Family First Implementation:
A One-Year Review of State Progress in Reforming Congregate Care

American Academy of Pediatrics
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CHAPIN HALL
AT THE UNIVERSITY OF CHICAGO

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I. Acknowledgements

The health and well-being of children and adolescents is the priority for pediatricians and the American Academy of Pediatrics (AAP). The AAP is grateful to have had the opportunity to lead this crucial assessment of early implementation of the congregate care provisions of the Family First Prevention Services Act. This would not be possible without the many individuals and organizations who contributed to it in its entirety.

To begin, we thank the Annie E. Casey Foundation for their generous financial support in making this project possible and for their expert consultation and feedback to ensure the successful development and execution of this project.

We thank each of the states that participated in the study. We acknowledge the pressures and workloads of our child welfare professional partners and are grateful to the child welfare agency staff who took the time to complete our survey and participate in our focus groups. We also thank leadership from participating Qualified Residential Treatment Programs (QRTP) and congregate care settings for generously lending us your time and insights to benefit this report.

We would be remiss if we did not also thank the wonderful child welfare stakeholder networks who helped us to recruit participants for our focus groups and survey, including Think of Us, FosterClub, the American Public Human Services Association (APHSA), and the Building Bridges Initiative.

To the young people with lived experience in congregate care settings who consulted on this project or participated in its focus group, this report was deeply enriched by your lived expertise. We are incredibly grateful for your invaluable contributions to this project. Your desire to prevent others from experiencing the harms you have experienced will leave an indelible impact on us and will be a catalyst for positive change in the world.

Finally, our deepest gratitude goes to Chapin Hall at the University of Chicago. The AAP was thrilled to have the opportunity to work with some of the nation's top researchers and policy experts at Chapin Hall. Your collaboration, thought leadership, and depth of research expertise was a guiding light throughout this project, which would not have been possible without you on our team. Thank you!

II. About the American Academy of Pediatrics

The American Academy of Pediatrics (AAP) is a non-partisan, non-profit professional membership organization of 67,000 pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young people. Pediatricians consistently advocate for the health and wellbeing of children and adolescents, and bring an emphasis on those issues for youth in foster care to AAP's work on child welfare policy.

Pediatricians' expertise allows them to speak to the science of trauma and childhood development and emphasize the long-term health implications that adverse childhood experiences have on children. The AAP is committed to working collaboratively with other child welfare stakeholders to serve as a champion for strong child welfare policies that ensure all youth and families have access to the resources they need to succeed.

About the Research Team

To conduct this work, AAP brought together a research team consisting of pediatrician experts, individuals with lived expertise, and researchers and policy experts from Chapin Hall at the University of Chicago. Chapin Hall at the University of Chicago is a non-partisan, non-profit organization that engages in rigorous research and dissemination to inform public and private decision-makers and evidence-based policies and practices to improve the lives of children, youth, and families.

III. Executive Summary

In 2018, the Family First Prevention Services Act (Family First) became federal law. Family First contains an array of significant child welfare policy reforms. The two largest reforms are allowing states to use Title IV-E funds to support services to safely prevent the need for foster care, and new quality and appropriateness standards for non-family settings to promote family-based foster care placements whenever possible.

The goal of Family First is to apply downstream pressure at all junctures of child welfare involvement by placing fewer children in out-of-home care and by placing children who are in out-of-home care in a family-like setting rather than in congregate care, whenever possible. Family First's requirements to drastically improve standards for congregate care placements (group homes, residential facilities, and other institutional settings) are critical to advancing that goal.

To achieve this goal, Family First created several categories of allowable non-family placement settings. According to the Administration for Children and Families (ACF) these settings include:

- A Qualified Residential Treatment Program (QRTP);
- A setting specializing in providing prenatal, post-partum, or parenting supports for pregnant or parenting young people;
- In cases when the child is 18 years old, a supervised independent living setting; or
- A setting with high-quality residential care and support services for youth who have been found to be, or are at risk of becoming, sex trafficking survivors, defined by each state's policies and procedures.

Family First created the model of QRTP to ensure residential treatment is appropriate, time-limited, and meets a child's treatment needs. To access Title IV-E maintenance payments, Family First requires congregate care facilities to meet a certain standard of care and be accredited as a QRTP. These essential requirements establish safeguards for states to prioritize high-quality care and family-based settings to allow children to heal and thrive.

Since the beginning of the development of these policies, the AAP endorsed and championed Family First because of the promise it offers children and families. AAP is committed to ensuring the law lives up to the vision it articulates and is focused on supporting effective implementation so that vulnerable children and families benefit from this critical and needed child welfare reform. Given AAP's commitment to the success of the vision of Family First, pediatricians want to clearly understand how the law's congregate care reforms are working on the ground. This understanding will support the assessment of the law's progress and inform future policy deliberations to continue building upon Family First.

October 2021 marked the deadline for states to implement the congregate care reforms included in Family First. Some states have made significant strides to implement these changes while others have opted out of implementing these changes. This report examines where states stand nearly one year after the implementation deadline.

This report draws on research findings from 1) a 50-state survey of child welfare agency leaders and 2) focus groups with child welfare administrators, congregate care settings that have converted to QRTPs, and young people with lived experience in facilities that converted to QRTPs during the implementation of Family First.

We recognize that this research was conducted shortly after implementation. As more time passes, further research will provide a more comprehensive understanding of the successes and barriers to Family First implementation and congregate care reforms. For now, this report provides a critical early snapshot to assess policy implementation progress to date.

In reviewing the research findings presented in this report, we encourage readers to consider several questions that guided this project:

- How are states changing congregate care related to Family First?
- Are states reducing the use of congregate care?
- How are states implementing QRTPs and other congregate care "specified settings" under Family First?
- How has financing for congregate care and QRTP changed since Family First?
- What are the barriers, successes, and recommendations for implementing congregate care changes under Family First?
- What policy recommendations are necessary to support Family First implementation and congregate care reforms?

a. Key Themes

This report examines the early status, successes, and barriers states have experienced in implementing the congregate care policy reforms in Family First. Key findings from the survey of states and focus groups include:

- **Ongoing congregate care reforms align with Family First.** States indicated their existing congregate care reforms, that often predated Family First, align with the vision and goals of Family First and anticipated more changes during the next two years.
- **States have reduced the use of congregate care and simultaneously increased the use of kinship foster care.** States indicated that they have reduced their use of congregate care since, and in some cases before, the passage of Family First. Kinship foster care capacity has increased after Family First's implementation.
- **QRTPs are now a primary component of congregate care placement arrays in many states.** However, some states rely primarily, even exclusively, on settings for youth in supervised independent living and youth at risk of sex trafficking. The use of out-of-state QRTPs due to youth's treatment needs and limited in-state QRTP capacity is also quite common. Other states have few to no QRTPs.
- **States undertake various strategies to establish and implement QRTPs to meet federal requirements.** Some states sought a waiver to streamline in-house independent assessments of QRTP placements while others did not; some states use court hearings while others use paper approval to adjudicate QRTP placements; some states use exclusively Title IV-E while others a combination of Title IV-E and Medicaid to fund QRTPs.
- **Top implementation barriers concern resource needs in: (1) workforce and staff; (2) therapeutic foster care models; (3) funding; and (4) foster families.** QRTP staff training, quality, and capacity vary greatly. There is a need for funding for transition of congregate care facilities to QRTPs, prevention of unnecessary congregate care placements through community-based services, community-based support for stepping young people down from QRTPs, deployment of aftercare services, and family and community integration at all points of care. States indicate funding is the most important factor to successful implementation.
- **QRTP treatment, quality staff, and aftercare tailored to youth's needs is lacking.** The use of QRTP as an individualized and quality treatment intervention, as opposed to a standardized placement, has yet to be realized. Concerns about the accountability, quality, and sustainability of the QRTP workforce stymy the implementation of individualized, trauma-informed treatment.
- **There is a perceived lack of change in QRTPs from pre-existing congregate care culture and practice.** While child welfare administrators and QRTP leaders believe QRTPs codify best practices that were already initiated in many states before Family First, young people with lived experiences in QRTPs see it otherwise; as a continuation of pre-existing practice with modest changes. That many of the states only began approving QRTP institutions after 2021 suggests a general delay in QRTP implementation.
- **Child welfare systems need evidence that QRTPs are accountable for improving young people's lives and outcomes.** Difficulty in tracking young people in QRTPs (e.g., numbers, duration) and the current focus on compliance (e.g., assessment, eligibility, court approval) overlooks the importance of ongoing tracking of the quality of QRTPs and youth outcomes under their care.

b. Policy recommendations summary

After analyzing all of the data collected, we recommend policymakers take the following actions:

1. Provide states with additional state and federal resources such as technical assistance and funding so that states can successfully implement the congregate care policy reforms in Family First by growing their capacity in: (1) child welfare staff, (2) foster homes, (3) therapeutic care models as alternatives to congregate care, and (4) an array of comprehensive community-based mental health services that support successful placement in the least restrictive environment
2. Professionalize and invest in QRTP staff to ensure high-quality, individualized treatment
3. Establish standards for youth- and family-driven QRTP treatment
4. Require oversight for the full array of congregate care placements including supervised independent living and settings for survivors of sex trafficking, and also of the use of out-of-state QRTP placements
5. Provide clear funding guidance to implement QRTPs
6. Facilitate cross-system collaboration to successfully implement Family First
7. Integrate QRTPs into a child welfare system's continuum of prevention, aftercare, and reducing the unnecessary use of out-of-state care
8. Establish performance- and outcome-based monitoring of QRTPs

Introduction

Federal policymakers took a significant step forward in recognizing that children fare best in families when Family First was signed into law in 2018. Congress designed Family First's congregate reforms with empirical evidence and lived experience in the foster care system as the foundation of these policies.

Family First offers states a new path to reduce the unnecessary use of congregate care and offer quality, time-limited support to youth who demonstrate an acute clinical need for placement in Qualified Residential Treatment Programs (QRTPs). These reforms to congregate care were coupled with more support for kinship care so that more youth in foster care could remain connected to family rather than in out-of-home care with strangers or in a facility. Additionally, these reforms came after decades of advocates and youth with lived expertise raising significant concerns about systemic abuse and mistreatment that was happening in many congregate care facilities across the United States.

Family First set October 2021 as the implementation deadline for redesigned federal fiscal participation in congregate care. As the nation approached October 2021, much remained unclear about the progress, or lack of progress, states had made in implementing the congregate care policy reforms described in Family First. Since the law passed, some states have expressed in ad hoc discussions that they were experiencing burdens to implementation while others were moving full speed ahead. For states that shared they were experiencing burdens, it was unclear if these obstacles resulted from the law or if they were tied to larger events impacting the country as a whole, such as the COVID-19 pandemic. The COVID-19 pandemic brought with it myriad additional challenges for the child welfare system. Reunification timelines were delayed, the number of available foster care placements dropped, and many youth were left sleeping in agency offices or in hospitals.[1] These system-specific challenges were exacerbated by widespread socioeconomic deprivation and public health pressures.

Given this public health and child welfare policy context, our goal was to gather research evidence to provide a more comprehensive understanding of where states stood in implementing the congregate care reforms included in Family First. We aimed to use our research findings to describe what was and was not working well for states in implementing Family First. Additionally, we hoped to discover strategic approaches states took to overcome any common barriers to implementation that could help other states, as well as additional supports states needed to implement these crucial reforms effectively.

In summary, we sought to answer the following questions:

- What progress have states made in implementing the congregate care policy reforms included in Family First now that we have passed the implementation deadline?
- What successes have states had in implementing the congregate care policy reforms in Family First?
- What barriers or burdens have states experienced in implementing the congregate care policy reforms in Family First?
- If states have experienced barriers to implementation, how did they overcome them?
- If states had not yet overcome implementation barriers, what supports do they need to implement the congregate care reforms in Family First effectively?

The following findings in the report are our understanding of the nation's answers to these questions.

[1] Beal, S. J., Nause, K., & Greiner, M. V. (2022). Understanding the impact of COVID-19 on stress and access to services for licensed and kinship caregivers and youth in foster care. Child and Adolescent Social Work Journal, 39(5), 633-640. https://doi.org/10.1007/s10560-022-00833-9
Goldberg, A. E., Brodzinsky, D., Singer, J., & Crozier, P. (2021). The impact of COVID-19 on child welfare-involved families: Implications for parent-child reunification and child welfare professionals. Developmental Child Welfare, 3(3), 203-224. https://doi.org/10.1177/25161032211045257
Patrick, S. W., Henkhaus, L. E., Zickafoose, J. S., Lovell, K., Halvorson, A., Loch, S., Letterie, M., & Davis, M. M. (2020). Well-being of parents and children during the COVID-19 pandemic: A national survey. Pediatrics, 146(4), e2020016824. https://doi.org/10.1542/peds.2020-016824
Pisani-Jacques, K. (2020). A crisis for a system in crisis: Forecasting from the short-and long-term Impacts of COVID-19 on the child welfare system. Family Court Review, 58(4), 955-964. https://doi.org/10.1111/fcre.12528

IV. Summary of Results

Key Survey and Focus Group Findings

The survey was sent to child welfare directors in 50 states, as well as Washington DC, and Puerto Rico. It received an overall response rate of 92% and a completion rate (i.e., excluding break-offs) of 81% **(Figure 1)**.

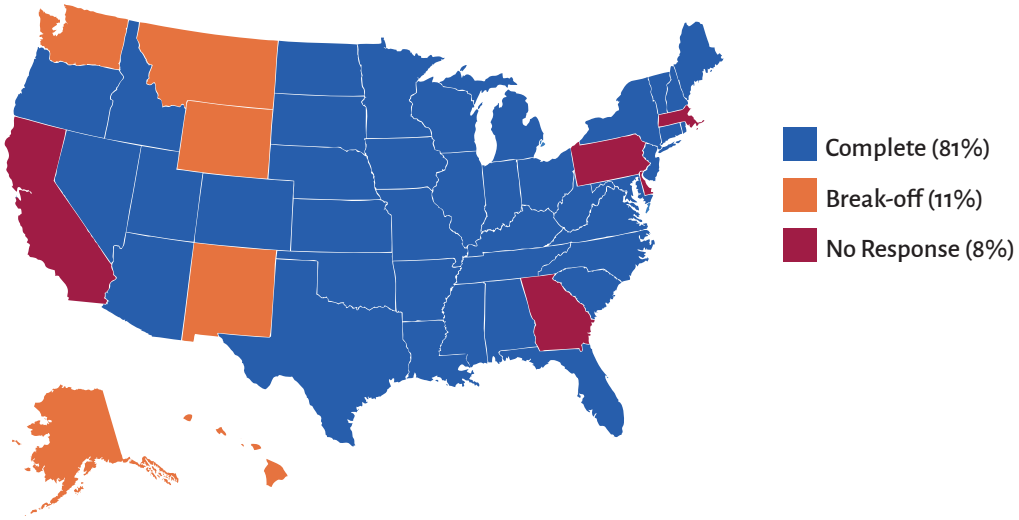

Figure 1. Response status, by state, district, and territory (n=52). Note: Washington, D.C. and Puerto Rico completed the survey. Overall rates included in parentheses.

Three focus groups were held to include young people with lived experiences in QRTPs (n=5, four states); four leaders of QRTP facilities (n=4, four states) and two leaders of other congregate care facilities (n=2, one state); and child welfare agency administrators who are responsible for implementing QRTPs (n=8, seven states), as well as one congregate care administrator (n=1, one state).

Alignment between State-Led Congregate Care Reforms with Family First and Reduction in the Use of Congregate Care

- The majority of states have changed their provision of congregate care to align with Family First. This was accomplished after extensive engagement with diverse stakeholders (child welfare agency staff, congregate care providers, legislators, among other involved groups) to implement Family First. The majority of states attributed those changes to both Family First and pre-existing and ongoing state-led reforms. Twenty-eight states, or 68% of respondents anticipate further changes to congregate care in the coming years.
- Compared to pre-Family First implementation, fewer youth are entering congregate care in some states. More states reported placing 10% or less of youth in foster care in congregate care. Kinship foster care has come to play a larger role in states' placement array, with congregate care playing a smaller role. Changes to use of non-kinship foster care were less clear.
- In the focus groups, child welfare administrators and QRTP leaders reflected on the reduction in the inappropriate use of congregate care driven by both pre-existing state-led reforms and Family First, which codified practice changes that are not necessarily new in some states. Young people who reported lived experiences in facilities that converted to QRTPs, however, saw the policy change without substantive change (or being notified) in their experience of receiving services in a QRTP, and noted the inconsistent implementation between federal, state, county, and urban/rural settings.

QRTP and Other Non-Family-Based Settings in the Congregate Care Placement Arrays

- QRTPs play a significant role in many states' congregate care array and represent a majority of congregate care institutions (i.e., over 50%). However, a significant number of states have few to no QRTPs in their state. Many states reported using out-of-state QRTPs primarily due to youth's treatment needs and a lack of in-state QRTP capacity.
- Most states have implemented the "specified settings" provision of Family First by expanding their use of QRTPs within the array of congregate care settings. A handful of states rely primarily on supervised independent living or institutions for youth at risk of sex trafficking.
- A majority of responding states reported decreasing the percentage of congregate care placement capacity while increasing the percentage of kinship care placement capacity within the placement continuum. Thirty responding states (75%) have kept some proportion of congregate care "as-is."

- Many state child welfare directors reported in the survey that states provided various supports to QRTPs to meet the core components of QRTPs and aftercare requirements. However, focus group findings indicated less optimistic impressions about the implementation of QRTP treatment and aftercare (permeability, customization, and community connections). Child welfare administrators reported youth being "stuck" in QRTPs and a dearth of community-based resources to support step-down from QRTPs. Young people highlighted the lack of specialized medical care, little support or assistance in fostering family connections, friendships, and access to extracurricular activities within the community. QRTP leaders noted the difficulty in the youth's transition from residential to school settings in the community.

Funding Strategies for Congregate Care and QRTPs

- Since the implementation of Family First, many states have reported a decrease in the proportion of congregate care funding provided by the federal government and an increase in the proportion provided by states.
- States primarily fund their QRTPs through either (a) Title IV-E alone, or (b) with Title IV-E and Medicaid. Few states reported decreasing their QRTP sizes to not be considered as Institutions for Mental Disease (IMDs) so that the states can receive Medicaid funding.

Barriers to Implementation of Family First and QRTP

- Many states indicated that top barriers to Family First and congregate care reform implementation are related to resource needs in: (1) workforce and staff; (2) therapeutic foster care models; (3) funding; and (4) foster families. Many states also indicated to address workforce and staff issues, ensure therapeutic models are available, and successfully recruit foster families, more funding is necessary to overcome these barriers.
- Barriers about workforce, staffing and funding were also expressed by focus group participants (young people with lived experiences, child welfare administrators implementing QRTPs, and leaders of QRTP facilities). Across all of the focus groups, participants reported significant concerns regarding QRTP staff training and capacity and capacity to tailor treatment to youth's needs. Staff shortages, retention, compensation, and a lack of sustainable careers for staff in QRTPs were noted.

Quality of QRTP Treatment and Monitoring

- Young people in the focus groups reported feeling that they had to fit into a set of limited pre-existing expectations for their participation in QRTP treatment. This type of rigidity offers little consideration of youths' individual circumstances (e.g., pregnant/parenting status, LGBTQIA+ identity) and overlooks the nuances of their individual health needs. In some specific examples, youth at QRTPs felt a pressure to participate in religious celebrations or services, their gender expressions being disrespected, medical conditions being overlooked, and psychiatric treatment consisting of over-prescription of psychotropic medications. Child welfare administrators reflected on the struggle to use QRTP as a specific treatment intervention as opposed to an available placement slot. In contrast, QRTP leaders were more optimistic about the QRTP model's ability to offer tailored care to meet individual needs.
- Systematic data tracking on QRTP performance including on the implementation of key components and outcomes of youth placed in QRTPs is lacking. Rigorously collecting this data is necessary to drive continuous quality improvement efforts and track outcome improvement over time.

Detailed Survey Findings

1. How are states changing congregate care[2] as related to Family First?

This area of inquiry examined states' pre-existing and ongoing congregate care reforms as related to Family First and states' plans for future reforms

- **Vision for Congregate Care Aligned with Family First:** 42 responding states[3] (88%) have developed a congregate care vision aligned with Family First, involving diverse stakeholder inputs (child welfare agency staff, congregate care providers, legislators, among other involved groups) to implement Family First and congregate care reforms (**Figure 2**).
- **State Efforts and Family First Driving Reforms:** 29 responding states (71%) attributed congregate care changes to both Family First and pre-existing and ongoing state-led reforms. Twenty eight responding states (68%) indicated further congregate care changes in the next two years.

[2] "Congregate care" refers to "group home" and "institution" as defined in a state's bi-annual reports to the federal Adoption and Foster Care Reporting System (AFCARS).
[3] Throughout this survey summary, "states" refer to states that responded to relevant survey questions.

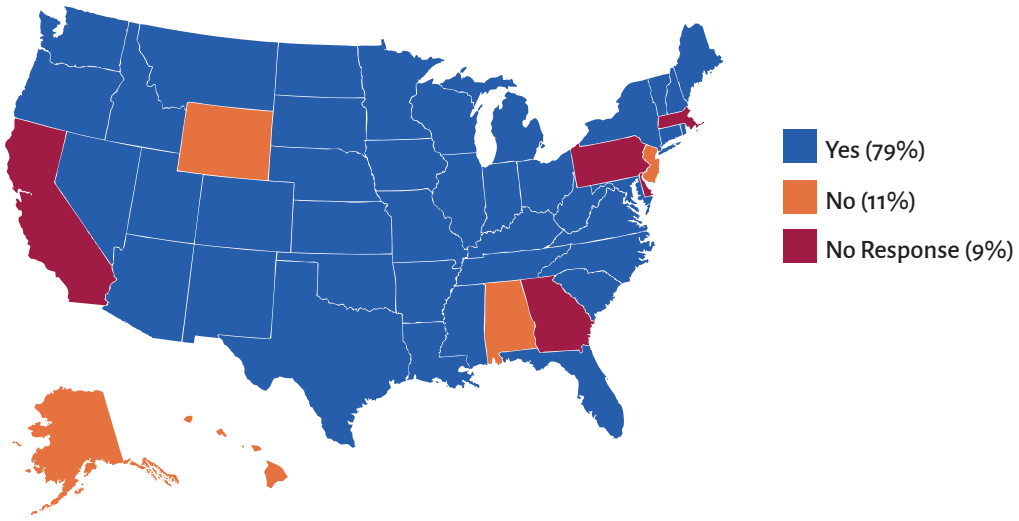

Figure 2. States' implementation of congregate care reforms aligned with Family First.

2. Are states reducing the use of congregate care?

This area of inquiry examined whether states changed the proportion of youth placed in congregate care before and after Family First, as well as the proportions of available placement capacity in congregate care, kinship, and non-kinship foster care.

- **Proportion of Youth in Congregate Care:** We provided respondents percentage "bins" to characterize the percentage of youth placed in congregate care "before" and "after" Family First to identify broad trends rather than precise magnitude of before-after changes[4] **(Figure 3)**. There is evidence that states reduced their use of congregate care relative to other forms of foster care after Family First Implementation: fewer states placed 21-25% of youth in foster care in congregate care (two states to zero states; 5% to 0%), fewer states placed 16-20% of youth in congregate care (five states to one state; 12% to 2%), and fewer states placed 11-15% of youth in congregate care (10 states to eight states; 24% to 19%). Furthermore, more states placed a relatively small percentage of youth in congregate care: more states placed 6-10% of youth in foster care in congregate care (18 states to 21 states; 43% to 49%) and more states placed 0-5% of youth in congregate care (seven states to 11 states; 17% to 26%).

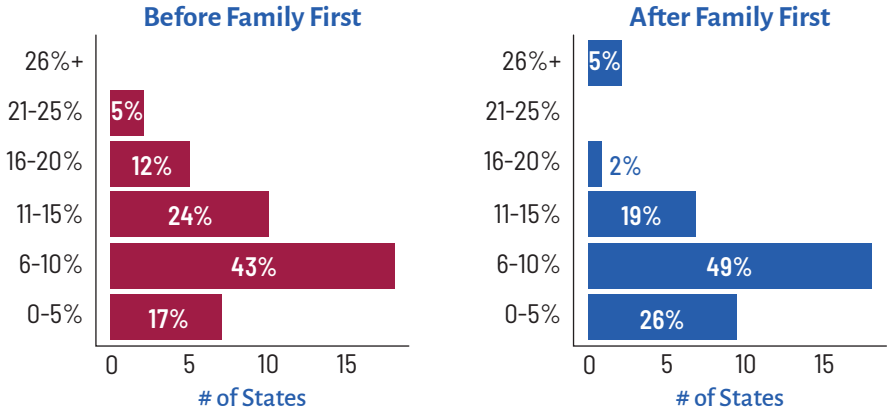

Figure 3. Percentages of youth in foster care placed in congregate care by state, before and after Family First implementation.

- **Proportions of Placement Capacity in Congregate Care, Kinship, and Non-Kinship Foster Care:** Twenty eight responding states (62%) reported decreasing the percentage of congregate care placement capacity[5] while 29 responding states (64%) reported increasing the percentage of kinship care placement capacity within the placement continuum **(Figure 4)**.

[4] Imagine "State A" placed 9.9% of youth in foster care in congregate care before Family First and 10.0% after. Now imagine "State B" placed 10.1% before and 14.9% after. We do not report state-level changes because our bins, which are designed to make it easier for states to respond, could distort readers' impression of states' placement arrays.
[5] In the survey, we used "slots" to denote rooms/beds for youth in care, whether in kinship foster homes, non-kinship foster homes, or congregate care.

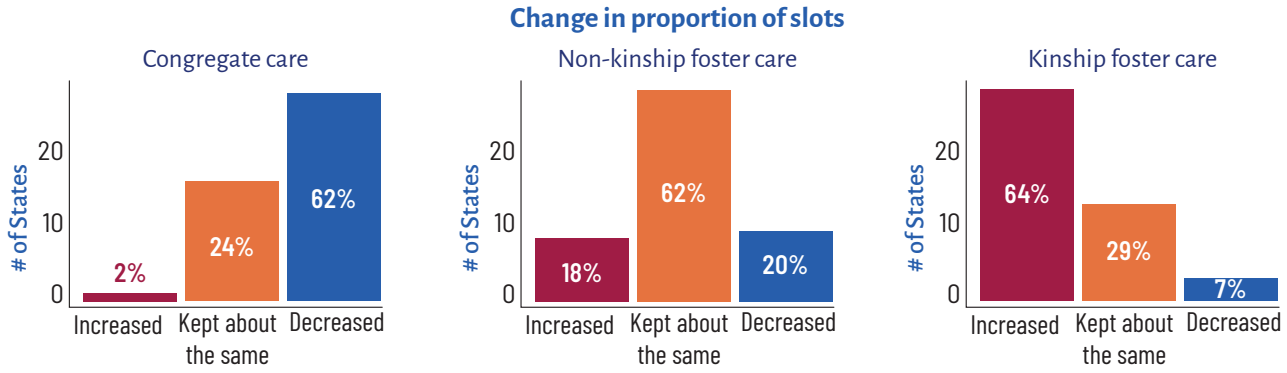

Figure 4. Change in proportion of placement capacity in placement continuum for youth in care after Family First.implementation.

3. How are states implementing Qualified Residential Treatment Programs (QRTPs)[6] under Family First?

This area of inquiry sought to assess the usage of QRTPs in states' congregate care placement arrays, implementation of core components of QRTPs to include Qualified Individuals conducting assessments to determine if the child or youth has needs requiring a QRTP, court reviews of the placement to determine its appropriateness for the child or youth, and length of stay in the QRTP.

- **Prevalence of QRTPs in Congregate Care Placement Arrays and Out-of-State QRTPs:** Seventeen responding states designated a majority of congregate care institutions (i.e., over 50%) as QRTPs **(Figure 5)**. Nineteen responding states (48%) reported placing youth in out-of-state QRTPs primarily due to youth's treatment needs and a lack of in-state QRTP capacity.

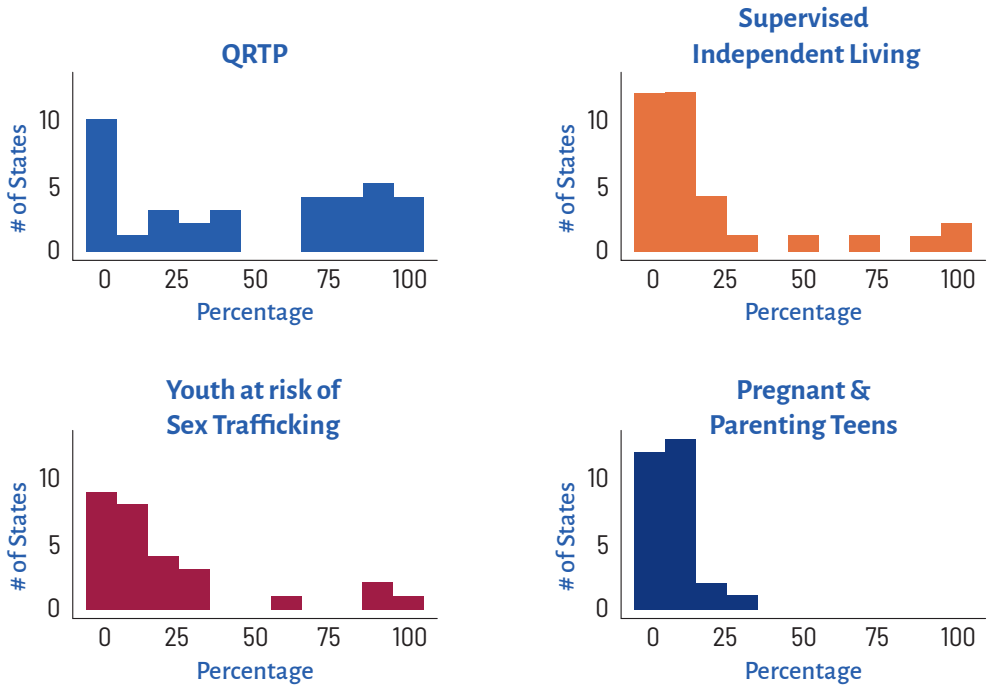

Figure 5. Estimated percentage of states' placement arrays constituted by each "specified setting."

[6]"Qualified Residential Treatment Program (QRTP)" is a non-foster family home, "specified setting" eligible for federal Title IV-E foster care maintenance payments under Family First. A QRTP must: (1) be accredited by an accrediting body approved by the U.S. Department of Health and Human Services (HHS) secretary; (2) have registered or licensed nursing staff available 24/7; (3) have other licensed clinical staff on site and available 24/7; (3) have other licensed clinical staff on site and available 24/7; (4) have a trauma-informed treatment model; (5) facilitate outreach to the family members of the child, including siblings, and document how the outreach is made; if in the best interests of the child, family members must be involved in the child's treatment; and (6) provide discharge planning and family-based aftercare support for 6 months after discharge.

- **Approval of QRTPs and State Supports Provided to QRTPs:** Two responding states (7%) provided their first QRTP approval in the first half of 2022, 18 responding states (62%) in 2021, and nine responding states (31%) in 2020. Most responding states reported that QRTPs received state supports to meet the core components of QRTP standards and aftercare requirements **(Figure 6)**.

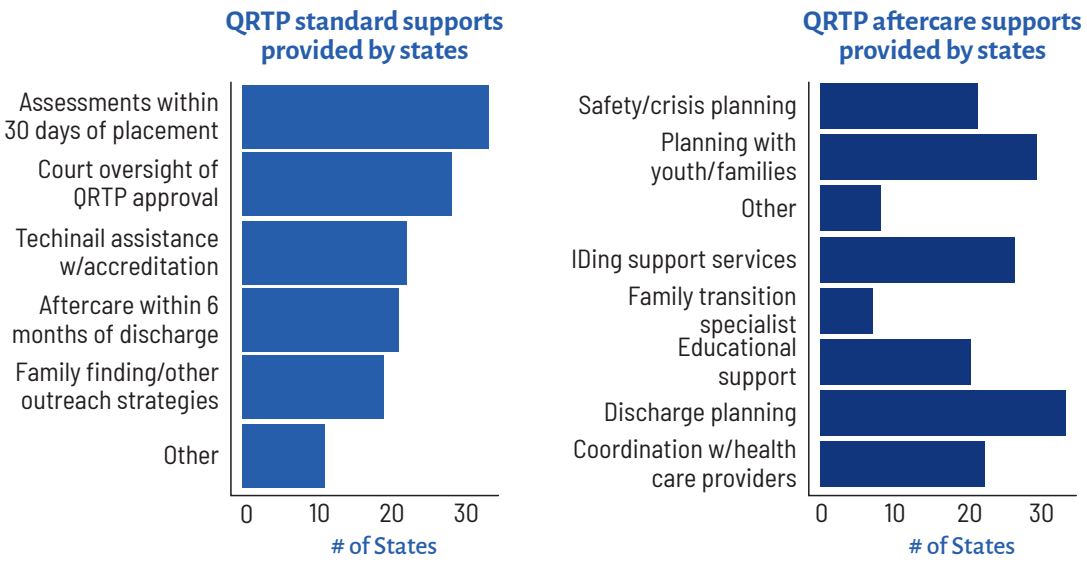

Figure 6. State supports provided to QRTPs to meet core components of QRTP standards and aftercare requirements. Percents not included as states could select more than one support.

- **Qualified Individuals (QIs) and Assessment Tools:** Sixteen responding states (38%) sought a waiver to allow their agency staff to serve as Qualified Individuals (QIs)[7] conducting independent QRTP assessments, which are conducted prior to youth's QRTP placement for 27 responding states. Thirty two responding states reported using the Child and Adolescent Needs Strengths (CANS) instrument as the assessment tool.
- **Court Review:** Court review of QRTP placements takes place in court hearings for 28 responding states or through paper approval for 22 responding states. When the court denies a QRTP placement, 24 responding states (83%) reported continuing the placement and using state funds solely to pay for the stay.
- **Length of Stay:** 11 responding states (48%) reported 180-360 days as youth's average length of stay in QRTPs.

4. How are states implementing other congregate care "specified settings"[8] under Family First?

This area of inquiry sought to assess the extent to which states have relied on "specified settings" other than QRTP as defined in Family First. These include congregate settings for youth needing supervised independent living programs, pregnant/parenting youth, and youth at risk of sex trafficking. Additionally, the inquiry sought to understand the extent to which none of the available four specified settings (i.e., QRTP, and settings to meet needs related to supervised independent living, sex trafficking, pregnant and parenting youth) are in use thereby maintaining historical congregate care settings primarily.

- **Supervised Independent Living:** Three responding states rely primarily (i.e., 90-100%) on settings for youth in supervised independent living (Figure 5).
- **Sex Trafficking:** Three responding states rely primarily (i.e., 90-100%) on settings for youth at risk of sex trafficking (Figure 5).
- **Maintaining Historical Congregate Care Settings:** Four responding states maintain primarily (i.e., 90-100%) congregate care institutions as none of the four specified settings.

5. How has financing for congregate care changed since Family First?

This area of inquiry sought to assess financing changes across state and federal funds to support implementation of congregate care reforms and the congregate care array of placements.

[7]"Qualified Individual" (QI) conducts an assessment to determine whether a child's QRTP placement is appropriate within 30 days of the QRTP placement.

[8]Family First allows for four "specified settings" where states can be reimbursed under Title IV-E for placing youth in these settings that are not family foster homes. The four specified settings are: (1) settings for youth 18 and older in supervised independent living; (2) settings for youth at risk or victims of sex trafficking; (3) settings for pregnant and parenting youth; and (4) Qualified Residential Treatment Programs (QRTPs).

- **Proportion of Funds:** Since the implementation of Family First, 17 responding states (40%) reported an increased proportion of congregate care funds provided by states. Twenty two responding states (52%) reported a decreased proportion of congregate funds provided by federal funding.
- **Average Cost:** Twenty eight responding states (74%) indicated an increase in average cost per youth per day in congregate care after Family First.
- **Mix of Funds:** To fund QRTPs, 15 responding states (48%) reported using both Title IV-E and Medicaid, 10 responding states (32%) reported exclusively using Title IV-E, and only three responding states (10%) reported exclusively using Medicaid. Six responding states (14%) reported a decrease in their QRTP sizes to not be considered as Institutions for Mental Diseases (IMDs) so that states can receive Medicaid funding.

6. What are the barriers, supports to be successful, and recommendations for implementing congregate care changes under Family First?

This area of inquiry sought to assess key barriers and what states need to be successful at this early stage of Family First congregate care reform implementation.

- **Top Barriers:** Top barriers to Family First and congregate care reforms implementation are related to resource needs in: (1) workforce and staff; (2) therapeutic foster care models; (3) funding; and (4) foster families.
- **Limited Capacity to Achieve Timely and Appropriate Placements:** Limited capacity of therapeutic foster care models, foster families, and appropriate congregate specified settings paired with limited workforce capacity and the need for additional funding are the reported reasons that thwart states' ability provide timely and appropriate placements for youth. There was no significant association between states' having reduced congregate care placement capacity and a lack of congregate care placement capacity being the reason for the inability to provide timely and appropriate placements **(Figure 7)**.

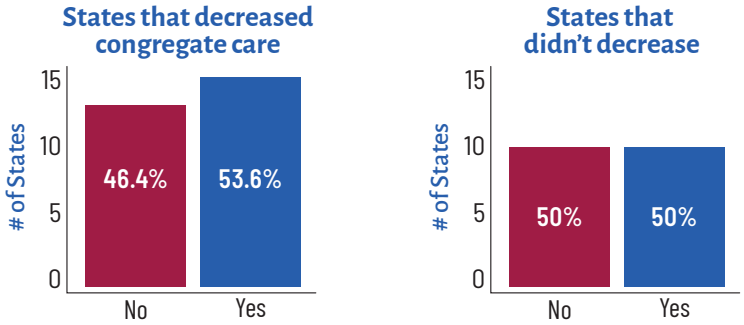

Figure 7. States that reported reducing congregate care capacity were not significantly more likely to identify a lack of congregate care capacity as a cause of being unable to identify timely and appropriate placements for youth.

- **Resources Needed for Implementation:** For implementation to be successful, 26 responding states (62%) indicated having the "highest need" for more funding, 19 responding states (45%) indicated having a "medium need" for technical assistance, and 20 responding states (48%) indicated having the "lowest need" for more information.
- **Importance of Addressing Clinical and Treatment Needs:** Several open-ended survey comments (shown below) by state child welfare directors convey a success of congregate care reform related to ensuring settings are used solely to meet clinical and treatment needs.

Survey responses from child welfare agency leaders:

"Congregate care should be the last resort. And if used, it should be brief and for clinically sound reasons."

"Having a well-developed system of mental/behavioral health services is critical to successfully reducing the number of youth in residential settings and having youth placed in the appropriate setting getting necessary treatment."

"There is a lack of requirements for treatment and outcomes, which do not support children improving clinically and being able to successfully transition to community and family settings. When we discuss congregate care, we must discuss the impact of Medicaid-covered institutional placements."

Detailed Focus Group Findings

Key themes emerged across all three focus groups as well as themes unique to each focus group, which highlighted the challenges, needed supports for successes, and recommendations for the implementation of Family First and QRTP. Below we summarize these themes with supporting de-identified quotes.

QRTP Staff Training, Quality, and Capacity

All three groups emphasized challenges associated with QRTP staffing capacity. These included the need for increased relevant staff training, skills, and ability to provide quality treatment to youth. The focus groups elevated needs related to inconsistent treatment services not tailored to youth's needs (e.g., trauma-informed, biopsychosocial) or individual circumstances (e.g., pregnant/parenting youth, LGBTQIA+ youth, trafficking population, navigating college and childcare).

The QRTP workforce faces significant shortages (i.e., not enough staff), retention challenges (i.e., high turnover), inadequate compensation (i.e., low pay for the clinical demands of the job), and unsustainable career pathways (i.e., a job with little professional growth). Furthermore, the use of restraints was troubling to youth in care. The young people focus group shared specific examples about staff's use of restraints, the trauma of witnessing these experiences and staff's lack of professionalism in handling grievances or scapegoating youth for reporting them.

These challenges counter the clearly defined Family First standards[9] for clinical staff, suggesting that classifying congregate care facilities as QRTPs does not solve existing staffing issues. The lack of a professionalized workforce to serve in QRTPs is limiting the implementation of the QRTP model.

> "I couldn't be myself."
>
> —Young person

> "My needs were met. But they weren't always met."
>
> —Young person

QRTP Treatment and Flexibility

The culture in QRTPs may retain that of historical congregate care. The young people focus group and child welfare administrators focus group indicated an overarching struggle in QRTP implementation to overcome the status quo/existing practice of a congregate care as a placement, rather than a treatment setting, for youth. Furthermore, QRTP's and their staff struggle to accommodate or customize care to youth's needs and implement trauma-informed treatment.

> "We [QRTPs] don't need to be told to change."
>
> —QRTP leader

In some cases, young people expressed concerns about religious participation being forced upon them, disrespect of their gender expression, medical conditions being overlooked or mistreated, and psychiatric treatment including over-prescription of psychotropic medications. Young people indicated that positive changes are only possible if youth's needs are genuinely heard through active engagement. QRTP leaders were optimistic about offering tailored care and the integration of continuum of care from prevention-focused, community-driven, and family/youth focused perspectives. However, QRTP leaders also noted increased complexity of youth's presenting problems (e.g., trauma, substance misuse) and the need for specialty child and adolescent psychiatry and crisis mobile response services available to youth in QRTP.

Community Connections and QRTP Aftercare

All three groups elaborated on how QRTPs are meeting the core components required by Family First regarding community connections and the permeability, customization, and connections to QRTP aftercare. Young people reported receiving weak support in maintaining family and social connection through their stay, as well as little assistance for their transition to the community. Child welfare administrators reported youth being "stuck" in QRTPs and not being able to transition back to the community, as well as a lack of community-based resources to support step down from QRTPs. QRTP leaders added the difficulty in youth's transition from residential to school settings in the community and a lack of sufficient funding to support aftercare community-based services or financial reinvestment in the community. Young people reported appreciating extracurricular activities (e.g., sports) to cultivate "normal" relationships, and voiced concerns about their facilities inhibiting connections to peers and friendships in the community (e.g., monitoring their calls, limiting call time), or their preparedness (e.g., tools, skills, resources) for their aftercare placements.

> "The kids that we currently have in QRTP levels of care, a lot of them do not need to be there anymore."
>
> —Child welfare administrator

[9] "Qualified Residential Treatment Program (QRTP)" is a non-foster family home, "specified setting" eligible for federal Title IV-E foster care maintenance payments under Family First. A QRTP must: (1) be accredited by an accrediting body approved by the U.S. Department of Health and Human Services (HHS) secretary; (2) have registered or licensed nursing staff available 24/7; (3) have other licensed clinical staff on site and available 24/7; (3) have other licensed clinical staff on site and available 24/7; (4) have a trauma-informed treatment model; (5) facilitate outreach to the family members of the child, including siblings, and document how the outreach is made; if in the best interests of the child, family members must be involved in the child's treatment; and (6) provide discharge planning and family-based aftercare support for 6 months after discharge.

Congregate Care Reduction and QRTP Implementation Progress

Both child welfare administrators and QRTP leaders reflected on the significant reduction in inappropriate use of congregate care from implemented precursors of Family First reforms (e.g., litigations, consent decrees) defining a general sentiment that Family First and QRTPs extended the momentum of existing reforms and codified recently implemented practices of higher quality. However, young people indicated that existing practices were not necessarily acceptable or up to their expected standards, unlike the perceptions of those in the child welfare administrator group and the QRTP leader group. Young people had little perception of the Family First policy change since it was not substantively experienced or discussed in their facilities. Of note, young people astutely pointed out the disconnect between federal, state, county, and urban/rural implementation of Family First and QRTPs, resulting in different experiences from one youth to another. They further argued that the decreasing number of congregate care placements are not necessarily solely because of Family First and that implementations of the law vary from county to county, and from rural to urban areas.

> "The need of having a place to stay was the only need that was consistently met."
>
> —Young person

Evidence of QRTPs Improving Young People's Lives and Outcomes

All three groups acknowledged the need for and associated difficulty of data tracking and collection to demonstrate QRTP outcomes. Child welfare administrators reported challenges in tracking youth in QRTP for Title IV-E reimbursement and the focus on compliance undermining quality; young people believed that every facility should participate in tracking of quality care and accountability measures; QRTP leaders suggested performance-based financial models for QRTPs, as well as systems-oriented comprehensive reforms rather than focusing on QRTPs in isolation.

> "Data tracking is a beast."
>
> — Child welfare administrator

Need for Additional Funding

Both the child welfare administrator group and the QRTP leader group highlighted the need for additional funding for congregate care facilities' transition to QRTPs, for community-based services preventing unnecessary congregate care placements and supporting aftercare services, and for adequately compensating QRTP staff and increasing workforce size. While young people did not offer direct suggestions for financial support for QRTPs, their experiences of inconsistent and inadequate physical, mental, psychological, and trauma-informed care provided evidence of service gaps.

> "Financing viability [of Family First] should not be pinned on QRTP. What is designed to fail is what happens in communities [whether reinvestment focuses on communities rather than QRTPs]."
>
> —QRTP leader

> "Some of the group homes are treated like a business. People that need mental health services did not receive them."
>
> —Young person

> "Families [pregnant/parenting mother and child] were separated because of lack of services, which is upsetting because that is what Family First is trying to prevent."
>
> —Young person

V. Policy Recommendations

- **Provide states with additional state and federal resources such as technical assistance and funding so that states can successfully implement the congregate care policy reforms in Family First by growing their capacity in:** (1) child welfare staff, (2) foster homes, (3) therapeutic care models as alternatives to congregate care, and (4) an array of comprehensive mental health services that support successful placement in the least restrictive environment.
- **Professionalize and invest in QRTP staff to ensure high-quality, individualized treatment.** Direct care, treatment, practice, and cultural shifts need to accompany the Family First policy-level changes. Retention strategies, specialized training, and compensations of the QRTP workforce need to be prioritized to actualize the vision that QRTPs provide a time-limited, high-quality, clinical interventions for youth who need it and benefit from it before returning to their community.
- **Establish standards for youth- and family-driven QRTP treatment.** Although youth and family voice is a core QRTP component required by Family First, they are not evident in the planning and individualization of treatment options and aftercare to meet the youth and family's unique needs. QRTPs should work closely with youth and families to creatively customize treatment plans and expand the service array, as needed. Youth and family engagement throughout implementation needs to be a central component of the success of the QRTP model.
- **Establish a technical assistance advisory committee on youth-and-family-driven QRTP treatment** that can help advise on best practices and can develop a template for states on what a customized plan for youth and family driven treatment would look like utilizing creative approaches such as alternative therapies.
- **Require oversight for the full array of congregate care placements including supervised independent living and settings for survivors of sex trafficking.** Although QRTP is generally the primary congregate care setting under Family First, states vary significantly in how they deploy non-QRTP congregate care settings (e.g., supervised independent living, settings for survivors of sex trafficking) that have less clearly defined federal standards than QRTPs.
- **Provide clear funding guidance to implement QRTPs.** States need clear federal guidance to navigate funding strategies and performance reviews to implement QRTPs and aftercare to ensure positive youth of outcomes. The fiscal viability and impact of variation in states' fiscal strategies (e.g., Title IV-E, Medicaid, state funds) needs to be monitored.
- **Facilitate cross-system collaboration to successfully implement Family First.** Cross-system collaboration that involves youth in foster care and placement is key. System collaboration between child welfare, juvenile justice, and health care is critical. Fiscal collaboration between Title IV-E and Medicaid must be cohesive to support state implementation of congregate care reforms under Family First.
- **Integrate QRTPs into a child welfare system's continuum of prevention, aftercare, and reduce the unnecessary use of out-of-state care.** QRTPs cannot exist in isolation. Coordination with and funding for prevention and aftercare resources in the community ensures that QRTP treatment operates in the context of the young people's needs and communities. Successful prevention through home and community-based services will reduce the need for out-of-home placement and placement in QRTP, and successful reintegration to home and community-based settings requires policymakers and researchers to learn more about the service and capacity gaps that prompt states to use in-state and/or out-of-state congregate care or QRTPs.
- **Establish performance- and outcome-based monitoring of QRTPs.** At this early stage of QRTP implementation, states are primarily focused on implementing the core components (e.g., assessment for eligibility, court oversight, claimability, length of stay). However, to know whether a reformed congregate care system vis-à-vis QRTPs work, QRTPs need to be evaluated against quality/outcome benchmarks such as evidence of or fidelity to trauma-informed treatment, family engagement and involvement, the readiness of youth to return to the community, maintenance of family-based settings and connection to the community, and progress towards permanency goals.
- **Ensure young people have access to high-quality specialized medical care and are supported in building family connections, friendships, and access to extracurricular activities within the community.** Young people with lived experience highlighted these areas as significant barriers to their overall physical, mental, and emotional health. Ensuring their health needs are met should be a top priority while also prioritizing healthy, caring, and consistent relationships as this is the number one factor to helping young people develop resilience.

VI. Research Methods

a. Institutional Review Board

The AAP Institutional Review Board (IRB) granted an exemption (AAP IRB#: 22 LA 01) for AAP to conduct the research activities of this project (i.e., survey and focus groups). The University of Chicago Crown Family School of Social Work, Policy, and Practice-Chapin Hall IRB granted approval (IRB22-0286) for researchers at Chapin Hall at the University of Chicago to conduct secondary data analyses of the survey and focus groups.

b. About the survey

i. Development process

The 2022 AAP Congregate Care Policy Survey was co-developed by researchers at Chapin Hall at the University of Chicago and project staff at the AAP. Pretesting and cognitive testing were completed with the assistance of a former child welfare agency director. The final survey included 80 questions, four of which collected basic information about respondents' roles. Many of those 80 questions were presented as grid matrices (i.e., like questions with same response options). We count each row of those matrices as a discrete question.

ii. Sample and recruitment process

The survey was an online, opt-in survey distributed via Qualtrics to an email list of 50 state child welfare directors, as well as the child welfare directors for the District of Columbia and Puerto Rico. The survey was fielded between June 9th and August 4th, 2022 (inclusive). The survey was initially planned to be in the field for a shorter period; however, initially, low response rates led the research team to unanimously agree to additional time in the field. Non-respondents were re-contacted programmatically by AAP staff; respondents who partially completed the survey (i.e., breakoffs) were also re-contacted.

In this survey, the unit of analysis is the child welfare agency of a state/district/territory (n=52). The survey received an overall response rate of **92.3%** and a completion rate (i.e., excluding break-offs) of **80.8%**. Completion by state/district/territory is mapped in **Figure 8**. All questions referred to the policy and practice of the agency. In four instances, we received multiple responses from the same state-agency. We discuss our protocol for recoding such responses in **Appendix 2**.

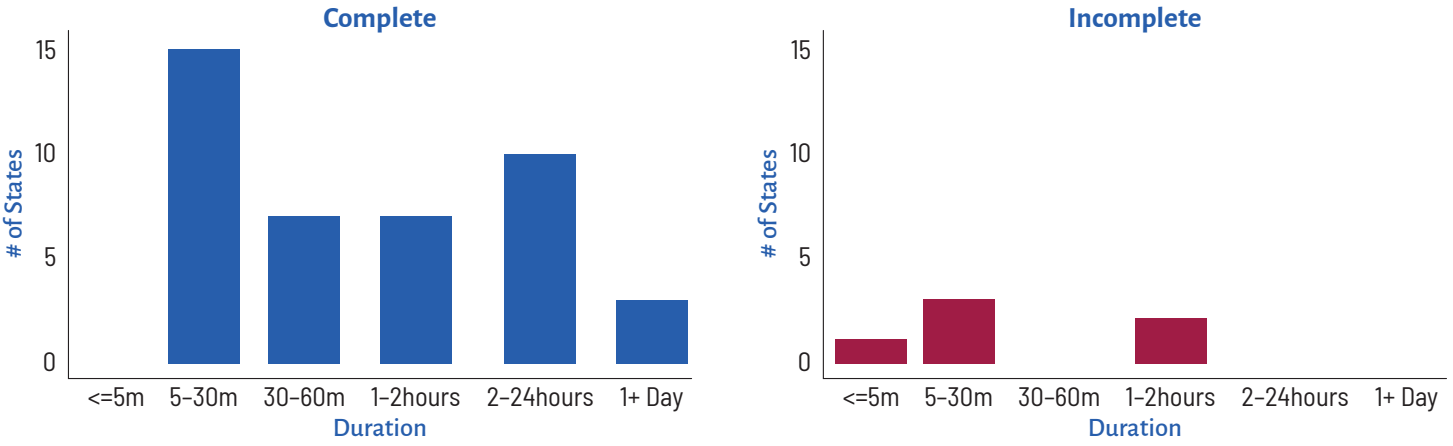

Figure 8. Survey completion status, by duration.

Respondents were not required to complete the survey in one sitting though most respondents did so (**Figure 8**). In one instance, a question about the appropriate response to an item was fielded by AAP staff after a consultation with the research team.

The following sampling and response validity checks were completed and reviewed by the research team.

1. No respondents appeared to "speed through" the survey (**Figure 8**).
2. Missingness increases throughout the survey, which is partially attributable to some questions not being applicable. This suggests cautious interpretation of the representativeness of findings.
3. The survey included 5 grid matrices, which are groups of questions with identical response options. If respondents are paying minimal attention to the survey, they will commonly "straightline" those matrices, by choosing the same response option for every row. Respondents did not appear to straightline any grid (with the exception of grid 2, which included only two rows, making the 50% straightline finding unremarkable.

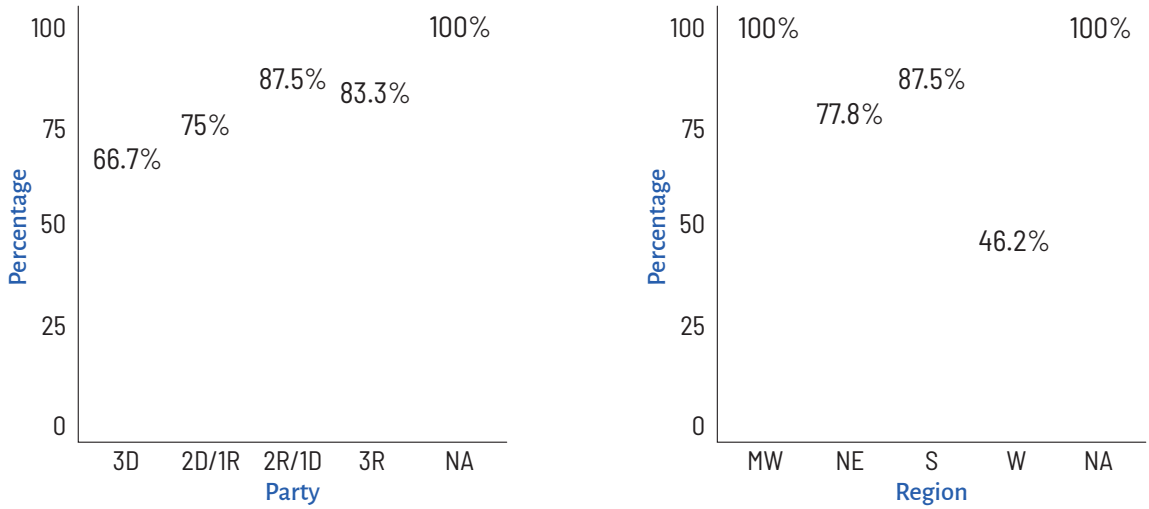

Figure 9. Percentage of survey questions completed, by partisan control of state governments and by region.

4. Examination of completion by state/district/territory presents some evidence of bias **(Figure 9)**. That bias is more strongly correlated with region than partisan control of state governments. Anecdotal evidence and the outcomes of follow-ups present reason to attribute regional bias to time differences rather than partisan-regional differences. This regional bias was strongest in the earliest stages of survey fielding. Follow-up with prospective respondents by AAP was able to largely attenuate this bias.

iii. Analysis

Researchers at Chapin Hall at the University of Chicago conducted descriptive analyses and visualizations of survey data using R 4.2.2.[10] Individual survey respondent data were aggregated at the state/district/territory level (n=52) (**Appendix 2**).

c. About the focus groups

i. Development process

Researchers at Chapin Hall at the University of Chicago and project staff at AAP co-developed focus group questions for three target populations: (1) young people with lived experiences in QRTPs (seven questions); (2) leaders of QRTP facilities (11 questions); and (3) child welfare agency administrators who are responsible for implementing QRTPs (eight questions). The goal of the three focus groups was to gather qualitative information from these three unique perspectives on the challenges, successes, and recommendations regarding congregate care reforms under Family First. All focus group questions were reviewed, vetted, and refined by a study team member with lived experience in congregate care to ensure sensitivity and appropriateness of the questions, prompts, and procedures. All three focus groups were approximately 90-minute long, recorded with participant consent on Zoom, and were facilitated by at least two research team members, including the study team member with lived experience in congregate care.

ii. Sample and recruitment process

We deployed different sampling and recruitment strategies for the three focus groups, with the common goal of ensuring adequate multi-state representation. For the focus group with young people with lived experiences in QRTPs, AAP fielded an online screening form with relevant eligibility questions (e.g., timing of young people's placement in congregate care with respect to Family First) through our networks at Think of Us, Foster Club and the American Public Human Services Association (APHSA) to reach the young people. Five young people from four states met eligibility and were available to participate in a focus group together. All young people received a gift card of $200 for their participation.

For the focus groups with QRTP leaders and with child welfare agency administrators who are implementing QRTPs, AAP partnered with Casey Family Programs, the Annie E. Casey Foundation, Building Bridges Initiative, APHSA, and Chapin Hall at the University of Chicago to reach out to their respective networks to recruit states that are implementing QRTPs for participation. Through these organizational networks, six QRTP leaders from five states and nine child welfare agency administrators from eight states participated in their respective focus groups. Due to scheduling conflict, one state child welfare administrator was separately interviewed using the same questions used in the focus group.

[10]The R Foundation for Statistical Computing. (2022). R version 4.2.2. The R Foundation for Statistical Computing.

iii. Analysis

Analysis of the focus groups occurred in three stages. First, the study team members individually listened to the recordings of all three focus groups, took notes, and convened as a group to discuss initial impressions of major themes related to the challenges, successes, and recommendations regarding congregate care reforms under Family First. Second, the study team members used a standardized framework **(Appendix 3)** to individually code the focus groups. Third, the study team members reconvened as a group to reach consensus on the elements of the coding framework for thematic synthesis for the report.

VII. Conclusion

Just past one year after the deadline for states to implement the congregate care policy reforms, implementation of Family First is still in progress. We hope that the findings from this report synthesize the key successes and barriers in the implementation process to inform policy recommendations. Additionally, we hope these findings and policy recommendations will orient federal policymakers to specific areas where states may need additional support to successfully implement the congregate care policy reforms included in Family First. We believe well-supported and well-resourced implementations of these changes could have a positive impact on youth and families. We also recognize that as states continue to adopt these changes, there will be more implementation lessons to learn from and important data points to track to inform the sustainability of these changes. As we look into the future, we encourage policymakers and researchers to focus on the following key research questions around congregate care placement, financing, staffing, individualizing treatment, and data tracking and outcomes:

- For states classifying the majority of congregate care institutions as independent living settings or settings for sex trafficking survivors, what were their rationale behind this policy change? Are these facilities meeting a specific need unique to that state's population? Are youth's well-being and placement in family-based settings being met as a result?
- Given the complexities of Medicaid funding and QRTPs, why did some states report not changing the size of their QRTPs to meet IMD requirements? Is it because they are not implementing QRTP? Or is it because their QRTPs are already less than 16 beds? What innovative financial models can states adopt to maintain successful and high-quality QRTPs?
- Of states' reported barriers to implementation —workforce/staff, treatment foster care models funding, foster families—which barrier is most urgent? What do states need and in what way to address these barriers?
- How can states develop quality standards and improve data tracking to measure the progress and impact of QRTP implementation?
- How can states develop sustainable professionalized career pathways for QRTP staff? How can states use further staff training, credentials, education, and support to improve the quality of care and services offered at QRTPs?
- What are effective strategies for individualizing and innovating QRTP treatment for youth, such as medical/health oversight, technology for maintaining social connections, transportation to/from community, access to extracurricular activities, schooling, and coordination with aftercare?

Study Limitations

Survey

- Despite a high survey response rate, four states did not respond to the survey, which included California, the country's largest state child welfare system.
- Variations in child welfare practices in county-administered states were not reflected in survey findings.
- Child welfare agency directors and their designees answered survey questions based on their understanding of Family First and congregate care implementation progress. Their responses to quantitative questions (e.g., percentage composition of congregate care placement capacity) were not expected to be precise. These data should not be thought of as an alternative to official federal administrative data sources like the Adoption and Foster Care Analysis and Reporting System (AFCARS).
- Survey questions were not designed to identify the causal effect of Family First and congregate care provisions, especially when many states reported pre-existing congregate reforms that preceded Family First. Respondents were instead asked to describe practice "before" and "after" key implementation dates.
- At this nascent stage of Family First and QRTP implementation (since October 2021), survey findings likely reflect baseline or early-stage implementation, as opposed to full implementation.

Focus Group

- Focus group recruitment relied on snowball sampling through organizational networks with target focus group participants and their connections, despite concerted efforts made to diversify state representation. Focus group findings should not be assumed to generalize to all states or QRTPs.

- Voluntary participation in focus groups, depending on participants' motivation (e.g., opportunity to share grievances, participation as evidence of early QRTP adopter behavior), could incur self-selection bias and impact generalizability of the findings.
- Despite initial screening and facility checks, young people' lived experiences with congregate care might not have coincided with their facilities' transition to QRTPs. Similarly, some child welfare administrators and facility leaders were not implementing QRTPs in their states. Thus, their perspectives could characterize congregate care in general as opposed to specific to QRTPs.

VIII. Appendices

Appendix 1. Commonly used terms and definitions

Below is a list of commonly used terms and definitions you will find throughout this report.

Congregate care refers to "group home" and "institution" as defined in a state's bi-annual reports to the federal Adoption and Foster Care Reporting System (AFCARS). AFCARS generally defines a "group home" as a licensed or approved home providing 24-hour care for children in a small group setting that generally has 7-12 children. AFCARS generally defines an "institution" as a facility operated by a public or private agency and providing 24-hour care and/or treatment for children who require separation from their own homes and group living experience. These institutions may include childcare institutions, residential treatment facilities, or maternity homes.

Family First refers to the Family First Prevention Services Act (P. L. 115-123), which was signed into law on February 9, 2018. Family First provides optional, conditional federal funding for select services to prevent placement into foster care and restricts funding for "specified settings" that are not foster family homes. Family First introduces the Qualified Residential Treatment Program (QRTP) model, one type of specified settings that is allowable for Title IV-E reimbursement under the new restrictions.

Federal funds in child welfare include dedicated funds such as Title IV-E; Title IV-B; Child Abuse Prevention and Treatment Act (CAPTA) programs, and non-dedicated funds such as Medicaid; Temporary Assistance to Needy Families (TANF); Social Services Block Grants (SSBG); and Social Security Insurance (SSI)/Social Security Disability Insurance (SSD).

Institution for Mental Disease (IMD) is an institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental disease. States are generally prohibited from drawing down federal Medicaid coverage for individuals placed in IMDs (i.e., IMD exclusion). In September 2019, the Centers for Medicare and Medicaid Services (CMS) issued guidance to clarify that state Medicaid offices will need to review each QRTP individually to determine whether it is an IMD per the CMS State Medicaid Manual. QRTPs that are classified as IMDs can still be eligible for Medicaid reimbursement if they are either classified as a Psychiatric Residential Treatment Facility (PRTF) or participate in a state's Section 1115 Medicaid demonstration waiver.

Kinship foster homes refer to all living arrangements in which children are cared for by relatives or fictive kin but neither of the children's parents or guardians live in the home.

Local funds in child welfare include all local funding sources (e.g., local tax levy dollars).

Non-kinship foster homes refer to all living arrangements provided by licensed foster parents who are not related to the children.

Qualified Individual (QI) is the professional who conducts an assessment to determine whether a child's placement in a Qualified Residential Treatment Program (QRTP) is appropriate within 30 days of the QRTP placement. Family First defines a QI as a trained professional or licensed clinician who is not an employee of the Title IV-E agency and who is not connected to, or affiliated with, any placement setting in which children are placed by the Title IV-E agency. However, a state can obtain a waiver from the Department of Health and Human Services (HHS) secretary from the specific QI requirements (e.g., state employees, qualifications).

Qualified Residential Treatment Program (QRTP) is a non-family "specified setting" eligible for federal Title IV-E foster care maintenance payments under Family First. A QRTP must: (1) be accredited by an accrediting body approved by the U.S. Department of Health and Human Services (HHS) secretary; (2) have registered or licensed nursing staff onsite and available 24/7; (3) have other licensed clinical staff on site and available 24/7; (4) have a trauma-informed treatment model; (5) facilitate outreach to the family members of the child, including siblings, and document how the outreach is made; if in the best interests of the child, family members must be involved in the child's treatment; and (6) provide discharge planning and family-based aftercare support for 6 months after discharge.

Specified settings are non-foster home settings eligible for states' claiming on foster care maintenance payments beyond 14 days under Family First by the federal Title IV-E program. These specified settings include: (1) Qualified Residential Treatment Programs (QRTPs); (2) specialized placements providing prenatal, post-partum, or parenting supports; (3) supervised independent living settings for children who are 18 years old; and (4) high-quality residential care that provides support services to children who have been found to be, or are at risk of becoming, sex trafficking survivors.

State funds in child welfare include all other state funding sources beyond federal matching requirements.

Appendix 2. Survey unit of analysis

In several cases (13) multiple respondents from a state opened the survey and gave consent, at which point we recorded a response. However, in nearly all cases, those respondents abandoned the survey after a handful of questions. We excluded their responses from analysis. In four cases, senior-level agency staff completed the survey, in addition to the Agency Director. When this happened, we primarily drew on the responses from the Agency Directors and applied the following rules:

1. If the Agency Director left a question blank, but their other agency staff did not, we retained the other agency staff's answer, and vice versa (if the other agency staff provided a response but the Agency Director did not).
2. For "choose-all-that-apply" questions, we combined responses by both senior-level agency staff and the Agency Director (including all items that were selected by at least one respondent). We reasoned that it was more likely that respondents' knowledge of practices and assessments in use complemented each other, rather than contradicted each other.
3. If one respondent's answer appeared more detailed than another, we chose that response.
4. If one respondent chose a "fill-in-the-blank" option but the other respondent did not, we retained the fill-in-the-blank option.
5. In one instance, the Agency Director listed an earlier approval date of their state's first established QRTP than the other respondent. We reasoned it was possible that the Agency Director was uncertain about the precise month of establishment because they chose the first month of the year. Furthermore, the other agency staff answered a parallel question that the Agency Director did not answer, indicating the other agency staff member's depth of knowledge; therefore, we chose the other agency staff member's response.
6. In another circumstance, one respondent estimated that 100% of congregate care placement capacity in their state were in QRTPs, another estimated 90%. We reasoned that picking those numbers on a scale with 10% increments likely reflected individual rounding decisions rather than underlying disagreements about QRTP prevalence. As such, we recoded that response to 95%, the average value we believe would most closely reflect that rounding uncertainty. Again, we emphasize that percentages included this survey are not intended to be precise, and that respondents' "best estimates" were solicited.

Appendix 3. Focus group coding framework

	Child Welfare Administrators	Young People	QRTP Leaders
What were the top 3 barriers?			
What were the top 3 successes?			
What was the most surprising?			
What were the top 3 things needed going forward?			
What were the common successes raised by each group?			
What were the common barriers raised by each group?			
Areas of future research, questions to be answered			
Key quotes			