Capacity Building
CENTER FOR STATES

Congregate Care in the Age of Family First

Trauma-Informed Care

There is broad recognition that children and youth engaged with the child welfare system experience exposure to trauma at significant rates. For youth in foster care, rates of trauma exposure approach 90 percent (Dorsey et al., 2012). Acute trauma can result from a single event, while complex trauma can result from exposure to multiple, pervasive, interpersonal traumatic events such as ongoing maltreatment. While trauma and toxic stress can lead to lifelong health impacts, emerging research indicates that trauma-exposed children and youth can heal and even thrive after trauma-informed treatment (Fuller-Thomson et al., 2020; Yoon et al., 2019).

This resource can help child welfare agency leaders and managers, residential treatment programs, and other organizations understand the trauma-informed care requirements of the Family First Prevention Services Act (FFPSA) and thoughtfully plan for a trauma-informed approach to residential treatment.

Read this if:

You are interested in learning more about steps states can take to ensure trauma-informed congregate care under the Family First Prevention Services Act (FFPSA).

Learn more about:

- Implementing FFPSA requirements
- Prioritizing trauma-informed care in residential treatment
- Centering equity in implementation
- Exploring potential considerations and next steps for planning

Understanding the Law

The FFPSA requires trauma-informed practice along the full continuum of child welfare services. Eligible services and programs must be "provided 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 trauma's consequences and facilitate healing" (Children's Bureau, 2018).

Residential programs approved as Qualified Residential Treatment Programs (QRTPs) must use an appropriately staffed trauma-informed treatment model that meets the behavioral health care needs of child and youth residents (Children's Bureau, 2018). Upon admission to a QRTP, a functional assessment must be completed by a "Qualified Individual" who is neither employed by the title IV-E agency nor affiliated with any QRTP, although there are options for states to request a waiver of these requirements (Children's Bureau, 2018). The functional assessment must indicate the QRTP is the most appropriate setting for reimbursement to continue past the 14th day of care (Children's Bureau, 2018).

Adverse Childhood Experiences

A landmark study in the 1990s established a link between early childhood experiences and adult health outcomes. The Adverse Childhood Experiences (ACE) Study found that childhood exposure to traumatic or adverse experiences contributed to adult physical and behavioral health conditions. Multiple adverse experiences were associated with the most severe health implications (Centers for Disease Control and Prevention, n.d.).

The original survey asked adults about exposure to the most prevalent and well-researched traumatic childhood experiences, including abuse, neglect, household mental illness and domestic violence, and loss of a parent due to death, incarceration, or divorce. As communities and states begin to administer local questionnaires, some have added questions about exposure to other types of ACEs, such as community violence, racism, and bullying (Philadelphia ACE Project, 2020; State of California Department of Health Care Services, 2020). Other efforts have focused on building protective factors to buffer adversity and support resilience (Child Welfare Information Gateway, 2020).

More information can be found at Child Welfare Information Gateway: Adverse Childhood Experiences (ACEs).

Core Principles of Trauma-Informed Care

Over the past few decades, professional understanding of trauma and its causes has expanded to include the traumatic impact of maltreatment on children and youth. As the understanding of trauma deepened, treatment approaches began to move away from addressing behavioral symptoms and toward addressing the root causes of those behaviors. As a result, professionals working with youth began asking "What happened to you?" instead of "What's wrong with you?" (Trauma-Informed Care Implementation Resource Center, 2019).

While a trauma-informed approach to individual clinical practice is critical, it must exist within an organizational commitment to trauma-informed care. Residential settings that treat children and youth with exposure to trauma must ensure that practice is rooted in the following principles (Trauma-Informed Care Implementation Resource Center, 2019).

- **Safety:** Children and youth feel both psychologically and physically safe in their environment and during interactions.
- **Trustworthiness and transparency:** Trust is an explicit organizational goal. Families and youth are engaged in partnership and included in decisions. Expectations and accountability are clear to youth, families, staff, and leadership.
- **Peer support:** Opportunities for peer support are available for youth and for families, including siblings, and are considered essential practice.
- **Collaboration:** Youth and families are empowered to share in decision-making and are viewed as experts in their own experiences.
- **Empowerment:** Staff at every level of the organization believe that youth are capable and able to heal from trauma. Youth and family strengths are celebrated and validated. Resilience is clearly defined. Youth are provided with the support necessary to make and learn from mistakes.
- **Humility and responsiveness:** Staff receive training in historical trauma. There are opportunities to reflect on and address implicit bias. Cultural and racial humility and responsiveness are organizational expectations and are reflected in policies and practices.

Centering Equity in Trauma-Informed Care

Historical trauma impacts generations of people following significant traumatic events such as enslavement or genocide. While many members of a population may not experience effects from historical trauma, for others it may contribute to poor physical and mental health outcomes or distrust of majority groups and government services (Administration for Children and Families et al., 2017). For children and youth of color in the child welfare system, historical trauma and exposure to racism can compound the toxic stress of maltreatment (Administration for Children and Families et al., 2017; Child Welfare Committee, National Child Traumatic Stress Network & Chapin Hall, 2020).

During service delivery, child welfare professionals should be mindful of historical trauma and its potential impact on children, youth, and families. In addition, agencies can foster organizational environments that promote cultural humility, an ongoing process that emphasizes self-reflection and a willingness to learn from others (National Child Welfare Workforce Institute, 2017; Ortega & Coulborn, 2011).

Agency leaders can consider the following questions as they work to center equity in trauma-informed care:

- Do leaders and staff understand the impact of historical trauma on behavioral health?
- Is equity reflected in the organization's mission, vision, values, and policies?
- Does the organization support cultural humility and do practices reflect it?
- Are youth and families from populations served involved in the development and implementation of programs, policies, and training?

Considerations for Residential Trauma-Informed Care

Assessment and Admission

Within 30 days of admission to a QRTP, a functional assessment must be completed by a skilled, well-trained clinician designated as a Qualified Individual. Qualified Individuals should understand trauma and appropriate treatment modalities and be comfortable talking about trauma and handling disclosures appropriately.

The assessment process should include gathering information from the child or youth, their families, and other important people in their life. A deeper understanding of the child's or youth's exposure to traumatic events can inform the most appropriate type of treatment setting. If the assessment indicates a need for residential treatment, the child or youth must have access to a trauma-informed treatment program that is appropriate to meet their identified needs.

Trauma-Informed Treatment

QRTPs must use trauma-informed treatment models that meet the behavioral health care needs of the children and youth in care and must be staffed by skilled clinicians with a deep understanding of trauma and its impact. Clinicians should be well trained in the model(s), with access to ongoing professional development and coaching for fidelity, as well as clinical supervision rooted in an understanding of secondary trauma and transference.

Families, including siblings, should be involved in treatment as appropriate. Families and youth should have clinical support to prepare for and debrief family visits. In preparation for discharge, families should have an opportunity to learn and practice skills that can be applied in the home setting and should be connected to community-based services and supports. Following discharge, families should receive a minimum of 6 months trauma-informed aftercare to support a stable transition home.

Trauma-Informed Organizations

The delivery of trauma treatment is critical but insufficient without "organizational models and cultures that are informed by trauma experienced by both youth and staff" (Child Welfare Committee, National Child Traumatic Stress Network & Chapin Hall, 2020).

The organizational commitment to and understanding of trauma-informed care should be clear to leadership, staff, youth, and families and should be reflected in organizational policy, workforce and professional development, clinical approach, and family engagement practices.

A variety of assessment tools exist that can help organizations assess current practice and identify areas for growth and attention.

- Sample Qualified Residential Treatment Program Assessment (Appendix A of Congregate Care in the Age of Family First)
- The Attitudes Related to Trauma-Informed Care (ARTIC) Scale
- Trauma-Informed Organizational Capacity Scale

Spotlight:
The Sanctuary Model

The Sanctuary Model is an organizational change model that seeks to create a trauma-informed community. There are four pillars that make up the core components of the approach: understanding of trauma theory, adherence to seven commitments to a safe environment, a problem-solving framework, and a set of practical tools to build protective factors and emotion regulation skills.

The California Evidence-Based Clearinghouse for Child Welfare rates the Sanctuary Model as a promising child welfare practice and describes the model as "a blueprint for clinical and organizational change which, at its core, promotes safety and recovery from adversity through the active creation of a trauma-informed community. A recognition that trauma is pervasive in the experience of human beings forms the basis for the Sanctuary Model's focus not only on the people who seek services, but equally on the people and systems who provide those services" (2018).

Find more information about the Sanctuary Model here.

Next Steps in Planning for Trauma-Informed Care

Becoming trauma informed requires a deep examination of current practice and policies, as well as a collaborative approach to organizational change. As organizations consider their readiness to embark upon change, they may wish to examine the common features of effective trauma-informed organizations (Dubay et al., 2018).

Build Awareness and Organizational Commitment

The following are indicators of an organizational commitment to trauma-informed care:

- The organization's change process is rooted in an understanding that trauma impacts youth, staff, leadership, and the organization itself.
- Families and youth are driving the change process.
- Internal champions are identified and supported in developing their own skills. These champions are offered opportunities to share information and build support among other staff.
- Leadership demonstrates commitment to change and facilitates an inclusive and thoughtful process.
- Policies, practices, and the environment reflect a commitment to the core principles of trauma-informed care.
- Trauma-informed care is reflected in the organization's budget. The budget includes funds to:
  - Train clinical and nonclinical staff
  - Hire a trauma-informed workforce
  - Train and coach as necessary to deliver a trauma-informed treatment model

Build a Trauma-Informed Workforce

The following are indicators of trauma-informed staffing and clinical practice:

- Hiring practices promote a trauma-informed workforce.
- Clinical and nonclinical staff receive training in trauma-informed care, including topics such as ACEs, secondary trauma, self-care, cultural humility, humility, and transference.
- The organization promotes and encourages staff to engage in self-care and personal growth.
- The organization and supervisors take steps to prevent secondary trauma in staff.
- The organization uses a trauma-informed treatment model.
- Children, youth, and families are involved in the treatment process.
- Children and youth in care are routinely screened for trauma. Functional assessments determine the most appropriate treatment modality.
- Staff receive clinical supervision on a regular basis. Supervisors are well trained and support staff in engaging in trauma-informed practice, addressing their own trauma, and preventing secondary trauma.

The Center for Health Care Strategies offers guidance to organizations ready to begin the change process in Laying the Groundwork for Trauma-Informed Care and Key Ingredients for Successful Trauma-Informed Care Implementation.

Agencies can work with the Center for States to develop and implement successful approaches to trauma-informed care. Visit the Child Welfare Capacity Building Collaborative Liaisons website to find your state's Tailored Services Liaison.

Conclusion

The FFPSA requires approved residential treatment programs to be trauma informed. While individual clinical practice must be informed by an understanding of trauma, treatment must be delivered within the context of a trauma-informed organization or system.

Additional Resources

Congregate Care in the Age of Family First Resources

Explore the Center's companion publications for more information on the appropriate use of congregate care and authentic family engagement:

- "Congregate Care in the Age of Family First: Overview"
- "Congregate Care in the Age of Family First: Family Engagement"

- "Becoming a Family-Focused System: Assessing Organizational Culture and Climate"
- Youth Engagement Blueprint Series
- "Recommendations for Trauma-Informed Care Under the Family First Prevention Services Act"
- *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*
- *SAMHSA TIP 57: Trauma-Informed Care for Behavioral Health Services*
- National Child Traumatic Stress Network
- Trauma-Informed Care Implementation Resource Center
- *Trauma-Informed Resource Guide*

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