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The Role of the National Training and Development Curriculum for Foster and Adoptive Parents in Improving Caregiver Perceived Preparation and Confidence to Parent

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ABSTRACT

Being a foster, relative or adoptive parent (herein referred to as 'resource parent') is a crucial but highly challenging role. Resource parent trainings are designed to build knowledge, skills, preparation and confidence in resource parents prior to beginning their support of children and youth. However, often resource parents go into these roles feeling unconfident and unprepared to fulfil their responsibilities. The National Training and Development Curriculum for Foster and Adoptive Parents (NTDC) is a new curriculum developed with support from the United States Children's Bureau. This study compares the perceived preparation, confidence and willingness to care for a variety of subgroups of children at baseline and 6 months after training of caregivers who participated in NTDC training curriculum versus training as usual to assess whether the NTDC curriculum led to improved caregiver preparation to foster or adopt. NTDC caregivers were found to have more positive differences than control group caregivers from baseline (pretraining) to follow-up on confidence to care for children considered challenging, confidence to care for children across multiple age ranges and perceived preparation to care for children aged 13 years and older. NTDC is a promising new resource that can help overcome some traditional resource parent training and preparation-related challenges.

1 | Introduction

The transition into being a foster, relative or adoptive parent (herein referred to as 'resource parent') represents a major life event with unique joys and challenges. However, research shows that they often do not feel prepared to step into their roles (Barnett et al. 2018; Day et al. 2018; Vanderwill et al. 2021). Resource parents experience their own psychosocial needs during this transitional period, and increased stress, depression, pressure to be perfect parents, gratitude and joy are all normal parts of adjusting from preplacement to postplacement time periods (Foli et al. 2017). Adequately preparing resource parents to feel confident in their role is crucial in preventing placement breakdowns that could lead to further disruption in children's lives. The level of ongoing support in areas such as prospective parent preparation, financial information and resources, and access to respite care is an important factor in preventing placement disruption (Dowdy-Hazlett and Clark 2023). Additionally, a lack of understanding of how to appropriately respond to the children's

needs has been identified by resource parents as a challenge that may motivate discontinuation of caretaking (Vanderwill et al. 2021). The current study evaluates resource parents' confidence and preparedness following participation in the newly developed National Training and Development Curriculum for Foster and Adoptive Parents (NTDC) and fills existing gaps in the research.

1.1 | Areas of Need for Caregiver Preparation and Confidence

There are several areas within which caregivers could benefit from additional training to feel more confident and prepared for their role. For example, resource parents need greater support and training on meeting the needs of youth with disabilities (Helton 2011; Seltzer, Johnson, and Minkovitz 2017), youth who have experienced trauma (Day et al. 2022), youth with mental health and/or behavioural challenges (Cooley et al. 2021), older youth (Day et al. 2022; Greeno et al. 2017), youth of colour (Beardall and Edwards 2021; Choate et al. 2021; Degener, van Bergen, and Grietens 2022) and youth with varying sexual orientations and gender identities (Schofield et al. 2019). Youth belonging to these groups have been historically labelled as 'difficult to place' and experience a higher number of placements and longer time in out-of-home care (Dave Thomas Foundation for Adoption 2017; Rock et al. 2015).

Beyond the importance of understanding normative child development and behaviour, resource parents are often tasked with understanding how to support children and youth with unique needs and histories, who may have experienced trauma and/or have mental health needs (Cooley et al. 2021; Day et al. 2022). In a mixed methods study of foster and adoptive parents in one state, parents reported feeling ill-prepared to fill their roles as foster or adoptive parents, in part due to lack of communication with child welfare staff around realistic expectations of what parenting a particular child may entail and a lack of understanding of children's needs and backgrounds (Barnett et al. 2018). Resource parents expressed a need to be better prepared to parent children who have experienced trauma, who may exhibit sexualized behaviour and/or who have difficult behaviours, but had been discouraged by the quality and availability of community mental health services they have encountered (Barnett et al. 2018). Similarly, Farmer, Lipscombe, and Moyers (2005) found that resource parents who considered youth in their care as having behavioural problems reported greater strain and were initially more reluctant regarding the prospect of a new placement. Internalizing and externalizing symptoms among youth have been shown to significantly increase resource parent strain (Leake et al. 2019). While there are nuances, caregivers generally report a lack of organizational support at needed times, challenging youth behaviours and lack of knowledge around youths' specific needs as prominent factors to placement breakdown (Hanlon et al. 2021; Khoo and Skoog 2014; McKeough et al. 2017).

Youth with disabilities experience significant placement disruption, and resource parents report care burden, stress and unmet training needs in understanding how to manage their roles and adequately provide care for children, especially those with higher or special needs (Barnett et al. 2018; Helton 2011; Kaasbøll et al. 2019; Seltzer, Johnson, and Minkovitz 2017). In an analysis of 538 695 youth receiving foster care services in 2014, Seltzer, Johnson, and Minkovitz (2017) found that youth with increasing medical complexity, defined by number of disability types, were more likely to have a non-permanency plan goal and experience greater placement instability.

Studies also consistently show that older youth experience greater placement instability (Jedwab et al. 2019; Konijn et al. 2019), and foster parents have frequently reported feeling unprepared to care for older youth (Day et al. 2022; Greeno et al. 2017). In a postconference survey regarding caring for older youth, resource parents indicated their greatest challenge was insufficient training and not feeling confident to help youth transition to adulthood (Greeno et al. 2017). Navigating child welfare and court systems as well as other community services can be challenging, and a need for additional support and resources has been identified by caregivers (Barnett et al. 2018). This may include the need to navigate school and medical systems, especially when parenting older youth and youth with increased medical needs (Foli et al. 2017).

Additionally, there is a need for increased preparedness to care for children of colour. Black youth and American Indian, Alaska Native (AI/AN) youth are overrepresented in the foster system (US Department of Health and Human Services 2019). Transcultural fostering poses challenges and can have deleterious effects on youths' ethnic identity if they are not placed in a culturally responsive home and, instead, pushed to assimilate (Beardall and Edwards 2021; Choate et al. 2021; Degener, van Bergen, and Grietens 2022).

LGBTQ2S youth are also disproportionately represented in the foster system, more likely to experience houselessness, and are at an increased risk of maltreatment from child welfare staff and placements than their straight peers (Baams, Wilson, and Russell 2019). In a study by Schofield et al. (2019) on resource parents caring for LGBTQ youth, interviewees reported a lack of informational and emotional support from social services in helping them to confidently provide care across multiple dimensions, such as sensitivity, acceptance and cooperation. Lack of cultural competence is a barrier for resource parents caring for LGBTQ2S youth, that is, a lack of affirmation, acceptance and empowerment which leads to placement breakdown, and contributes to youth experiencing increased placements in group homes, rejection and further exacerbates mental health problems (Baams, Wilson, and Russell 2019; Grooms 2020; Jacobs and Freundlich 2006; McCormick, Schmidt, and Terrazas 2016; Prince et al. 2022). While transgender and sexual minority adults express a greater willingness to foster LGBTQ2S youth, which would be a culturally responsive placement, these prospective caregivers face discrimination (Goldberg et al. 2020). Additionally, Goldberg et al. (2020) found that transgender individuals reported more fears around fostering discrimination than cisgender sexual minority men or women.

Given the various demands on caregivers, a vital consideration for resource parents is the real or perceived time they have that may be needed to provide for the diverse needs of children in

their care. While there are limited empirical studies investigating the ways in which resource parents perceive the time commitment and capacity to fill their roles as caregivers, the many asks of resource parents have been documented. In a qualitative study investigating resource parent experiences, Shklarski (2019) found that after parents began fostering, they often needed to adjust other aspects of their lives, such as reducing their work hours or taking on a more flexible job, to accommodate the need for increased availability. In addition to the time spent providing for the social, emotional, recreational and physical needs of children in their care described above, many resource parents provide a wide range of activities and supportive roles, such as time spent on visitation with and forming relationships with birth parents (Shklarski 2019) and managing and providing transportation to medical and mental health appointments (Kerns et al. 2014; Pasztor et al. 2006). Resource parents may also provide academic support including helping with homework (Shklarski 2019) and also spend time communicating and meeting with child welfare workers and participating in court hearings. Adding to this complexity, resource parents often experience having to wait for approval for things like permission slips and vacations, and lengthy court processes sometimes contribute to the length of time spent waiting for decisions to be made (Barnett et al. 2018). Finally, resource parents spend time in ongoing training intended to support them in their roles. Effective training and education are critical in adequately preparing resource parents, as feeling competent and confident in their roles as parents may increase their perceptions of available time and are positively related to the intention to continue in their caregiving roles (Cherry, Orme, and Rhodes 2009). However, there remains a need for effective and relevant training that adequately supports resource parents in meeting the unique needs of youth in their care (Mallette, Almond, and Leonard 2020).

1.2 | National Training and Development Curriculum for Foster and Adoptive Parents

1.2.1 | Overview

To help prepare current and prospective resource parents to fulfil their roles as caregivers with an increased sense of confidence, the National Training and Development Curriculum for Foster and Adoptive Parents (NTDC) was developed. Funded by the United States Children's Bureau, a 5-year cooperative agreement was led by Spaulding for Children in conjunction with other nationally recognized entities to develop and rigorously evaluate the curriculum. The goal of NTDC is to increase permanency and stability for children and their resource families by providing a trauma-integrated training curriculum in which current and prospective caregivers can assess their capacities to provide care, increase their knowledge and skills and continue their development as parents through training that is accessible to them whenever they need it.

A multi-step process informed curriculum design, theme selection and the development of corresponding competencies. Curriculum development included a systematic literature review (Vanderwill et al. 2021) and input from stakeholders with lived experience (Day et al. 2018), along with a prioritization of potential curriculum themes and competencies determined via a rating and consensus building Delphi process (Patterson, Day, and Wright 2019). Caregiver usability tests of curriculum components were also conducted, during which participants offered feedback on curriculum elements they found particularly helpful or for which they had suggestions for improvement (Salazar et al. 2020). NTDC was designed with three target audiences in mind: (1) families fostering, providing kinship care and/or adopting through the child welfare system; (2) families adopting through intercountry or the private domestic process; and (3) American Indian and Alaska Native families fostering, providing kinship care and/or adopting through the tribal child welfare system. NTDC was evaluated in seven child welfare system-focused pilot sites (six states and one tribal nation). Evaluation of the programme demonstrated increased knowledge and skills among participants following completion of the curriculum and training components (Salazar et al. 2023).

1.2.2 | Curriculum Components

NTDC includes three primary curriculum components, which are briefly described below. All NTDC materials, including materials adapted specifically for use by American Indian and Alaska Native families, are freely available on the NTDC Portal (ntdcportal.org).

1.2.2.1 | Self-Assessment. The self-assessment is a 58-item self-administered instrument designed to help resource parents identify their current capacities, competencies, knowledge, characteristics, values and attitudes/beliefs that may impact their ability to effectively care for a child. It aims to help caregivers anticipate potential family or parenting issues they may face and what knowledge, skills and abilities they may need to develop to be prepared for these challenges. The self-assessment is designed to be taken prior to classroom-based training and could also be taken again after training is complete to assess growth and remaining challenges.

1.2.2.2 | Classroom-Based Training. The classroom-based training is 27 h in length and is designed to provide concrete information on the roles and responsibilities of resource parents as well as the knowledge, skills and attitudes they need to have to effectively parent children who have experienced trauma, separation, loss and grief. Using Dr. Benjamin Bloom's (1956) taxonomy to promote higher forms of thinking in education, each of the 19 general training modules (two of which are online; e.g., Attachment; Trauma-Informed Parenting; Creating a Stable, Nurturing and Safe Home Environment) includes activities that incorporate interactive learning approaches such as role-plays, simulations and partner and small group work to engage participants. The trauma-based components of the curriculum included content on the human brain, sensitization and tolerance, and threat response patterns (Perry 2013a, 2013b, 2013c). There are also two modules focusing on kinship care and one intercountry/private domestic adoption module. The classroom-based training has also been adapted for use in American Indian/Alaskan Native communities. NTDC has a larger focus on trauma-informed practice and culturally attuned parenting than many other trainings available in the field (Lin et al. 2023).

1.2.2.3 | Right-Time Training. Right-Time Training is a 15-module as-needed training resource designed to provide resource parents with ongoing skill development and access to information on specific challenges that they may experience while caring for children in their homes. Right-Time Training is made accessible to resource parents through a web platform and can be used on their own, as part of support groups or in conjunction with case manager home visits. Each training module takes approximately 1 h and includes a variety of formats such as videos, articles and interviews with experts, parents and youth. Examples of Right-Time Training modules include 'Managing Placement Transitions' and 'Responding to Children in Crisis'.

1.3 | Current Study

The goal of the current study is to compare the perceived preparation, confidence and willingness to care for a variety of subgroups of children at baseline and 6 months after training of caregivers who participated in NTDC training curriculum versus training-as-usual to assess whether the NTDC curriculum led to improved caregiver preparation to foster or adopt.

2 | Method

The University of Washington's IRB reviewed this study and found it exempt from review. Each site's state public child welfare system and/or tribal council also had the opportunity to review and approve this research.

2.1 | Sites

The NTDC project team conducted outreach to inform states, tribal communities, and private agencies about the opportunity to participate in this project as a pilot site (defined as a state, tribe, county or private agency). The pilot site selection process had two phases. The first involved assessing site demographic characteristics such as urbanicity, whether the child welfare system was state- or county-run and size of population served to ensure that the selected pilot sites would result in a diverse sample. The second phase involved conversations with site leadership to assess whether the project would be of interest and a good fit to the site, as indicated by factors such as leadership commitment, organizational capacity, willingness to offer NTDC in its entirety and commitment to participate in the evaluation portion of the project. Seven out of 16 sites that were interviewed as part of phase 2 were recruited as pilot sites and fully completed the study. Each pilot site then had to select an area in which to implement NTDC and a comparison area. These two areas had to be geographically separate as to prevent cross-contamination of training approaches, but similar on various characteristics including socioeconomic factors, geography and number and racial/ethnic makeup of children in that region's child welfare system as determined by data from the Adoption and Foster Care Analysis and Reporting System (AFCARS).

2.2 | Intervention Implementation

Participants in the areas of each pilot site designated as the intervention area received the NTDC training, while those in the control area received the site's training-as-usual. A description of each site's service as usual training curriculum is described in Lin et al. (2023), but all were between 24 and 32 h long, so comparable to the 27-h NTDC classroom training. Trainings took place from September 2020 through September 2022. All three curriculum components were implemented in the NTDC condition. However, participants were only required to complete at least one of the 15 available Right-Time Training modules while they were completing their classroom training. Some sites mandated that all of their resource parents complete one specific pre-selected Right-Time Training module, while other sites allowed their resources parents to select which module(s) they completed. The COVID-19 global pandemic started at the beginning of the intervention implementation window of this study, resulting in all training having to be conducted via a remote platform rather than in-person as originally intended. However, trainings were still delivered live, to cohorts of participants, as they would have been in-person.

2.3 | Participants

Each site was asked to recruit 160 NTDC participants and 160 comparison participants. All caregivers in the current study were preservice resource parents participating in the training in order to qualify for licensure. States recruited participants for this study based on those signing up for resource training. There were no specific participant inclusion or exclusion criteria—if anyone was excluded, it was at the state's discretion. Kinship and foster carers participated in trainings together. Baseline demographics of the 949 caregiver participants who took part in both the baseline and 6-month follow-up caregiver survey between June 2020 and January 2023 can be found in Table 1. Statistics are provided for both the full sample ($N = 949$) and propensity score-matched sample ($N = 794$). Please see Section 2.6 below for more information about propensity score weighting.

Most participants were female, married and White, with an average age in the mid-30s. In addition, over half of participants were college graduates. Ethnicity was only one statistically significant demographic difference between the full sample groups, X^2 (1, $N = 949$) = 4.68, $p = 0.031$, while gender approached but did not reach statistical significance, X^2 (2, $N = 949$) = 5.51, $p = 0.064$. There were no statistically significant differences between the propensity-matched caregiver groups on any demographics.

2.4 | Data Collection

Participants completed the baseline outcome survey prior to the start of either NTDC or their state's service as usual licensure training, and then completed the follow-up outcome survey approximately 6 months after completion of their classroom-based

TABLE 1 | NTDC outcome survey caregiver demographics overall and by study condition.

	All sites, full sample $N = 949$		All sites, propensity score-matched sample $N = 794$	
	NTDC $N = 540$	**Control $N = 409$**	**NTDC $N = 397$**	**Control $N = 397$**
Role training for[a]	*N* (%)	*N* (%)	*N* (%)	*N* (%)
Foster parent	191 (35.4%)	141 (34.6%)	140 (35.3%)	137 (34.5%)
Foster care and adoption (including foster to adopt)	300 (55.6%)	240 (58.8%)	227 (57.2%)	234 (58.9%)
Kinship caregiver	49 (9.1%)	27 (6.6%)	30 (7.6%)	26 (6.5%)
Gender	*N* (%)	*N* (%)	*N* (%)	*N* (%)
Female	359 (66.5%)	290 (71.1%)	281 (70.8%)	283 (71.3%)
Male	176 (32.6%)	118 (28.9%)	116 (29.2%)	114 (28.7%)
Other	5 (0.9%)	0 (0%)	0 (0%)	0 (0%)
Relationship status	*N* (%)	*N* (%)	*N* (%)	*N* (%)
Married	417 (77.2%)	305 (74.8%)	309 (77.8%)	298 (75.1%)
Living with a partner	34 (6.3%)	24 (5.9%)	28 (7.1%)	24 (6.0%)
Separated	3 (0.6%)	2 (0.5%)	1 (0.3%)	2 (0.5%)
Divorced	20 (3.7%)	22 (5.4%)	12 (3.0%)	21 (5.3%)
Widowed	5 (0.9%)	1 (0.2%)	3 (0.8%)	1 (0.3%)
Single	61 (11.3%)	54 (13.2%)	44 (11.1%)	51 (12.8%)
Has other supportive caregiver in home	*N* (%)	*N* (%)	*N* (%)	*N* (%)
	356 (65.9%)	270 (66.2%)	263 (66.2%)	263 (66.2%)
Has bio child(ren)	*N* (%)	*N* (%)	*N* (%)	*N* (%)
	271 (50.2%)	209 (51.2%)	194 (48.9%)	205 (51.6%)
Has had one or more children placed with them since licensure	*N* (%)	*N* (%)	*N* (%)	*N* (%)
	267 (49.4%)	228 (55.7%)	210 (52.9%)	221 (55.7%)
Race[b]	*N* (%)	*N* (%)	*N* (%)	*N* (%)
American Indian or Alaska Native	17 (3.1%)	6 (1.5%)	13 (3.3%)	6 (1.5%)
Asian	11 (2.0%)	5 (1.2%)	6 (1.5%)	5 (1.3%)
Native Hawaiian/Other Pacific Islander	1 (0.2%)	1 (0.2%)	0 (0.0%)	1 (0.3%)
Black or African American	63 (11.7%)	52 (12.7%)	42 (10.6%)	50 (12.6%)
White	454 (84.1%)	352 (86.1%)	341 (85.9%)	343 (86.4%)
Other	16 (3.0%)	5 (1.2%)	11 (2.8%)	5 (1.3%)
Ethnicity	*N* (%)	*N* (%)	*N* (%)	*N* (%)
Hispanic or Latino	51 (9.4%)	23 (5.6%)	30 (7.6%)	22 (5.5%)
Age	Mean	Mean	Mean	Mean
	38	36	37	36
Sexual orientation	*N* (%)	*N* (%)	*N* (%)	*N* (%)
Lesbian	26 (4.8%)	16 (3.9%)	22 (5.5%)	15 (3.8%)
Gay	11 (2.0%)	8 (2.0%)	10 (2.5%)	7 (1.8%)
Bisexual	9 (1.7%)	11 (2.7%)	8 (2.0%)	10 (2.5%)
Heterosexual	480 (88.9%)	361 (88.5%)	350 (88.2%)	353 (88.9%)
Other	6 (1.1%)	4 (1.0%)	2 (0.5%)	4 (1.0%)
Chose not to identify	8 (1.5%)	8 (2.0%)	5 (1.3%)	8 (2.0%)

(Continues)

TABLE 1 | (Continued)

	All sites, full sample $N=949$		All sites, propensity score-matched sample $N=794$	
	NTDC $N=540$	Control $N=409$	NTDC $N=397$	Control $N=397$
Highest education level completed	*N* (%)	*N* (%)	*N* (%)	*N* (%)
Some high school	11 (2.0%)	9 (2.2%)	7 (1.8%)	8 (2.0%)
High school grad	40 (7.4%)	35 (8.6%)	30 (7.6%)	34 (8.6%)
Some college	104 (19.3%)	75 (18.4%)	73 (18.4%)	73 (18.4%)
Trade/technical/ vocational training	34 (6.3%)	31 (7.6%)	28 (7.1%)	30 (7.6%)
College grad	173 (32.0%)	128 (31.4%)	132 (33.2%)	127 (32.0%)
Some post grad work	26 (4.8%)	26 (6.4%)	21 (5.3%)	23 (5.8%)
Post grad degree	152 (28.1%)	104 (25.5%)	106 (26.7%)	102 (25.7%)
Primary language	*N* (%)	*N* (%)	*N* (%)	*N* (%)
English	529 (98.0%)	403 (98.8%)	393 (99%)	392 (98.7%)
Spanish	9 (1.7%)	3 (0.7%)	3 (0.8%)	3 (0.8%)
Other	2 (0.4%)	2 (0.5)	1 (0.3%)	2 (0.5%)

[a]Sites had different answer choice options for role. For the purposes of this report, roles were recoded to fit within three categories. All kinship roles were included in the kinship category.

[b]Participants were able to choose more than one race. The statistical test for comparing race proportions compared two groups: White non-Hispanic versus any identity of colour.

training. Consent was obtained electronically, and surveys were offered only in an electronic format using REDCap online survey technology (Harris et al. 2009). The baseline and follow-up surveys took approximately 45 min to complete. Participants received a $15 (intervention) and $30 (comparison) gift card for completion of the baseline outcome survey and a $20 to $75 (amount changed over time) gift card for completion of the second outcome survey for both intervention and comparison. A total of 2289 intervention and comparison resource parents completed the baseline survey, and a total of 949 completed the second outcome survey for a total attrition rate of 59%. The attrition rate for NTDC caregivers was slightly higher than that of comparison caregivers. Of those in the intervention group who did not complete the second survey, 15.0% did not complete the training while 85.0% did complete the training but just did not complete the second survey. Of those in the comparison group who did not complete the second survey, 25.2% did not complete the training while 74.8% did complete the training but just did not complete the second survey.

2.5 | Measures

A variety of measures was included in the caregiver outcome survey to assess caregiver preparation and confidence. These measures are described below.

2.5.1 | Challenging Children (CC) Applicant Subscale

The CC Applicant Subscale of the Casey Foster Applicant Inventory (CFAI-A; Orme et al. 2007) is comprised of 13 items and specifically measures the potential to successfully foster children who may be considered more challenging to care for, such as children with behavioural challenges. An example scale item is *I can foster/care for/adopt a child who says mean and hurtful things to me*. Answer choices ranged from *Strongly disagree* (1) to *Strongly agree* (4). A higher scale score indicates more willingness to care for children considered challenging. Orme et al. (2007) found an internal consistency of $\alpha=0.85$. In the current study, a subset of 7 of the original 13 items (I can foster/care for/adopt a child who lies about everything; who rejects me; who says mean/hurtful things; who uses bad language; who has a bad temper; who steals; who doesn't try in school) plus one item developed by the evaluation team (I can foster/care for/adopt a child with inappropriate sexual behavior) was included. Some items were adapted for clarity in language for the intended population (i.e., changing wording to 'foster/care for/adopt' rather than just foster). An internal reliability of $\alpha=0.80$ was found for the 8-item subset with the 1887 participants who participated in the baseline NTDC survey (Salazar et al. 2021).

2.5.2 | Caregiver Acceptance and Support of LGBTQ2S Youth

The Caregiver Acceptance and Support of LGBTQ2S Youth is a 6-item scale developed by the evaluation team to assess the potential to successfully support LGBTQ2S youth in foster care. Possible answer choices vary between 4- or 5-point Likert scales depending on the question. An example survey items is *How confident would you feel caring for an LGBTQ2S youth?* This item set was found to have an internal reliability of $\alpha=0.890$ with the baseline data from the current sample.

Three subscales from Casey Home Assessment Protocol (CHAP; Orme et al. 2006) were used in the outcome survey: Cultural Receptivity in Fostering Scale (CRFS), Foster Parent Role Performance Scale (FPRP) and Available Time Scale (ATS). The subscales are described in detail below.

2.5.3 | Cultural Receptivity in Fostering Scale (CRFS)

The CRFS is a 25-item subscale designed to assess the level of openness towards activities that support a child's cultural development. Orme et al. (2007) found an internal consistency of $\alpha = 0.97$ for this subscale. A 9-item subset of the original 25 items was included in the NTDC caregiver survey which included 8 items with factor loadings found to be greater than 0.75 in a previous study (Coakley and Orme 2006) and an additional item about culturally relevant skin and hair care. Participants were asked to select which response reflects the level of effort they are willing to give to a variety of activities using response choices ranging from *None* (1) to *Whatever it takes* (5). A sample item is *becoming more aware of how racism or discrimination affects people from different cultures*. For the NTDC Study, the evaluators found the 9-item subset to have internal reliability of $\alpha = 0.96$ with the 1887 participants who participated in the baseline NTDC survey (Salazar et al. 2021).

2.5.4 | Foster Parent Role Performance Scale (FPRP)

The FPRP is a 40-item self-reported measure to assess applicants' perceived degree of responsibility for tasks relating to being a foster parent. The FPRP is made up of two subscales focusing on perceived responsibility for parenting (FPRP-P) and for working with the foster care agency (FPRP-A). The FPRP-P measures how much responsibility participants feel they have for family-oriented tasks such as providing for social, emotional, and cultural needs. A sample item is *helping the child with emotional problems*, with possible answer choices ranging from *No responsibility* (1) to *Complete responsibility* (5). Orme et al. (2006) found the FPRP-P subscale to have an internal consistency of $\alpha = 0.88$. The NTDC caregiver survey uses a 9-item subset of the 23-item FPRP-P along with two items from the FPRP-A (arranging visits with the child's siblings, arranging visits with birth parents) and one item developed by the evaluation team (providing transportation to visits with family members). This 12-item subset had an internal reliability of $\alpha = 0.87$ with the 1887 participants who participated in the baseline NTDC survey (Salazar et al. 2021).

2.5.5 | Available Time Scale (ATS)

The ATS is a 20-item measure that assesses anticipated available time for completing tasks that may be involved with foster parenting. Sample items ask how often the participant has time for various activities such as *play games with a child* or *be home to care for a sick child*, with possible choices ranging from *Never* (1) to *Very often* (5). Orme et al. (2007) found the 20-item subscale to have an internal consistency of $\alpha = 0.87$. An 8-item subset from the original 20 items was included in the NTDC caregiver survey, and was found to have an internal reliability of $\alpha = 0.91$ (Salazar et al. 2021).

2.5.6 | Items Assessing Caregiver Confidence to Care for Children Within Various Age Ranges

These items were developed by the evaluation team. The question *How confident do you feel that you can successfully care for foster/kin/adoptive child(ren) placed in your care?* was asked about three different age groups reflecting various developmental stages: 0–5 years old, 6–12 years old and 13 years or older. Possible choices ranged from *Not at All Confident* (0) to *Very Confident* (10). In addition, caregivers were asked *Are you having second thoughts about being a foster/relative/adoptive caregiver?* with possible answer choices ranging from *No, Not at All* (1) to *Yes, a Lot* (4).

2.5.7 | Items Assessing Perceived Preparation to Care for Children Within Various Age Ranges

These items were also developed by the evaluation team. Caregivers were asked whether they felt prepared to care for children aged (a) 0–5 years old, (b) 6–12 years old and (c) 13 years or older at this time, with answer choices being *Yes* or *No*.

2.6 | Analyses

Propensity-score matching was used to create a sample of NTDC and control group caregivers with baseline equivalence (Rosenbaum and Rubin 1983; Stuart 2010). Establishing a sample with baseline equivalence means that any differences observed in caregiver outcomes between the NTDC and control groups in our regression analyses can be attributed to group assignment rather than any underlying demographic differences. Given a set of measured characteristics, a propensity score estimates the likelihood that a participant would be in the intervention group (Starks and Garrido 2014). PSM allows us to compare participants in the intervention and control groups who have similar likelihoods of receiving an intervention based on a set of variables. In this study, these variables include the following demographics: caregiver state of residence, education level, age, race, ethnicity, gender and role (foster parent, foster to adopt or foster and adopt or adoptive parent and kinship caregiver of any type). This analysis used a logistic regression with nearest neighbour matching and a ratio of 1 to compute a composite score (usually ranging between 0 and 1) for each participant. These scores are then used to match participants. Two measures—the absolute standard mean difference and variance ratio—for each demographic variable are reported to gauge the propensity-score matching quality. Absolute standard mean difference (ASMD) is a measure of effect size with values closer zero indicating a better match. In particular, an ASMD of 0.25 or less indicates that a variable has baseline equivalence but should be included as a control in future regressions, while an ASMD of 0.05 or less indicates that a variable has baseline equivalence to an extent that it does not need to be included as a control (Wilson et al. 2019). A variance ratio is a measure that only applies to continuous variables and a value near one indicates baseline equivalence. In this study, the PSM matched sample has a sample size of $N = 794$. In this matched sample, the variables of education level, gender and role have an ASMD value of

less than 0.05, and the race, ethnicity, age and caregiver state of residence variables each have an ASMD of less than 0.25. The age variable (which is the only continuous variable in the set of demographics) had a variance ratio of 1.1. These results indicate the intervention and comparison groups in the PSM sample are balanced. The race, ethnicity, age and caregiver state of residence variable ASMD values indicate that these variables should be included as controls in future regressions while the education level, gender and roles variable ASMD levels indicate those variables are balanced well enough in the PSM sample so that they do not need to be included as controls in future regressions.

The analysis approaches used to assess between-group differences were ANCOVA for continuous dependent variables and logistic regression for binary dependent variables. For continuous dependent variables, a baseline ANCOVA with baseline scale score as the dependent variable and study condition, state, race/ethnicity and age as independent variables was conducted to assess baseline equivalency for each measure. Then, a second ANCOVA was conducted with the difference score between the 6-month follow-up scale score and the baseline scale score as the dependent variable, and all of the same independent variables with the addition of the baseline scale score, to assess whether differences between baseline to 6-month follow-up varied between the NTDC and comparison groups. For binary dependent variables, the same process was used, except for instead of a difference score for the second regression the follow-up yes/no response was used.

Partial eta squared was used as an indicator of effect size to assess the magnitude of statistically significant differences for dependent variables assessed using ANCOVA. Interpretations of effect size were based on those considered 'rules of thumb' in the field, which are $\eta^2 = 0.01$ is a small effect, $\eta^2 = 0.06$ is a medium effect and $\eta^2 = 0.14$ is a large effect. Odds ratios were used as the indicator of effect size for dependent variables assessed using logistic regression, with OR = 1.5 reflecting a small effect, 2.7 reflecting a medium effect and 4.7 reflecting a large effect (Chen, Cohen, and Chen 2010).

3 | Results

Table 2 shows the descriptive statistics of the scales by study condition at baseline and follow-up as well as statistical tests of changes between groups over time.

3.1 | Challenging Children (CC) Applicant Subscale of the CFAI

At baseline, NTDC caregivers (mean score = 2.79) scored statistically significantly higher than control group participants (mean score = 2.72) on the Challenging Children subscale of the Casey Foster Applicant Inventory. By the 6-month follow-up survey, the mean scale score of NTDC participants increased to 2.84 while that of control group participants decreased to 2.69; this difference between groups was statistically significant, $F(1, 755) = 17.78$, $p < 0.001$. The effect size was small to medium ($\eta^2 = 0.023$).

3.2 | Caregiver Acceptance and Support of LGBTQ2S Youth

At baseline, NTDC caregivers scored slightly higher than control group caregivers on the Caregiver Acceptance and Support of LGBTQ2S Youth scale, but this difference was not statistically significant. Similarly, the NTDC group had a slight increase in their score at the 6-month follow-up while the control group's mean score decreased slightly, but again these changes were not statistically significant, $F(1, 746) = 0.73$, $p = 0.394$.

3.3 | Cultural Receptivity in Fostering Scale (CRFS)

The NTDC and control groups did not differ statistically at either baseline or 6-month follow-up on the CRFS, $F(1, 760) = 2.36$, $p = 0.125$.

3.4 | Foster Parent Role Performance Scale (FPRP)

The NTDC and control groups also did not differ statistically at either baseline or 6-month follow-up on the FPRP, $F(1, 740) = 0.75$, $p = 0.387$.

3.5 | Available Time Scale (ATS)

The NTDC and control groups also did not differ statistically at either baseline or 6-month follow-up on the ATS, $F(1, 761) = 0.02$, $p = 0.894$.

3.6 | Caregiver Confidence

Caregivers were asked at both baseline and at the 6-month follow-up what age ranges (0–5 years old, 6–12 years old or 13 and older) of children they felt confident that they could successfully care for. There were no statistically significant differences between groups at baseline for any of the three age ranges. However, by the 6-month follow-up, NTDC caregivers' confidence in caring for children aged 0–5 had increased while that of the control group decreased, a difference that approached but did not quite reach statistical significance, $F(1, 767) = 3.25$, $p = 0.072$, $\eta^2 = 0.004$. For 6–12 years old, the confidence of NTDC caregivers decreased very slightly, while the decrease for the comparison group was larger, a difference that was statistically significant, $F(1, 765) = 4.74$, $p = 0.30$. The effect size was small ($\eta^2 = 0.006$). Finally, by the 6-month follow-up, NTDC caregivers' confidence in caring for children aged 13 and older had increased while that of the control group decreased, a difference that was statistically significant, $F(1, 765) = 6.50$, $p = 0.011$. The effect size was again small ($\eta^2 = 0.008$).

Regarding having second thoughts about being a foster or adoptive caregiver, a question only asked at the 6-month follow-up, NTDC caregivers were slightly more likely to be having second thoughts, a difference that approached but did not reach statistical significance, $F(1, 784) = 3.22$, $p = 0.073$, $\eta^2 = 0.004$.

TABLE 2 | Scale means by study condition and statistical comparisons at baseline and 6-month follow-up.

	NTDC $N=360$		Control $N=384$		ANCOVA					
	Mean (SD)		Mean (SD)							
	Baseline	6-month follow-up	Baseline	6-month follow-up	Type III sum of squares	*df*	Mean square	*F*	Sig	Effect size η^2
Challenging Children Applicant Subscale (possible range: low (1) to high (4) potential towards fostering more challenging youth)	2.79 (0.40)	2.84 (0.43)	2.72 (0.44)	2.69 (0.43)	2.31	1	2.31	17.78	**<0.001**	0.023
Caregiver Acceptance and Support of LGBTQ2S Youth (possible range: low (1) to high (4) potential for supporting LGBTQ youth in foster care)	3.31 (0.89)	3.33 (0.94)	3.21 (0.92)	3.17 (1.00)	0.26	1	0.26	0.73	0.394	0.001
Cultural Receptivity in Fostering (possible range: no openness (1) to high openness (5) towards child's cultural development)	4.60 (0.52)	4.62 (0.53)	4.56 (0.53)	4.55 (0.53)	0.47	1	0.47	2.36	0.125	0.003
Foster Parent Role Performance Scale (possible range: low (1) to high (5) perceived responsibility for tasks relating to being a foster parent)	4.37 (0.48)	4.34 (0.47)	4.32 (0.50)	4.27 (0.50)	0.13	1	0.13	0.75	0.387	0.001
Available Time Scale (possible range: never (1) to very often (5) availability for completing foster parenting tasks)	4.58 (0.49)	4.61 (0.50)	4.58 (0.51)	4.60 (0.51)	0.00	1	0.00	0.02	0.894	0.000
Confidence in caring for children... (possible range: not confident (1) to (10) very confident in caring for children aged...)										
0–5 years old	8.78 (1.90)	8.80 (1.81)	8.71 (1.94)	8.52 (2.14)	8.41	1	8.41	3.25	**0.072**	0.004
6–12 years old	8.07 (2.18)	8.02 (2.10)	7.92 (2.17)	7.65 (2.22)	16.16	1	16.16	4.74	**0.030**	0.006
13 and older	6.69 (2.97)	6.76 (2.93)	6.38 (3.17)	6.12 (3.03)	41.25	1	41.25	6.50	**0.011**	0.008
Having second thoughts about caregiving (possible range: 1 = no, not at all, to 4 = yes, a lot)		1.51 (0.80)		1.42 (0.70)	1.83	1	1.83	3.22	**0.073**	0.004

(Continues)

TABLE 2 | (Continued)

	%		%		Logistic regression				
	Baseline	6-month follow-up	Baseline	6-month follow-up	B	SE	Wald	*df*	Sig	Effect size OR (95% CI)
Perceived preparation to care for children... (yes or no; % who responded 'yes')										
0–5 years old	82.9%	83.1%	82.6%	79.1%	0.39	0.23	2.97	1	**0.085**	1.473 (0.948–2.287)
6–12 years old	64.5%	64.2%	59.2%	61.2%	−0.06	0.18	0.12	1	0.733	0.941 (0.663–1.336)
13 and older	30.5%	35.5%	30.7%	30.0%	0.44	0.19	5.34	1	**0.021**	1.559 (1.070–2.273)

Note: Findings < 0.10 are indicated in bold.

3.7 | Perceived Preparation to Care for Children

Caregivers were also asked at both baseline and at the 6-month follow-up whether they feel prepared (yes or no) to care for children at the same three age ranges (0–5 years old, 6–12 years old or 13 and older). Again, there were no statistically significant differences between groups at baseline for any of the three age ranges. However, by baseline, the NTDC caregivers had a slight increase in the percentage of those who reported feeling prepared to care for children aged 0–5 (up to 83.1% from the baseline of 82.9%) while the control group's percentage decreased (down to 79.1% from the baseline of 82.6%). This difference approached but did not reach statistical significance (OR = 1.473, 95% CI = 0.948–2.287, $p = 0.085$). For children aged 6–12 years, there was no significant difference at the 6-month follow-up between how much the two groups had changed (OR = 0.941, 95% CI = 0.663–1.336, $p = 0.733$). Finally, for children aged 13 and older, the percentage of NTDC caregivers who felt prepared increased from 30.5% to 35.5%, while the percentage of control caregivers decreased from 30.7% to 30.0%, a difference that was statistically significant and small in terms of effect size (OR = 1.559, 95% CI = 1.070–2.273, $p = 0.021$).

4 | Discussion

This study tested the efficacy of a resource parent training intervention in increasing various indicators of caregiver perceived preparation and confidence. Resource parents who participated in NTDC were more likely to report feeling prepared for and confident in parenting older youth (ages 13 and older) and reported an increased perceived ability to manage children who were presenting with challenging behaviours than resources parents who participated in their states' training as usual. This is especially encouraging given that caregivers often report often not feeling prepared or confident to care for older youth and youth with behavioural challenges (e.g., Barnett et al. 2018; Day et al. 2022; Farmer, Lipscombe, and Moyers 2005; Greeno et al. 2017). The results of the current study were also validated through a related study that utilized secondary analysis of AFCARS data for each of the pilot sites and demonstrated statistically significant improvements in NTDC foster parent acceptance of older youth and those that were identified by the child welfare authority as having disabilities (Fowler et al. 2024).

The findings regarding caring for children 0–12 were mixed, which may mean that both NTDC and the trainings as usual may not have had younger child-focused training content that substantially differed. Additionally, no differences were observed across groups related to cultural receptivity in parenting children across different racial groups, caregiver acceptance in parenting children that identified as being LGBTQ2S, foster parent role performance, and available time to parent foster children. The nonsignificant finding related to cultural receptivity in parenting children across different racial groups and caregiver acceptance in parenting LGBTQ2S children were surprising findings as only three of the seven states in the pilot were using curricula in their training-as-usual sites that addressed transcultural parenting, and none of the training-as-usual curriculum descriptions specifically

described material related to parenting LGBTQ2S children (Lin et al. 2023). Additionally, most families in both groups identified as white and heterosexual, so they likely had little lived experience to draw on that would prepare them for parenting transracially or parenting LGBTQ2S youth if these topics were not offered during training.

The current study provides validation for the need to continue the national movement of building resource parent training that is trauma informed, prepares resource parents to parent across the developmental spectrum and includes sufficient content to prepare caregivers to successfully care for teens—the subset of the foster care population that is hardest to recruit caregivers for and who often manifest behaviours that caregivers of younger children are often not readily prepared to address.

4.1 | Study Strengths and Limitations

The major strength of the current study is the sheer size of the resource parent population and geographies from which they participated. To see similar patterns across multiple states that participated in the infusion of NTDC increases the generalizability of the current findings on what is likely to be observed in other states that may utilize NTDC in the future. A major limitation of this study (that was largely due to cost prohibitions) was high attrition and, relatedly, that resource parents who did not complete NTDC training were not invited to take the second survey, which means that we were not able to capture information on families who started but failed to complete training (and thus the licensure process). Understanding how the training could have influenced caregivers to self-select out was a missed opportunity in the current study, as jurisdictions invest millions of dollars in the training and licensure process, and supporting families to opt out early in the process could produce significant cost savings for states (Font and Gershoff 2020). Another limitation of the study was the low enrolment rates of kinship caregivers as compared to nonrelative foster and adoptive parents. We understand that the training needs of kinship caregivers are likely to look very different than the needs of nonrelative caretakers. A future study will look more closely at the experiences of the small sample of kinship carers in this study. An additional limitation was that the training-as-usual in the control groups was not one specific training model but a variety of different models, so NTDC was not being compared to one specific alternative but many. NTDC sites also participated in different Right-Time Training modules, so this introduced cross-site variability in the intervention study condition as well. Recruitment was also more difficult in the comparison sites due to lower study engagement of staff in comparison sites, which may have biased the study sample. This COVID-19 global pandemic also started in the middle of this study, forcing planned in-person implementation of classroom training to be conducted in a remote platform. A smaller scale study is still underway to assess effectiveness of the NTDC when it is conducted in person. This study relied on self-report data, which makes the study at risk of influence by response bias. Finally, the funding period of this study was not long enough to assess whether child outcomes such as placement stability or timely reunification were better for children placed with caregivers who received the NTDC curriculum.

4.2 | Implications for Policy, Practice and Future Research

Foster parent training is a well-recognized component of providing quality care in child welfare, and well-trained foster and adoptive parents can improve placement stability, reduce behavioural problems and encourage successful reunification and adoption (Benesh and Cui 2017). The current study provides additional support for the need to continue to expand the use of foster and adoptive parent training guidance and policies that support state and federal investments in trauma informed and strengths based resource parent preparation and licensure training curriculums that are aimed at increasing permanency by targeting resource parent knowledge and competencies (Day et al. 2022; Sullivan, Murray, and Ake 2016). NTDC is a free, state of the art, open-access training programme that is designed to equip both prospective resource parents as well as those who are already caring for children. Although the pilot sites were required to offer the full classroom-based training and one Right-Time Training theme as pre-service licensure training, a strength of NTDC is its flexibility in terms of when topics can be offered (i.e., either at pre-service/licensure training or as post-licensure maintenance hours). This flexibility allows it to be easily utilized by other states who have varying licensing training requirements and preferences for what to offer in pre-service versus maintenance training. It is hoped that the use of NTDC and other similar curricula that show promising evidence for increasing foster parent capacity to care for children with more challenging behaviours and teens can decrease the need for teens and children with challenging behaviours to be placed in congregate care, which would in turn allow states to meet federal mandates to reduce reliance on congregate care settings for children in foster care as directed by the Family First Prevention Services Act of 2018 (Casey Family Programs 2019). Congregate care settings are more expensive and are associated with higher levels of emotional and behavioural problems and poorer educational outcomes than family-based settings (National Conference of State Legislators 2020). Additionally, many children who exit foster care from family-based settings maintain permanent connections to their caregivers that they can rely on for relational support even if they did not experience legal permanency (Singer, Berzin, and Hokanson 2013). Additional research is needed to assess the specific long-term impacts of the NTDC curriculum on congregate care placement, placement stability, permanency and well-being of children who were placed in NTDC trained resource parent homes.

5 | Conclusion

Resource parents provide a critical service to our communities by caring for children in highly vulnerable situations. In order for those children to have the best possible chance to thrive, resource parents need high-quality training and preparation that will allow them to meet the unique and diverse needs of children and youth who have experienced abuse, neglect, and other adverse experiences. NTDC is one new tool that may contribute to improved preparation and confidence for resource parents to successfully fulfil their roles.

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Ethics Statement

The University of Washington's IRB reviewed this study and found it exempt from review.

Consent

Research participants in this study completed an informed consent process.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study may be available upon request from Dr. Angelique Day. The data are not publicly available due to privacy or ethical restrictions.

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