



Recommendations for Trauma-Informed Care Under the Family First Prevention Services Act

Key Highlights

The federal Family First Prevention Services Act provides a significant opportunity for child welfare systems to better support children and families. The National Child Traumatic Stress Network and Chapin Hall at the University of Chicago have partnered to outline recommendations for how jurisdictions can understand Family First's policy requirements for trauma-informed approaches and ensure that implementation of the law meets the trauma-related needs of children, youth and families. This paper:

- Describes key Family First provisions that address trauma;
- Defines and describes the components of trauma-informed child welfare practice;
- Suggests ways to consider parental, caregiver and child trauma in the design and delivery of prevention and kinship navigation services;
- Recommends the consideration of trauma and traumatic stress to inform placement decisions;
- Describes how residential facilities can implement trauma-informed clinical approaches and organizational practices to best support youth and their families;
- Offers insight on trauma-informed reunification planning; and
- Outlines opportunities to better support the workforce and foster families in providing trauma-informed care.

Introduction to the Family First Prevention Services Act

The federal Family First Prevention Services Act (Family First), which was enacted in February 2018, provides multiple opportunities for states to leverage funds in support of child welfare system transformation towards better outcomes for children and families. In part, the law signifies a set of federal investments and incentives in efforts to prevent children from experiencing maltreatment and subsequently entering foster care, to support children remaining in their homes and communities with kin, and to encourage family-like settings when foster care placement is necessary. In addition to promoting these overall system outcomes, in some areas the law has specific requirements about the practices used to engage and include families to achieve those ends, including being trauma-informed.

The National Child Traumatic Stress Network (NCTSN) was created by Congress in 2000 to raise the standard of care and increase access to services for children and families who experience or witness traumatic events. Since its inception, it has had a strong focus on the trauma-related needs of children, youth and families involved in the child welfare system, and has developed a number of resources to help child welfare providers better address trauma experienced by their clients. Chapin Hall is an independent policy research center at the University of Chicago focused on providing public and private decision-makers with rigorous data analysis and achievable solutions, including partnering with jurisdictions to prepare for successful implementation of Family First. The NCTSN and Chapin Hall have partnered on this brief to specifically address 1) how Family First emphasizes trauma-informed approaches, 2) provide information about how the NCTSN defines and operationalizes “trauma-informed child welfare practice” (TICWP), and 3) offer recommendations and examples of how states, jurisdictions and child welfare providers can leverage Family First to become more trauma-informed in alignment with the letter and spirit of the law.

Trauma-informed Child Welfare Practice

Family First prioritizes trauma-informed practice because children and youth become involved with child welfare systems due to suspected abuse or neglect, which are often linked to traumatic stress reactions.¹ Additionally, child welfare system-involved parents often have their own histories of traumatic events and experience involvement with the child welfare system itself as traumatic.² Given the prevalence of traumatic experiences and reactions among child welfare system-involved children, youth, and families, it is important for child welfare professionals to integrate an understanding of trauma into their own practice to best serve their clients.

Trauma can disrupt and derail typical development in children, causing changes in both brain structure and brain chemistry.³ Children who experience trauma may have delays in meeting developmental milestones, may see impacts on their ability to learn, and may experience long term physical and emotional impacts.⁴ Parents who have experienced trauma may have difficulty assessing risk to themselves and their child, trouble regulating their own and their child’s emotions, and have developed coping strategies that were protective at the time of the traumatic event but have become maladaptive over time.⁵

Trauma can influence both children’s and parents’ ability to feel safe and to trust and engage with caretakers, caseworkers, services providers and others.⁶ However, there are opportunities to build resilience and change the trajectory of the negative effects of experiencing trauma. This is especially critical in child welfare, as experiencing child abuse and neglect influences a child’s understanding of the world and ultimately may affect their ability to successfully parent their own children, thus perpetuating the cycle of abuse and neglect.

A trauma-informed child welfare system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, youth, caregivers, and service providers themselves. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive.

Several organizations have identified elements of trauma-informed practice; the NCTSN's child welfare-specific elements are listed in Box 1. [See NCTSN's website for a resource on trauma-informed practice recommendations for child-serving systems.](#)

Importantly, trauma-informed child welfare practice should *not* be conceived as a collection of new programs or services, and it cannot be achieved through staff training alone. Effectively addressing trauma experienced by children, youth, and parents requires a change in an agency's orientation in how it works with its clients and how cases are discussed by team members. All agency policies, practices and individual interactions with children, youth and parents need to be examined through a "trauma lens" to determine how traumatic stress symptoms and additional trauma exposure are identified and mitigated, and how psychological safety can be increased. Additionally, trauma-informed child welfare practice includes a strong focus on the experiences of child welfare staff, who have high levels of trauma exposure related to their work.

The NCTSN recommends trauma screening for all children involved in child welfare programs, and working with parents to better understand their own trauma histories. This information can help everyone connected with the family – including children and parents themselves – better understand how past trauma exposure impacts their current functioning and to make changes in their physical and social environments that limit traumatic reminders. However, even without information about a child's or parent's specific trauma history, child welfare providers can take a 'universal precautions' approach, which would assume past trauma exposure and frame current behavior – which might otherwise be pathologized – as being driven by a perceived lack of safety and/or by traumatic stress symptoms. This approach can also put an emphasis on restoring individuals' sense of agency and control, which are often undermined by past trauma experiences and further eroded by child welfare system involvement.

It is important for child welfare agencies and providers to consider the intergenerational and historical trauma experienced by many child welfare system. Poor families of color, particularly Native American and African-American families, are over-represented in the child welfare system.⁷ These communities and others have also experienced generations of discrimination, disinvestment, and governmental intervention. This history can further influence individuals' experience of child welfare system involvement and make it even more challenging to establish psychological safety and partner effectively.

Box 1 NCTSN Components of a Trauma - Informed Child Welfare System.

1. Continuously expands workforce knowledge and skills about trauma and its effects.
2. Addresses primary and secondary traumatic stress of the workforce.
3. Partners with child, youth, and families at the individual and organizational level.
4. Partners with agencies and systems that interact with children, youth, and families.
5. Maximizes physical and psychological safety of children, youth, and families.
6. Routinely screens for trauma-related needs of children and youth.
7. Delivers and connects children and youth to services and supports that promote family well-being, healing and resilience.
8. Understands parent and caregiver trauma and links to services and supports that promote family well-being, healing, and resilience.

Although most trauma screening tools do not consider racism and other forms of discrimination to be sources of trauma, child welfare agencies and providers should take these experiences and dynamics into account in their work on both an individual and organizational level.

A system or agency cannot be effective in responding to trauma experienced by its clients if its workforce itself feels unsafe. Typically, agencies looking to address secondary trauma in their workforce focus on training and self-care activities for direct service staff, which on their own have limited effectiveness in mitigating trauma exposure and reducing trauma reactions.⁸ [Child welfare supervisors](#) should be able to identify potential trauma symptoms among their staff, know how to distinguish them from performance concerns, and be trained on how to address them effectively. Organizational culture and functioning can also be influenced by trauma exposure, which can create traumatogenic environments that negatively impact both clients and staff.⁹ Child welfare agencies should understand that all of their staff, regardless of their role, level of seniority or personal exposure to traumatic material, can be affected by their agency's trauma work, and should develop strategies to respond to its impact on an organizational level.

In order to be effective, trauma-informed child welfare practice must not exist in silos, existing separately from the other systems and organizations that support families. Although Family First addresses specific child welfare programs and services, child welfare-involved children and families interact with staff from many other parts of the system and across sister agencies and partner organizations that are all involved in family support work. For families that move across different levels of care, and to different providers and agencies, it is critical that their trauma-related needs continue to be identified and treated in a coordinated manner. Strategies that have been successful in responding to traumatic stress reactions, or reducing additional trauma exposure, should be shared between agencies and providers. Family members should be active participants in their service planning and have opportunities to voice what their needs are and to choose how they can best be met.

To this end, in the following sections we identify several areas of Family First that are relevant to the development of trauma-informed child welfare practice, some of which explicitly require that interventions be trauma-informed and others of which do not, and offer our recommendations about how states, jurisdictions and child welfare providers can address each element. In those cases where Family First does not require that programs be trauma-informed, we explain why we believe that a trauma-informed approach is still needed to meet the goals of the Act.

Family First Components

A. Preventive Services

For several decades the federal government, through title IV-E of the Social Security Act (title IV-E), has shared with statesⁱ the costs of maintaining children from certain low-income backgrounds in foster care, and supporting legal guardians and adoptive parents who have created permanent families with children formerly in foster care. Prior to Family First, title IV-E did not provide states with funding to support prevention efforts, except in the case of the jurisdictions that had a waiver from the federal government to use their title IV-E funds more flexibly.¹⁰

Family First authorizes an optional reimbursement program for states to provide mental health and substance abuse prevention and treatment services and parent skill-based programs to prevent children who are deemed at imminent risk of entering foster care from needing that out of home placement. The law additionally targets those same services to pregnant or parenting young people who are in foster care to prevent their children from also being placed in foster care.

ⁱ States is used for ease in this document, but the title IV-E program supports states, the District of Columbia, Puerto Rico and ten federally recognized tribes.

Unlike the foster care program, the federal government’s reimbursement for these prevention services is available regardless of the low-income status of the children or their originating families; and, the services can be provided to the child, parents, or kin with whom the children may be living outside of foster care. States must develop a five-year plan for the provision of these prevention services and utilize only evidence-based programs. Moreover, the law requires that states deliver prevention services “under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing”.¹¹

Recommendations for trauma-informed preventive services:

Parents’ experience of trauma is very relevant to their own and their children’s safety. Parents’ history of trauma exposure has the potential to impair their ability to manage stress, their attachment and social functioning, and their executive functioning, including those functions necessary for consistent parenting, such as planning, attention and flexible perspective taking.¹²

Trauma-related coping mechanisms such as avoidance or dissociation may affect a parent’s ability to identify risks to their children’s safety; additionally, their children’s trauma responses may heighten parents’ own trauma symptoms, impairing their ability to care for themselves or their children. [See NCSTN’s website for a resource on how child welfare staff can identify and address trauma experienced by parents.](#)

In addition to recognizing and addressing parents’ history of trauma and ongoing adversities, such as poverty, mental health concerns, ongoing domestic conflict and poor social supports, a trauma-informed prevention plan will consider the ongoing stress parents experience when involved in child welfare services.¹³ This is particularly true when parents experience a change in caseworkers and/or shifting expectations, which may result in increased self-protection in the form of defensiveness, withdrawal or hostility.

It may take time for parents to feel comfortable enough to disclose their personal trauma histories to child welfare staff and trust that they will not be used against them. In the meantime, given the high prevalence of trauma exposure among parents involved with preventive services, understanding parents’ behaviors in the context of how trauma impacts the stress response system, attachment and relationships, attunement, and judgements around safety (their own and their children’s) can increase the benefit of programs that target parents’ needs and build on their strengths.²

Additionally, making community-based preventive services available to families who have not been the subject of a child protective investigation may reach more families at risk of maltreatment without the stigma and potential trauma associated with services that are mandated by an agency or court. States have flexibility around how families’ eligibility for such services is determined, and are able to get title IV-E reimbursement for the costs associated with training their workforce, managing family cases and other infrastructure needs to support providing allowable prevention services.

Regardless of how families access preventive services, providing parents with information about what kinds of experiences can be traumatic, how trauma can impact both parents and children, and ways to recognize trauma triggers and traumatic stress responses can be empowering and increase their engagement. [NCTSN’S website has trauma-related resources for parents and additional guidance on protective factors that have been linked with a lower incidence of child maltreatment.](#)

B. Residential Services

One of the main categories of title IV-E funding available prior to Family First was for ‘maintenance and board’ of children placed away from their parents in foster care settings, i.e., the costs of food, clothing, shelter and daily supervision. There used to be little federal fiscal incentive for placing children in one foster care setting versus another; states would receive reimbursement for maintenance and board of eligible children whether they were placed in licensed foster homes settings or in group care settings, with few exceptions (State plan for foster care and adoption assistance, n.d.).

A brief by the Children’s Bureau and a Congressional Senate Finance Committee Hearing in 2015 are just two examples of an escalating concern in the field about the preponderance of federal child welfare funding supporting children in out of home settings regardless of their quality, the lack of incentives for family-based care, and the potential for using congregate care when it is not clinically appropriate to address children’s identified needs.¹⁴

Policy-makers, consequently, created provisions that ensure that ongoing title IV-E funding for most group care is only available if states: (1) assess children and determine that a high quality group care setting will best meet their clinical needs, and (2) ensure those group settings are capable of addressing child trauma, engaging families throughout and after treatment, and meeting those clinical needs.¹⁵ Specifically, states that are seeking ongoing federal funding for children in group care must ensure that facilities are “qualified residential treatment programs (QRTP)” and have a trauma-informed treatment model that is designed to address and treat the assessed needs of children with serious emotional or behavioral disorders or disturbances. Functional assessments must be completed by objective professionals or clinicians and address whether the facility is appropriate to the child’s assessed needs.

The QRTPs are to form family teams, continue contact with family and siblings, and otherwise engage family members in all aspects of the child’s care including assessment, treatment, and decisions about the appropriateness of the child’s placement. Further, courts are to provide heightened oversight of these assessments and confirm that children’s needs cannot be met in more family-like settings, as well as periodically review the treatment and service needs of the child.¹⁶

These provisions not only raise the expectation for the quality of care in group care facilities but are likely to create increased demand for trauma-informed assessments and therapeutic foster care settings that can align with children’s behavioral health needs.¹⁷

There are limited exceptions to the QRTP requirements for federal funding of group care (for residential settings specific to pregnant and parenting youth, young people who are at risk of or are victims of sex trafficking, and supervised independent living programs) – these are addressed separately below. The federal government will still share in the costs of children placed in these facilities even if there is no assessment of the child’s needs or a trauma-informed framework guiding the facility’s care.

Another key provision now allows states to receive federal funding for eligible children who are placed with their parents in licensed residential substance use disorder treatment facilities, when previously funding was only available for the child if separated from their parent. Policy-makers were keenly aware that the impact of the opioid crisis and parental substance use disorders of all kinds lead to the increase in the rate of children entering foster care.¹⁸ Congress sought to address this through the prevention provisions described earlier, but also by ensuring that there was financial support for effective residential substance use disorder treatment programs while children were in foster care that could “support parent-child bonding and reduce relapses”.¹⁹ For a state to receive this funding, the treatment facility must provide parenting skills training, parent education, and individual and family counseling under a trauma-informed organization structure and framework.

Recommendations for trauma-informed screening and functional assessment:

Within a trauma-informed approach, the early identification of trauma and mental and behavioral health issues in children and youth known to the child welfare system is crucial to ensure they receive services and interventions that promote psychological safety and healing from trauma. As noted above, Family First refers to the use of a functional assessment process to support whether a youth would require the services of a QRTP as well as the type of services that should be provided while the youth is in the program.

Functional assessmentⁱⁱ involves periodic evaluation of a child's well-being using standardized, valid and reliable measurement tools.²⁰ Several functional assessment tools are available, and their use varies by state systems. In general, these tools are not diagnostic; rather, they provide individual-level data on a child's strengths and needs to inform case planning processes, including placement recommendations.

Functional assessment tools can be administered by a range of professionals, depending on the requirements of the particular tool and can involve child, caregiver and/or professional reporters. The use of a standardized functional assessment tool should ideally involve professionals gathering information from multiple informants, including the child, the caregiver(s), and others involved in the child's life, such as teachers or day care providers in order to create an accurate picture the child's needs and strengths. The information usually includes questions about social/emotional, behavioral, cognitive and physical domains, and/or symptoms a child/youth may be demonstrating.²⁰

Within a trauma-informed approach, functional assessments should also include questions on the child's exposure to potentially traumatic events (e.g., sexual abuse, physical abuse, witness to family violence, exposure to community violence, etc.) and their reactions to that exposure. This information helps the caseworker understand the parent, child and family's unique strengths and challenges, while also providing direction on how to work with them in a tailored and individualized manner that incorporates their trauma-related needs, both initially and over time. This knowledge can be brought to team meetings to inform both initial and ongoing case planning and referral efforts. Re-administration of the functional assessment tool while accounting for trauma exposure and reactions can assist in determining if the level of care continues to be appropriate and if the intervention services are addressing the child/youth's individual trauma-related needs.

Finally, while a functional assessment can be completed by a range of professionals, it is highly recommended that those who conduct the functional assessment have specific training on trauma and its impact and possess a sense of comfort in talking about trauma, handling potential disclosures, and normalizing the child/youth's reactions to their experiences.

Recommendations for trauma-informed residential services:

Trauma-informed residential programs do not simply provide one-on-one trauma treatment to individual residents, but have organizational models and cultures that are informed by trauma experienced by both youth and staff, and guide all youth-staff interactions.²¹ Components of a trauma-informed residential program include a focus on strengthening relationships and attachments; building competencies; adjusting expectations to account for youth's developmental stage and trauma history; actively involving families in the youth's care, treatment and permanency planning; and enriching dimensions of the environment to create a more therapeutic milieu.²²

ⁱⁱ In the context of this paper, a functional assessment is different from both a screening process and a clinical assessment process ([NCTSN has additional resources for understanding screening and clinical assessment](#)).

Trauma-informed residential programs provide ongoing training, support and supervision geared toward ensuring that all program staff understand the impact of trauma on children’s development; how to respond to the behavior caused or triggered by trauma; and how to provide trauma-informed care that focuses on providing a secure base and sense of safety through a developmental relationship.²³ Additionally, staff need good self-regulation skills and the ability to help children learn to regulate emotions through co-regulation and interpersonal skill development.

Successful implementation of trauma-informed residential models requires active engagement and support by the organization’s senior leadership and ongoing guidance and support from those supervising direct care staff (both caseworkers and clinicians).²⁴ For many organizations, this process requires changes in theoretical perspectives, organizational norms and role expectations.²⁵ Data-informed decision-making is another necessary component of implementing and sustaining a trauma-informed setting level program model.²⁶ Including youth and families as active participants in planning and policy making, day-to-day decision-making, and programming provides another essential element of creating a trauma-informed environment that is in partnership with children and families.²⁷

C. Family Reunification Services

While the title IV-E program is by far the largest source of federal funding for child welfare, the title IV-B program is one of the few dedicated federal funding sources for child welfare services.²⁸ For over twenty years, the title IV-B program has authorized funding for states to support families reunifying, among other services that are intended to enhance permanent families. Prior to Family First, states could use funds earmarked for reunification for counseling, substance abuse treatment, mental health and/or domestic violence services, but only to support safe reunification of the child within 15 months of the child’s placement into foster care.¹⁶ Although the time limit was originally designed to incentivize timely reunification efforts, policy-makers acknowledged that this time limit could prevent some states from taking full-advantage of this funding.¹⁹ Family First removed the time limit tied to the child’s entry into foster care, allowing these services to be delivered for 15 months from when the child goes home. Unlike the prevention program discussed earlier, which can also support families who have reunified (or who have formed through guardianship or adoption), these services do not need to be evidenced-based and there is no specific trauma requirement.

Recommendations for trauma-informed family reunification services:

Although Family First does not require family reunification services to be trauma-informed, given the prevalence of trauma among child welfare-involved families the NCTSN recommends that both parents’ and children’s trauma histories and ongoing traumatic stress symptoms are addressed as part of a family reunification plan. Parents whose children have been in foster care may have histories of domestic violence, substance abuse, homelessness and other significant life stressors; additionally, out-of-home placement itself is traumatic not only for the child but also for the parent.

As much as parents and children may want to reunify, services must include practice activities for gradual reunion and avoid sudden efforts to reunify. An “all or nothing” approach does not permit the practice and coaching time necessary for the parent to incorporate the parenting- and trauma-related skills they have learned, get feedback from providers, and make real changes in the family functioning. Abrupt reunification also does not allow for the safe processing of children’s feelings about their past trauma exposure, which can include anger, blame or fear towards/of their parent. Preferably, parent-child visits and sessions are part of the practice time for the changes the family is making as a system and not taken as escapes or vacations or reward time from the out-of-home placement.²⁹

A core feature of trauma is that it takes away control; a trauma-informed reunification would gradually shift control from the provider to the parent, allowing the parent to take a leadership role in the process as the parent's capacity increases. In addition the reunification services should include practice activities for the out-of-home placement providers (i.e., the foster parent or residential program) in how to reinforce trust in the parent/family of origin and in how to identify the parent/family of origin as the leader in the reunification process; emphasizing that they are a team and the child has "all" of them and does not have to choose between them.³⁰

During the reunification process, parents' and children's trauma histories may be triggered; this possibility should be discussed transparently, and traumatic stress reactions should be monitored and responded to by program staff. Providers and policy-makers must also recognize that relapse is not an indicator of failure, and that the disclosure of real needs and problems that occur during the reunification process are signs of progress and not failure. [CEBC'S website has additional guidance on trauma-informed approaches.](#)

D. Kinship Navigator Programs

While the title IV-E program is by far the largest source of federal funding for child welfare, the title IV-B program is one of the few dedicated federal funding sources for child welfare services.³¹ For over twenty years, the title IV-B program has authorized funding for states to support families reunifying, among other services that are intended to enhance permanent families. Prior to Family First, states could use funds earmarked for reunification for counseling, substance abuse treatment, mental health and/or domestic violence services, but only to support safe reunification of the child within 15 months of the child's placement into foster care.²⁸ Although the time limit was originally designed to incentivize timely reunification efforts, policy-makers acknowledged that this time limit could prevent some states from taking full-advantage of this funding.³² Family First removed the time limit tied to the child's entry into foster care, allowing these services to be delivered for 15 months from when the child goes home. Unlike the prevention program discussed earlier, which can also support families who have reunified (or who have formed through guardianship or adoption), these services do not need to be evidenced-based and there is no specific trauma requirement.

Recommendations for trauma-informed kinship navigator program:

Research demonstrates that kinship caregivers have lower overall service utilization rates and access to resources, including monetary support, than non-kinship caregivers.³¹ While this differential can be partially attributed to lack of awareness, it is important to recognize that the abrupt placement of relative children in their homes can kinship caregivers can be experienced as a crisis for both them and the children in their care. Kinship caregivers may also experience stress related to the familial circumstances leading up to the placement, which can involve current or past traumatic events also experienced by the kinship caregivers themselves. While kinship navigators can play an important role in educating caregivers about available services and removing barriers to access, it is critical that they are knowledgeable of resources and supports to help the caregivers address any of their own trauma-related needs or stress, as well as those of the children in their care who have experienced a loss of their immediate family.

E. Pregnant and Parenting Youth

Family First carves out pregnant and parenting youth as the sole group of young people in foster care that can receive prevention services. The children of the pregnant or parenting youth do not have to be at imminent risk of being in foster care for the (prospective) parent or child to receive services, but the youth's case plan must indicate how services are designed to prevent the child from entering foster care. Legislative history shows that policy-makers were particularly interested in prevention services that could avoid the comparatively poorer outcomes for young mothers and fathers in foster care than in the general population, including avoiding intergenerational child welfare system involvement.¹⁹

Also, the law allows federal reimbursement to flow to states that place pregnant and parenting youth in group settings specializing in providing prenatal, post-partum, or parenting supports for youth. This provision recognizes the unique needs of pregnant and parenting youth to receive support as a family unit.

Residential programs that serve pregnant and parenting youth are not considered QRTPs under Family First and are therefore not required to meet the trauma-related requirements of other residential programs.

Recommendations for programs for pregnant and parenting youth:

Preventing the intergenerational transmission of trauma requires systems and service providers to be proactive when working with pregnant and parenting youth in foster care. Several promising models of working with this specialized population emphasize the importance of cross-system collaboration and “teaming” upon discovery of a pregnancy; Child and Family Teams, Family Group Decision-Making, and similar collaborative models provide a strong foundation for discussing the youth’s evolving needs in a strengths-based, youth-centered environment. Early identification of and response to pregnant youth in foster care is critical to ensuring sufficient prenatal care, as more than 40% of pregnant teens in foster care don’t receive prenatal care in their first trimester.³⁴

If unaddressed, trauma experienced by parents can lead to a range of unsafe parenting practices.⁶ While Family First excludes residential programs serving pregnant and parenting youth from the QRTP provisions, it is critical that such residential programs nevertheless identify and address trauma among their residents and focus on creating safe attachments between young parents and their children. Additionally, residential placement of foster youth and their children should be based on actual need for institutional care vs. perceived need based solely on parenting status. Practices such as including the recruitment of specialized foster families with training in parent-child attachment and the dual development of the young parents and their small children show promise and should be considered.³²

F. Sex Trafficking Programs

Family First makes an exception to the two-week payment limit for placements in settings “providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims.” This exception relieves such programs from QRTP requirements, which may provide youth who have experienced trafficking, or are at high levels of risk, with readier access to such specialized programs.

Recommendations for programs for sex trafficking victims:

Family First does not require that programs serving youth who have experienced, or are at risk of, sex trafficking to be “trauma-informed.” However, given the particularly high rates of trauma amongst children and youth in these programs, several of the QRTP requirements are especially relevant, including trauma-informed care, assessment, and transition support requirements.

Trafficked and youth at risk of being trafficked typically have extensive histories of multiple early traumas that contribute to trafficking vulnerability, as well as traumas experienced while being trafficked.³⁴ As a result, trafficked youth often present with significant trauma-related symptoms and impacts, even greater than sexually abused but not trafficked youth.³⁵

For this reason, the importance of trauma-informed treatment and care is strongly underscored. Both trauma-focused evidence-based treatment, and trauma-informed care that is organizational in scope as outlined elsewhere in this document, are needed to ensure that settings provide physical and psychological safety and promote healing and resilience.

This is especially important for trafficked youth who often experience considerable shame, stigma, and blame regarding their trafficking experiences, including from the professionals responsible for their well-being. A trauma-informed organization is also essential for staff well-being. Professionals working closely with trafficked youth are especially vulnerable to secondary traumatic stress due to their exposure to the significant trauma experiences of trafficked youth and ongoing safety threats.³⁶

Because many youth who have been trafficked have significant and highly complex histories, high-quality functional assessment, as outlined earlier, is particularly needed. Not only does such assessment better ensure that youth needs are identified and interventions targeted, it also specifically informs placement decision-making. It is important that the full spectrum of a youth's needs are taken into consideration, and that the experience of having been trafficked is not the sole consideration for placement in a specialized residential program.

Trafficked youth appear to be more likely than non-trafficked systems-involved youth to have been placed in residential settings rather than family foster homes.³⁷ Given that this disparity in placement type may play a role in vulnerability, it would be unfortunate if an unintended consequence of Family First is that trafficked and at-risk youth continued to be disproportionately placed in non-home-based foster care, even when not clinically indicated. Furthermore, because trafficked youth so often have prior histories of multiple and disrupted placement, it is important that every effort is made to “get it right” the first time and minimize subsequent transitions.

An additional requirement of QRTPs that has particular merit for settings serving youth who have been or are at risk of being trafficked is transition support. Trafficked youth who leave residential care often return to the communities where their exploitation occurred, and the circumstances that contributed to their initial vulnerabilities. Moreover, they are often transitioning from a safe, supportive, structured environment with a high level of supervision and engagement, to environments lacking many or all of these features. Given this, the six months of after-care support required of QRTPs are recommended for trafficked youth, as well.

Finally, the above recommendations regarding residential care broadly (see Recommendations for trauma-informed residential services) apply as well to residential care of trafficked and at-risk youth.

G. Supervised Independent Living Programs

Family First makes an exception to the two-week payment limit for placements in settings “providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims.” This exception relieves such programs from QRTP requirements, which may provide youth who have experienced trafficking, or are at high levels of risk, with readier access to such specialized programs.

Recommendations for supervised independent living programs:

While youth residing in SILPs have demonstrated an ability to live independently, that does not mean that they have not experienced trauma or are not experiencing the ongoing impacts of trauma. While trauma symptoms can impact one's ability to effectively engage in educational and vocational programs,³⁸ most services available to young adults are not trauma-informed.³⁹ It is critical that foster care programs overseeing youth in SILP settings recognize that they may also require specialized support and services, and ensure access to those services as needed.

Other Considerations

While Family First's provisions are designed to better support children and families who are at risk of involvement with the child welfare system, any major system change can have unintended consequences or come with unanticipated burden without intentional planning. To ensure that the law can be leveraged for the most positive impact on children and families, the NCTSN has identified several opportunities to infuse a trauma-informed approach into Family First-related planning and implementation efforts:

Workforce needs:

Family First's attention to the trauma experienced by children and families in the system reflects an important shift in the child welfare system's focus, from emphasizing physical safety and well-being of children, to considering the psychological safety and well-being of all family members. As noted previously, this emphasis should be extended to those who work in the child welfare system, both those identified as "professionals" (caseworkers, clinicians, supervisors) and the many others who have regular contact with children and families, including foster parents, and agencies' administrative and support staff (receptionists, drivers, security personnel). These individuals can experience both primary and secondary exposure to trauma and develop symptoms that impact both their personal well-being and professional effectiveness.

Additionally, organizations' culture and functioning can be negatively shaped by trauma and impact even those staff who do not have direct exposure to trauma survivors' stories. As child welfare agencies focus more on the trauma experienced by their clients, they should recognize that their staff's exposure to traumatic material will also increase and take proactive steps to mitigate its impact.

Family First's requirements may also demand more of child welfare staff, supervisors and administrators, who may not have the knowledge and skills necessary to identify and effectively respond to their clients' trauma. Child welfare agencies may be in a new role providing direct or indirect oversight of an evidence-based program's fidelity to trauma-informed care. As child welfare supervisors often do not get adequate preparation for all aspects of their roles, it will be incumbent on child welfare agencies to ensure that supervisors and other staff in oversight or continuous quality improvement roles are adequately trained and prepared in applying this trauma lens, while also having the support they need given their own high levels of trauma exposure and other job-related stress.

Impact on family foster care programs:

One of the largest system changes imagined by Family First is a residential care system that is better aligned with and able to meet the clinical needs of those children and youth in need of this higher level of care. As a result, many children and youth who historically have been placed in residential programs may instead be placed in family-based settings. In particular, as jurisdictions evaluate which children can be stepped down from residential care, or not placed in residential care to begin with, there may be an increased demand for treatment foster care (TFC) programs (also called therapeutic foster care and special-). However, Family First does not explicitly require or provide trauma-related resources to meet the needs of children and youth family-based settings, including TFC programs. Both staff and foster parents in these programs will need additional training and supports to ensure that they are able to manage this population's needs – and in some cases, additional foster parents may need to be recruited, trained and supported in order to meet the demand. States should take advantage of federal reimbursements for recruitment and training, simultaneously increasing investment in family foster care and TFC programs while utilizing quality residential care only when it best meets the clinical needs of children and youth.

Without such efforts, the benefits of family-based settings could be lost on this group of children and youth, and they could instead experience a series of disrupted placements, thus adding to the trauma they have already experienced prior to coming into foster care.

Conclusion

The Family First Prevention Services Act represents an important step in better supporting families who become known to the child welfare system, limiting the use of residential foster care programs for those children with the highest level of clinical need, and both recognizing and addressing trauma experienced by youth in such programs. However, as described in this document, “trauma-informed child welfare practice” cannot be achieved through piecemeal changes; rather, it requires a systemic approach to trauma that accounts for how it also impacts professionals and organizational culture and functioning.

As with any new effort, jurisdictions should be encouraged to use Family First as an opportunity to align best practices, policy and accompanying resources while avoiding unintended consequences for groups of children or other parts of the child welfare system. In order to truly address the trauma-related needs of children, youth and parents involved in the child welfare system, and take advantage of the opportunities provided by Family First, providers and systems will need to take steps beyond what is required by law. The engagement of cross-sector partners and families, and use of data, can guide visioning, decision-making and investments in support of positive outcomes across the child welfare continuum. While some of these steps will require additional resources at the local level, they are both necessary and could ultimately create savings for the child welfare system in the form of fewer movements between foster care settings, re-entry into foster care, and turnover of child welfare staff.

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