention and Intervention in the Community, 41*(3), 176–187.

Webb, S., Janus, M., Duku, E., Raos, R., Brownell, M., Forer, B., Guhn, M., & Muhajarine, N. (2017). Neighbourhood socioeconomic status indices and early childhood development. *SSM - Population Health, 3*, 48-56.

White House Council on Women and Girls. (2014). *Rape and sexual assault: A renewed call to action.* CreateSpace Independent Publishing Platform.

Wilkin, L., & Hillock, S. (2014). Enhancing MSW students' efficacy in working with trauma, violence, and oppression: An integrated feminist-trauma framework for social work education. *Feminist Teacher, 24*(3), 184.

Wilson, F. (2016). Identifying, preventing, and addressing job burnout and vicarious burnout for social work professionals. *Journal of Evidence-Informed Social Work, 13*(5), 479-483.

Wilson, J., & Brwynn, R. (2004). *Empathy in the treatment of trauma and PTSD.* Brunner-Routledge.

Wolf, M. R., Green, S. A., Nochajski, T. H., Mendel, W. E., & Kusmaul, N. S. (2013). 'We're civil servants': The status of trauma-informed care in the community. *Journal of Social Service Research, 40*(1), 111-120.

Zoellner, T., & Maercker, A. (2006). Posttraumatic growth in clinical psychology: A critical review and introduction of a two component model. *Clinical Psychology Review, 26*, 626–653.

Appendix A: Recruitment/Marketing Material

(Electronic mail, social media, telephone communications)

Social Work Research Participants Needed

Nature of study: The purpose of this capstone project is to support the development of a trauma-informed capacity building program to assist service providers.

Participation requirements: If you consent to participate, we will be conducting a virtual focus group at predetermined times to collect data. The focus group of licensed and unlicensed social workers will include discussing what capacity building program content can improve an agency's system readiness and ability to deliver effective trauma-informed care. The focus groups will take about 90 minutes to complete per session, with no more than two sessions. The session will take part on a Saturday in a virtual forum, such as Zoom, to minimize conflicts with work schedules and confidentiality concerns during operational hours. With permission, the sessions will be audio recorded for data collection. Manual note taking procedures will also be performed to record information. An anonymous electronic demographic survey (see appendix E) will be required to be completed prior to participation.

Risks and benefits: This researcher does not anticipate any risks to you participating in this study other than those encountered in day-to-day life. Potential benefits are not individual but societal, and include helping social workers understand the challenges that agencies experience in serving trauma vulnerable populations.

Compensation: There will be no monetary compensation for participation.

Confidentiality: The records of this study will remain private. Data will not be used for any purposes other than research. Any reports made public will not include any identifying information. Records will be maintained in a locked file; only the researcher will have access to the information. Audio recordings will be secured after transcription and destroyed in accordance with Walden University guidelines.

Voluntary participation: Your participation is completely voluntary and participants have the right to decline or discontinue participation at any time. You may forgo replying to a question that you may not wish to answer. If you decide to forgo answering a question, your relationship with the researcher will not be adversely impacted. Declining or discontinuing with the project will not negatively impact the participant's relationship with the researcher or the participant's access to services. If you consent to participate, you can withdraw at any time.

Conflicts of Interest: The researcher does not stand to gain financially from conducting this study, nor does she have any financial interest in obtaining the study results.

Questions: The researcher conducting this study is Juan M. Medina, LMSW, as partial fulfillment of Walden University's Doctor of Social Work requirements. Please direct

any questions to Mr. Juan M. Medina at 1(661) 747-2697 or juan.medina@waldenu.edu. If you have questions or concerns regarding your rights as a research participant, you may contact the Institutional Review Board at Walden University at http://www.irb.waldenu.edu.

Appendix B: Informed Consent Form

My name is Juan M. Medina and I am a student in the doctor of social work program with Walden University. Thank you for your consideration to participate in a research study aimed at helping our community social services become more trauma-informed. The purpose of this capstone project is to support the development of a trauma-informed capacity-building program to assist service providers.

Please review the consent form and ask questions prior to signing.

Nature of study: The purpose of this capstone project is to support the development of a trauma-informed capacity-building program to assist service providers.

Participation requirements: If you consent to participate, we will be conducting a virtual focus group at a predetermined time to collect data. The focus group of licensed and unlicensed social workers will include discussing capacity-building components needed to improve trauma-informed services in local agencies. The focus group will take about 90 minutes to complete. The session will take part at a mutually agreed upon day and time in a virtual forum, such as Zoom, to minimize conflicts with work schedules and confidentiality concerns during operational hours. With permission, the sessions will be video and audio recorded for data collection. An anonymous electronic demographic survey will be required to be completed prior to participation (see appendix E).

Risks and benefits: This researcher does not anticipate any risks to you participating in this study other than those encountered in day-to-day life. Potential benefits are not individual but societal, and include helping social workers understand the challenges that agencies experience in serving trauma vulnerable populations.

Compensation: There will be no monetary compensation for participation.

Confidentiality: The records of this study will remain private. Data will not be used for any purposes other than research. Any reports made public will not include any identifying information of the participants. Records will be maintained in a password protected and encrypted computer kept in a secured location; only the researcher will have access to the information. Audio recordings will be secured after transcription and destroyed in accordance with Walden University guidelines.

Voluntary participation: Your participation is completely voluntary and participants have the right to decline or discontinue participation at any time. You may forgo replying to a question that you may not wish to answer. If you decide to forgo answering a question, your relationship with the researcher will not be adversely impacted. Declining or discontinuing with the project will not negatively impact the participant’s relationship with the researcher or the participant’s access to services. If you consent to participate, you can withdraw at any time.

Conflicts of Interest: The researcher does not stand to gain financially from conducting this study, nor does she have any financial interest in obtaining the study results.

Questions: The researcher conducting this study is Juan M. Medina, LMSW, as partial fulfillment of Walden University's Doctor of Social Work requirements. Please direct any questions to Mr. Juan M. Medina at (661) 747-2697 or juan.medina@waldenu.edu. If you have questions or concerns regarding your rights as a research participant, you may contact the Institutional Review Board at Walden University at http://www.irb.waldenu.edu.

Statement of consent: I have read the above information, and I have asked and received answers to my questions. I consent to participate in this qualitative research study.

In addition to participating, I also consent to having the focus group audio recorded.

Signature Date

Printed Name Date

Signature of person obtaining consent Date

Printed name of person obtaining consent Date

This consent form will be maintained for 5 years after the study concludes. Please retain a copy of this form for your records.

Appendix C: Focus Group Research Questions

The following questions will be asked during the focus groups:

1. What is the Early Childhood Coalitions primary goal(s) in regard to the effect that trauma has on the community?
2. What is the ECCs social work action committee's task(s) regarding trauma-informed care?
3. What components of the trauma assessment and walk-through protocol model by Brown et al. (2013) apply to our community agencies? And why?
4. What relevant components would you want to be added to this trauma-informed capacity-building program that are not identified in this model by Brown et al. (2013)? And why?
5. What are some barriers or challenges to developing and implementing the Early Childhood trauma-informed capacity-building program? What strategies could you employ to address those barriers and challenges?

Appendix D: Focus Group Script

Welcome everyone to the study!

Background: High rates of children in Wichita County, Texas have experienced persistent developmental delays attributed to trauma or Adverse Childhood Experiences. You were invited to take part in this voluntary research study to support the development of a trauma-informed capacity building program to assist service providers that serve the vulnerable children of Wichita County. You were selected for the study because you are a member of the Early Childhood Coalition's social work action committee and in some manner, you serve Wichita County in bringing awareness to Adverse Childhood Experiences.

Researcher: You might already know this researcher as Juan M. Medina a LCSW-Intern in Wichita County. However, this study is separate from my role as a mental health clinician serving the local community. I am not an employee of any organizations from which participants may be recruited. I am not a member of any agency that may have an oversight or administration relationship to these organizations, and there are no conflicts of interest.

Purpose of the study: The aim of the study is to support the development of a trauma-informed capacity-building program to assist service providers in our community.

Confidentiality / Privacy: I will maintain confidentiality throughout the research process, and you are also asked to keep confidentiality in the focus group. If the information is shared, it could create adverse consequences that may impact yours or others career and or well-being. If an individual participating in the research project

expresses a risk of harm to themselves or others or are engaged in illegal activities that may be harmful to others I will be obligated to share this information with the appropriate authorities. Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the agency in which a social worker is employed will not be shared. I will not use your personal information for any purpose outside of this research project. Data will be kept secure by password locked computers and all information being kept under locked file cabinet. Codes will be used in place of names in the study. Data will be stored for at least 5 years, as required by the university.

Risks and Benefits of Being in the Study: I do not anticipate any risks to you participating in this study other than those encountered in day-to-day life. Potential benefits are not individual but societal, and include helping social workers understand the challenges that agencies experience in serving trauma vulnerable populations.

Today's Focus Group Session: Today's focus group session will discuss the six focus group questions that were sent to you via email. The group will last approximately 90 minutes. As discussed in the informed consent there will be periods of follow-up contact with you after the conclusion of the focus group. The purpose of follow-up contact is for clarification and review of your input to ensure that your views reflect your wishes.Please remember that this study is voluntary. You are free to accept or turn down the invitation. If you decide to be in the study now, you can still change your mind later. You may stop at any time with no penalty. If you have any questions feel free to ask them now.

Next Steps: I would like to begin discussion about your views on the six Focus Group Questions.

Conclusion: Thank you for attending the focus group. I will be in touch for follow up over the next 8-10 weeks. Thank you so much.

Juan M. Medina, LCSW-Intern

Appendix E: Demographic Survey Script

1. What is your age?
2. What is your gender?
3. What is your education level?
4. What degree(s) do you hold?
5. What is your current job title?
6. What is your social work training or expertise?
7. How long have you practiced social work?
8. In what capacity do you serve the children of Wichita County?
9. How long have you been a resident in Wichita County?

Appendix F: Letter of Cooperation

Dear Ms. Marlar,

This letter of cooperation is to ask permission to use the Early Childhood Coalition for the collection of data for my doctoral research project. The project serves in the fulfillment of my studies in the Doctor of Social Work program with Walden University. The purpose of the project is XYZ. The project consists of interviewing between ten to twelve social workers in a virtual focus group setting. Social workers participating in the Early Childhood Coalition will be asked to participate. Preapproved questions will be asked to identify the themes associated with building a trauma-informed capacity-building program. I have attached the questions and interview protocol for your review.

All information will be protected for confidentiality and privacy. The records of this study will remain private. Any reports made public **will not** include any personal or professional identifying information. Records will be maintained in a locked filing cabinet or a password protected computer; only the researcher will have access to the information. Digital recordings will be secured and destroyed in accordance with Walden University guidelines. The results of the study will be available following completion and approval by Walden University.

The study will take place during nonoperational hours and will not conflict with day to day work requirements. The session will take part on a Saturday in a virtual forum, such as Zoom, to minimize conflicts with work schedules and confidentiality concerns during operational hours. I will use my personal computer to record the sessions. There

will be no more than one focus group session conducted. No site personnel is providing any supervision of the research activities. Remote faculty members are supervising the researcher; however, I do not anticipate any risks to volunteers participating other than those encountered in day-to-day life. It is not anticipated that participating in the study will be more stressful than every day life events. In the event of an individual being distressed, the researcher will provide crisis and support numbers..

Your title, signature, contact info

Appendix H: Guidelines for Trauma-Informed Assessment

Guidelines for Trauma-Informed Assessment

Walk-Through Exercise
For maximum effectiveness, a manager and/or client advocate/mentor should be part of the walk-through of the agency. Begin with calling the intake point as a potential client and document the process of admission. Examples: Do you get a welcoming respectful, and engaging person on the phone? Do you have to call back? Do you feel motivated to enter the program? The set up an intake appointment/screening and assessment. Proceed through the entire process of entering the program and experiencing the first few days/sessions of treatment, case management, etc. Document the process, as well as your feelings at each step of the process, and identify problems/barriers/bottle necks.

A. Safety

1. Where are services delivered? Does the agency location feel safe?
2. Are security personnel present?
3. How would you describe the reception and waiting areas? Are the comfortable and inviting?
4. Are the first contacts with consumers welcoming, respectful, and engaging?
5. Do the clients receive clear explanations and information about each program procedure?
6. Are staff attentive to signs of consumer discomfort or unease? What do staff do about the discomfort?
7. Are there any events that indicate a lack of safety, e.g., arguments, conflicts, etc.?
8. In intake, is there sensitivity to unsafe situations, such as domestic violence? Is the client asked about the safety of his/her living situation?
9. Do staff understand the need for clear boundaries?

B. Choices

1. How much choice does the client have over what services she/he receives? Are clients given choices regarding services for children?
2. Do the clients have a choice how contact is made (e.g., by phone, mail, visit to home)?
3. Do the clients get a clear and appropriate message about their rights and responsibilities?
4. Do the clients have a significant role in planning and evaluating the agency's services?
5. Do providers communicate respect for clients life experiences and histories?

C. Service Policies

1. Are policies regarding confidentiality clear and do they provide adequate protection for the privacy of consumers?
2. Does the program avoid involuntary or potentially coercive aspects of treatment, whenever possible?
3. Has the program developed a de-escalation policy that minimizes the possibility of retraumatization?
4. Are staff sensitive to the potential of retraumatization of the clients during certain procedures (e.g., urine testing, searching belongings, administration of medications?

D. Trauma Screening, Assessment, and Service Planning

1. Are two questions about trauma, at a minimum, included in program screening: Have you experienced sexual abuse at any time in your life? Have you experienced physical abuse at any time in your life? If yes, currently?
2. Does the screening/assessment integrate substance use, mental health, and trauma?
3. Does the program recognize that the process of screening and assessment is as important as the content?
4. Does the screening and assessment process avoid unnecessary repetition?
5. Do staff have an understanding of the clients cultural/ethnic/racial identities and how trauma may have different meanings for different cultural groups (e.g., historical trauma)?
6. Are initial community support contacts facilitated for the clients? Are transitions from one phase of treatment/service to another facilitated

E. Services

1. Are trauma specific services available?
2. If possible, observe a trauma specific group. How do the clients respond to the content and the facilitators? Are clients taught skills (e.g., grounding and self-soothing) for dealing with trauma symptoms?
3. Do staff use shaming or demeaning language?

Team Meeting
When you have completed the walk-through, meet with the team. For each trigger or barrier you have identified, brainstorm with your team members what possible changes could be made. At this point, if staff need to get back to their work, schedule another session. When time is available, the team can begin to rate priority (greatest risks) and feasibility (how "doable") for each possible change listed. The team then discussed how these possible solutions fit into an Action Plan, including who might be responsible for taking the lead on each action item and the dates when each item is to be completed. Then discuss the proposed Action Plan with managers and staff, and revise if necessary. The Plan-Do-Study-Act (PSDA option allows staff to try out all possible solutions/changes, they have come up with and to see which lead to the best outcomes. Although originally enumerated as components of the walk-through process, the following issues also would be addresses in the Team meeting after the walk through has ended.

F. Administrative Support for Trauma-Informed Services

1. Is there a "trauma initiative" in place in the program (e.g., workgroup, trauma specialist)?
2. Is there a consumer advisory group that includes significant trauma survivor membership?
3. Have administrators attended trauma trainings?
4. Do administrators make basic resources available in support of trauma informed service modifications (e.g., time, space, training funds)?

G. Staff Trauma Training

1. Has general education (including basic information about trauma and its impact) been offered to all employees in the program?
2. Have clinical staff members received trauma training involving specific modifications for trauma survivors in their program areas: clinical, residential, case management, outpatient, substance use?
3. Have staff members received training in trauma-specific interventions?
4. Are staff aware of current knowledge, theory, and treatment models from a variety of diverse knowledge base?
5. Are the staff who are offering trauma specific services provided adequate support via supervision and/or consultation?
6. Have staff been educated about vicarious traumatization and staff self-care?

Note. Guidelines for Trauma-Informed Assessment. From "Moving toward Trauma-Informed Practice in Addiction Treatment: A Collaborative Model of Agency Assessment" by Brown et al., 2013, *Journal of Psychoactive Drugs*, *98*, pp. 389-390.
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