



# Congregate Care in the Age of Family First

## Overview

### Introduction

High-quality and customized congregate care can be lifesaving for children and youth with such complex clinical or behavioral needs that a short-term stay in a residential treatment facility is essential (Annie E. Casey Foundation, 2015). Most children and youth will never need that level of care, however, and will experience far more positive outcomes in family-based settings (Casey Family Programs, 2017). Children and youth should never experience congregate care simply because a family foster home is not available.

National trends indicate a steady decrease in the number of children and youth placed in congregate care. A review of Adoption and Foster Care Analysis and Reporting System (AFCARS) data indicates the number of children and youth in congregate care facilities decreased by approximately 12 percent between 2011 and 2017 (Chronicle of Social Change, 2019). National averages are not always an accurate reflection of state experiences, however. During the same 6-year period, 10 states increased congregate care usage by more than 20 percent (Chronicle of Social Change, 2019).

The 2018 passage of the Family First Prevention Services Act (FFPSA) builds on national child welfare trends to improve family connections and reduce congregate care. While permanency has long been a core child welfare goal, the FFPSA includes new requirements and funding pathways to keep families together, promote family foster care placements, and protect against inappropriate use of congregate care (Children's Bureau, 1998; Children's Bureau, 2018b).

Child welfare administrators, managers, and others working with children and youth in congregate care can use this brief to gain foundational information for implementing the FFPSA provisions regarding appropriate use of congregate care and qualified residential treatment program (QRTP) assessment, see examples of how these provisions have been implemented, and review possible next steps.

### Read this if:

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

#### Learn more about:

- ◆ Implementing FFPSA requirements
- ◆ Reducing congregate care usage
- ◆ Centering equity in implementation
- ◆ Exploring potential considerations and next steps for planning
- ◆ Assessing residential treatment programs

## Definitions

- ◆ **Congregate care:** This term represents a wide array of out-of-home settings, including group homes, child care institutions, residential treatment facilities, emergency shelters, and in-patient hospitals (Payne, 2016). This resource uses the umbrella term “congregate care” unless otherwise indicated.
- ◆ **Qualified residential treatment programs (QRTPs):** As defined in the FFPSA, QRTPs are residential programs that (Children’s Bureau, 2018b):
  - Use a trauma-informed treatment model meeting the identified needs of youth residents
  - Work with families in treatment as appropriate
  - Provide onsite nursing and clinical staff who are registered or licensed and are available 24 hours a day and 7 days a week
  - Engage in and document outreach to family members and family integration in treatment
  - Provide discharge planning and a minimum of 6 months family-based aftercare services
  - Meet title IV-E licensure requirements
  - Have accreditation from approved independent, nonprofit organizations
- QRTPs do not represent a new level of care, but reimbursement is primarily restricted to QRTP facilities.
- ◆ **Trauma-informed care:** Defined by FFPSA guidance as those services “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 the consequences of trauma and facilitate healing” (Children’s Bureau, 2018c). The legislation requires prevention services, residential programming, and QRTP treatment models to be trauma informed.
- ◆ **Family engagement:** Defined by the Children’s Bureau as a “family-centered and strengths-based approach to partnering with families in making decisions, setting goals, and achieving desired outcomes. Beyond specific cases, engaging families as key stakeholders must extend to policy development, service design, and evaluation.” Family engagement, as appropriate and in the child’s best interests, is a core component of the QRTP model. “Family” includes parents and siblings, as well as other relatives, foster parents, and fictive kin. Programs must document family outreach and inclusion throughout the child’s stay and provide 6 months of family-based supports after discharge (Children’s Bureau, 2018b).
- ◆ **Qualified Individual:** Clinician responsible for conducting an appropriate and evidence-based functional assessment within 30 days of a QRTP admission. The Qualified Individual may not be employed by the title IV-E agency or affiliated with any residential program, although there are some allowances for waivers in certain instances (Children’s Bureau, 2018b).

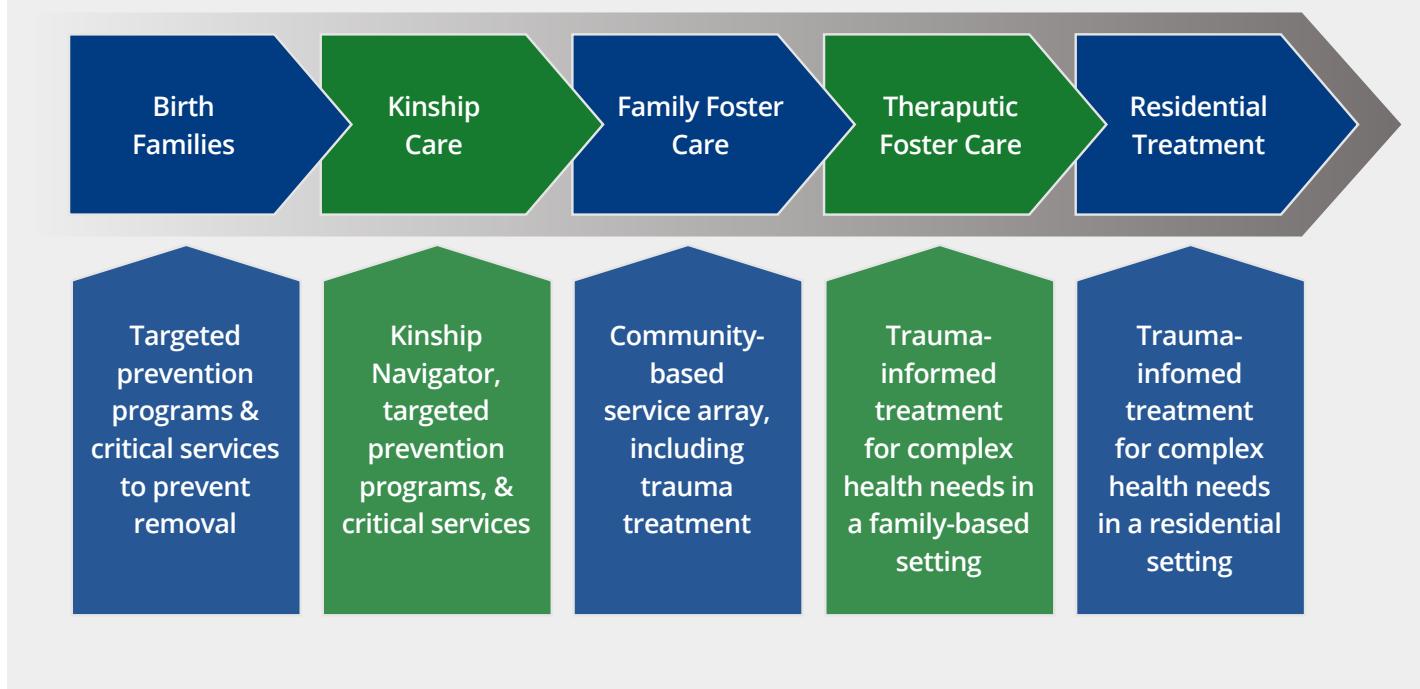
## The Family First Prevention Services Act

The FFPSA represents a significant child welfare reform effort focused on building and supporting each child’s connection to a nurturing, supportive family. By redirecting federal title IV-E funds away from congregate care and toward prevention services, the legislation seeks to prevent entry into foster care, increase the use of family-based placements, and improve access to high-quality residential care for children and youth who need it (Children’s Bureau, 2018b).

In 2019, Congress passed the Family First Transition Act, which provides funding and federal resources to assist states in moving toward FFPSA implementation. The legislation provides funding for states and for federal infrastructure and extends timelines for implementation. In early 2020, additional funds were made available for the development, enhancement, or evaluation of Kinship Navigator programs, a key strategy to keep children and youth in family-based settings with kinship caregivers (Children’s Bureau, 2020).

The following graphic illustrates the child welfare continuum of care settings. Children and youth coming into care should always have access to the least restrictive setting possible.

## The Child Welfare Care Continuum



## Centering Equity in FFPSA Implementation

Children and families of color experience disproportionate rates of child welfare involvement at various points along the child welfare continuum (Child Welfare Information Gateway, 2016). This includes overrepresentation of children and youth of color in congregate care settings. In 2019, for example, Black children and youth represented 26 percent of youth in congregate care (Children's Bureau, 2018a) and only 14 percent of the total population (Annie E. Casey Foundation, 2020). Black male children and youth are almost 30 percent more likely to experience congregate care than other children and youth in care (Miller et al., 2014).

Efforts to address disproportionality and disparities in child welfare must be grounded in an understanding of contributing causes. Explanatory factors may include one or a combination of the following:

- ◆ Decision-making, which may reflect implicit biases (Boyd, 2015; Ellis, 2019; Fluke et al., 2011)
- ◆ Child welfare agency and system characteristics, including factors related to institutional racism, organizational culture, limited services, and disengagement from the community (Boyd, 2015; Fluke et al., 2011)
- ◆ Disproportionate and disparate needs, particularly related to poverty and community factors (Boyd, 2015; Ellis, 2019; Fluke et al., 2011)
- ◆ Geographic context (Ellis, 2019; Fluke et al., 2011)

Child welfare leaders can adopt multiple approaches to examine disproportionality and disparities in congregate care at state and local levels, explore their underlying causes, and identify strategies to address them. Examining disaggregated demographic data is an important first step when coupled with analysis of the meaning of the data. In addition, an internal review may uncover systemic biases or policies that worsen disparities. For example, policy restrictions on placements with undocumented or formerly incarcerated kinship caregivers may separate children from communities and kin and may increase the likelihood of entry into foster or congregate care. Engagement of youth, family, and community members can offer important insights into data findings, root causes of disparities, and potential strategies to achieve equity.

The following sections present an introduction to the law and some examples of strategies and next steps to prompt ideas and considerations for child welfare administrators, managers, and other stakeholders.

# Understanding the Law: Prevention of Entry Into Care

The FFPSA emphasizes keeping families together and shifts funding traditionally used to support foster care placements into prevention services. This shift allows states to use title IV-E dollars for the delivery of approved mental health, substance use, and parenting skills programs targeted at: 1) children at risk of entry into care and their parents or caregivers; 2) children in subsidized adoption or kinship guardian homes at risk of placement disruption; and 3) pregnant and parenting foster youth. Children at risk of entry (candidates for foster care) must have a prevention plan that identifies the services necessary for them to remain safely at home with their parents or a kinship caregiver (Children's Bureau, 2018b).

A list of already approved interventions is available on the [Title IV-E Prevention Services Clearinghouse](#).

## Strategies

States have some flexibility in how they define "at risk of entry into care." For example, Arkansas defined candidates for care as children whose families meet one or more of 14 identified risk factors (Arkansas Division of Children and Family Services, 2019) while Washington, D.C. targets prevention services at families with prior child welfare engagement and those with open cases (Washington, D.C. Child and Family Services Agency, 2019).

Analyzing data to understand the profile of children and youth coming into care, including those likely to experience congregate care, can help states develop a strong prevention service array. Effective, targeted, and family-centered prevention services can keep more children and youth from entering into foster care, including those at highest risk for congregate care.

## Considerations for Future Planning

The following questions can help agencies apply FFPSA provisions on prevention of entry into care and think about the various ways that prevention services may impact congregate care usage:

- ◆ What type of data analysis is your state using to define candidacy for foster care?
- ◆ Has your state developed a profile of youth entering congregate care? Does the current service array meet the specific needs of children and youth at risk of entering congregate care?
- ◆ How are families engaged and matched with community supports, including relatives and other families with lived experience, to help them successfully complete their case plan?
- ◆ How are stakeholders, including families, providers, and community-based agencies, involved in prevention planning?



### State Spotlight: Kentucky

Prior to identifying prevention strategies, [Kentucky](#) analyzed child welfare data to determine why children were coming into care, prevalent risk factors for maltreatment, and geographic distribution of risk factors and services. The state developed a readiness assessment for providers, including community-based service providers and congregate care facilities. The assessment results and child welfare data analysis together drove the development of the proposed list of prevention programs (Kentucky Cabinet for Health and Family Services, Department for Community Based Services, 2019).

Contracts with service providers require that programs are delivered within a trauma-informed framework. Additional training in trauma-informed care will be available through the Department for Behavioral Health and Developmental and Intellectual Disabilities. The state will oversee implementation of programs and will ensure a collaborative network of services and providers is available to meet the needs of children and families (Kentucky Cabinet for Health and Family Services, Department for Community Based Services, 2019).

# Understanding the Law: Family-Based Placements

Federal law requires children to be placed in the least restrictive, most family-like setting (National Conference of State Legislatures, 2019). The majority of children engaged in the child welfare system should be able to remain with their family of origin and, when removal is necessary, a kinship placement should be considered first. Congregate care should be used sparingly and only when absolutely necessary to meet a child's or youth's treatment needs.

The FFPSA does not define "kinship caregiver," but federal guidance refers to grandparents, other relatives, tribal kin, extended family or friends, as well as other fictive kin (Children's Bureau, 2018d). The law supports the increased use of kinship placements by directing additional resources toward evidence-based Kinship Navigator Programs, addressing barriers to licensing, and allowing reimbursement for Title IV-E Prevention Services Clearinghouse prevention programs delivered to kinship caregivers (Children's Bureau, 2018d).

The FFPSA promotes the increased availability of high-quality family foster home placements more broadly by addressing the need to both improve family foster home safety and reduce barriers to licensure, as well as by authorizing competitive grant funds for the recruitment and retention of foster families.



## State Spotlight: New York

A public/private partnership between the New York Office of Children and Family Services and the Redlich Horwitz Foundation builds on results from county-based congregate care reduction projects. With funding from the Redlich Horwitz Foundation, several counties have successfully decreased congregate care use and improved access to safe and stable family-based placements (Redlich Horwitz Foundation, n.d.).

For example, Onondaga County has been able to successfully increase kinship and foster family placements, substantially reduce congregate care bed days, and reinvest \$1 million back into family support services. The county's identified keys to success included congregate care gatekeeping and reinvestment, as well as collaboration and buy-in. Specific activities include the development of "Triage Teams" tasked with finding kin placements within 72 hours of removal, expedited licensing of homes willing to care for teens and sibling groups, dedicated Functional Family Therapy slots for kinship families, consistent congregate care placement reviews, and the reinvestment of funding into aftercare, staffing, and enhanced rates for therapeutic foster homes (Redlich Horwitz Foundation, n.d.).

Learn more about county results and New York's efforts to prepare for FFPSA implementation at [FamilyFirstNY.org](http://FamilyFirstNY.org).

## Strategies

Many successful state or local efforts to reduce congregate care have focused on family finding or other kin placement initiatives, as well as child-centered or targeted foster family recruitment. The most impactful approaches are those that find meaningful ways to engage youth and families in decision-making. Building effective and accessible supports for children, youth, and foster parents can prevent placement disruptions and strengthen foster family capacity. Mobile response and stabilization teams and wraparound supports are examples of approaches some states have used to effectively stabilize placements and prevent unnecessary congregate care entry.

The provider community has also expanded its array of services to include therapeutic or treatment foster care as an option for children and youth to receive clinical care in a home-based setting. Therapeutic foster care is now a widely used alternative to congregate care for children and youth with severe emotional and behavioral disorders (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014).



## State Spotlight: North Carolina

North Carolina's [Partnering for Excellence](#) (PFE) initiative has focused on improving child welfare outcomes and reducing costs since 2012. PFE counties screen all children coming into the system and, when trauma is identified, a trained clinician completes a Trauma-Intensive Comprehensive Clinical Assessment (TiCCA). The TiCCA includes interviews with key partners (schools, pediatricians, and birth parents, for example), resulting in a robust understanding of child and family needs, including appropriate treatment and potential placement types (NC Division of Social Services & Family and Children's Resource Program, 2016).

There are several advantages of this approach when considering FFPSA implementation. The initiative is trauma informed, prevention focused, and evidence based. It has effectively bridged child welfare with Medicaid managed care organizations and clinicians and other child-serving community systems, promoting the type of cross-system collaboration necessary to successful implementation. An approach like PFE may give families and agencies an opportunity to address family needs at home with targeted evidence-based interventions. If a QRTP admission becomes warranted, the jurisdiction will have good information about a child's clinical needs that can be used to inform the placement decision.

## Considerations

The following questions can help your agency apply the FFPSA's provisions on family-based placements and reducing congregate care:

- ◆ Does your state engage in family finding or kin placement initiatives? Are youth involved in identifying family and fictive kin?
- ◆ How are families and youth involved in placement decisions?
- ◆ Does your state use targeted foster parent recruitment? Are resource families approached as partners, trained in shared parenting, and provided adequate resources and support to successfully parent the children and youth in their care?
- ◆ How are therapeutic foster homes supported in caring for youth who might be at risk of congregate care placements?
- ◆ Is the child welfare system trauma informed? What are the expectations for a trauma-informed workforce?
- ◆ How are data used to improve practice, including service array and placement options?

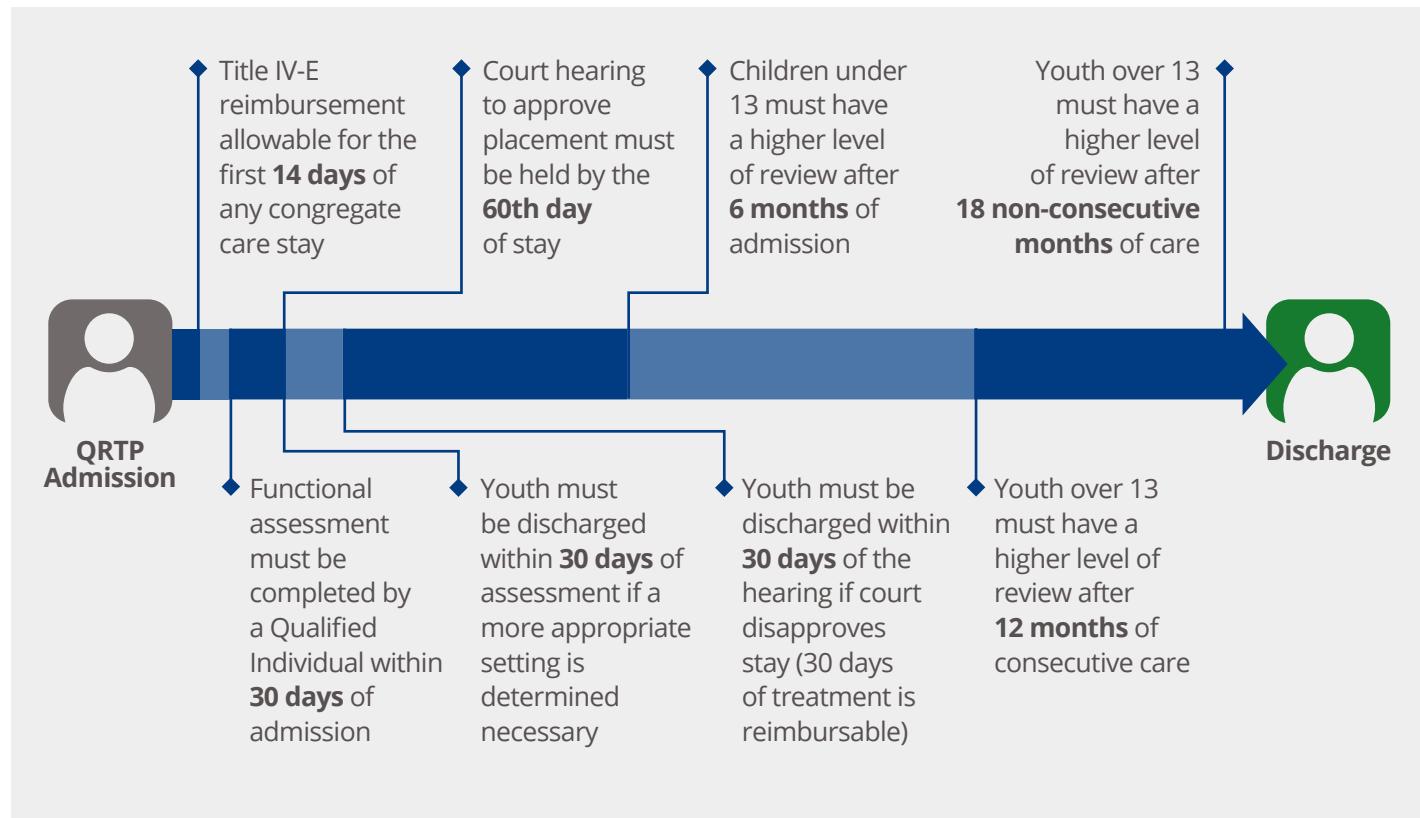
## Understanding the Law: Residential Treatment Program Requirements

The FFPSA promotes the use of congregate care as a limited strategy that is to be used primarily to support the complex clinical needs of children and youth with significant exposure to trauma. The FFPSA created the QRTP designation to meet the needs of children and youth who require residential treatment to address serious emotional and behavioral disorders (Children's Bureau, 2018b). The law mandates the following requirements (Children's Bureau, 2018b):

- ◆ The FFPSA **restricts title IV-E reimbursement** for any child or youth in a congregate care setting that extends beyond 14 days, unless the program is licensed and accredited as a QRTP and a functional assessment indicates the setting is in the best interests of the child
- ◆ The **assessment** must indicate that the QRTP is the least restrictive treatment intervention possible and that the child's clinical needs will be met by the facility's treatment model
- ◆ The assessment process must include a **family and permanency team**, which may include parents, other relatives, fictive kin, professionals such as therapists or teachers, and additional supports selected by youth over age 14

- ◆ The state must transition the child to an alternate program if the assessment determines a child's needs can be more appropriately met in a **less restrictive setting**
- ◆ States are required to develop procedures to **prevent inappropriate mental health diagnoses** that may lead to an unnecessarily restrictive setting

The legislation does not restrict length of stay. However, within 60 days of a child's admission to a QRTP, the court must review the admission. In addition, the FFPSA requires increased review when a child younger than 13 years of age is in residential care for 6 months and increased review when a child over 13 years of age is in residential care for 12 consecutive months. For these children, the state also must submit to the Children's Bureau justifying documentation with the signed approval of the IV-E agency head (Children's Bureau, 2018b). QRTPs are intended to be time limited and meet the needs of youth who need temporary, intensive clinical care before they are discharged into a family setting (Children's Bureau, 2018b). The graphic below illustrates key timeframes and deadlines.



## Strategies

QRTPs may offer a range of different treatment modalities as long as they are **trauma informed** and meet a child's specific clinical needs as identified through the functional assessment. States have flexibility in how they choose to ensure the delivery of trauma-informed treatment models as long as they meet the broad federal definition of trauma-informed care. Trauma-informed treatment programs should be delivered within a larger trauma-informed organizational framework and approach, promoting healing through the delivery of individualized, skilled, child-centered, and developmentally appropriate programming (National Child Traumatic Stress Network Child Welfare Committee & Chapin Hall at the University of Chicago, 2020).

Because QRTPs are designed to address the serious clinical needs of children and youth with behavioral health disorders, the legislation requires 24/7 access to **clinical and nursing staff**. Those staff must be appropriately registered, licensed, and available onsite as required by the agency's trauma-informed treatment model. QRTPs can approach this requirement in a number of different ways, ranging from rotating on-call staff to consistently staffed onsite clinics.

QRTPs are required to provide, or contract with another agency to provide, a minimum of 6 months of family-based aftercare following discharge, regardless of the discharge setting. Some QRTPs offer **aftercare** through the delivery of a targeted evidence-based intervention while others may offer a more homegrown approach. While aftercare services can be approached in different ways, they must be inclusive of families, trauma informed, and tailored to meet the needs of individual children and families.

QRTPs must be intentional about **family engagement** through specific activities, such as family and permanency teams, as well as through discharge planning and aftercare. To achieve the best results, family engagement must be meaningful and authentic, involving siblings, parents, relatives, and fictive kin. Families and youth should be approached and included as equal partners and drivers of decision-making.

States have some flexibility in how they approach FFPSA congregate care provisions. A range of self-assessments and QRTP applications are being used by states to determine if congregate care programs meet QRTP requirements. A sample assessment and links to state examples can be found in appendix A.

### Organization Spotlight: The Children's Village

The Children's Village is an example of a congregate care facility that meets QRTP requirements. More than a decade before passage of the FFPSA, the Children's Village began to shift from an exclusive focus on residential care to a comprehensive array of community and home-based services, combined with short-term trauma-informed residential treatment. Family engagement is woven throughout treatment, discharge planning, and aftercare (Casey Family Programs, 2019).

The facility's treatment model, the Integrated Treatment Model, includes both Dialectical Behavioral Therapy (DBT) and Multi-Systemic Therapy-Family Integrated Transitions (MST-FIT). Throughout the term of treatment, families are trained to use DBT strategies. Following discharge, clinicians provide 6 months of intensive, home-based MST-FIT (Casey Family Programs, 2019).

Learn more about the Children's Village at [childrensvillage.org](http://childrensvillage.org).

## Considerations for Future Planning

The following questions can help agencies apply the FFPSA's congregate care provisions:

- ◆ What approach is your state considering for identifying Qualified Individuals?
- ◆ What type of functional assessments will be used? Are they valid and reliable instruments? Does the assessment process include gathering information from significant people in the child's life, including family members and professionals (social workers, doctors, teachers, clinicians, etc.)?
- ◆ How will your state safeguard against inappropriate mental health diagnoses?
- ◆ Has your state adopted a trauma framework or principles of a trauma-informed approach to which QRTPs must adhere?
- ◆ How will your state ensure QRTP compliance with requirements, including but not limited to: implementing a trauma-informed approach, ensuring family involvement, having adequate staffing, and providing aftercare?

## Next Steps in Planning for Congregate Care

Proactively and collaboratively planning for the appropriate use of congregate care will set the stage for success. Consider taking the steps listed below in moving forward with a collaborative and data-driven process.

### Congregate Care in the Age of Family First Resources

Explore the Center's companion publications for more information on authentic family engagement and trauma-informed care:

- ◆ "Congregate Care in the Age of Family First: Family Engagement"
- ◆ "Congregate Care in the Age of Family First: Trauma-Informed Care"

## Develop an Internal Implementation Team

When developing an internal implementation team to address changes to congregate care:

- ◆ Cultivate internal champions for team leaders and members
- ◆ Include members with direct service experience, as well as members with decision-making power across departments (e.g., human resources, IT, continuous quality improvement)
- ◆ Consider the need for external consultation and consult with other states on their approach to implementation

The Center for States' "[Change and Implementation in Practice: Teaming](#)" brief and related resources offer additional information and considerations for team development and communication planning.

## Convene a Stakeholder Group

While the implementation team identifies and implements internal approaches, successful changes to congregate care will require a cross-system, collaborative planning process. The internal team and the external stakeholder group should work together to identify and implement external reforms. When convening stakeholders:

- ◆ Consider critical stakeholders such as families and youth with lived experience, congregate care facilities and private providers, court representatives, Medicaid and behavioral health representatives, community service providers, policymakers, and others
- ◆ Consider your strategic vision and detailed implementation goals when determining team structure and meeting frequency
- ◆ Agree on common definitions for terms such as trauma informed, evidence based, family engagement, and youth engagement

## Examine the Data

In order to use data effectively in planning:

- ◆ Review disaggregated child welfare administrative data to understand risk factors for entry into child welfare, entry into foster care, and entry into congregate care; examine racial representation and disproportionality along the continuum
- ◆ Develop a profile of youth entering congregate care
- ◆ Survey community-based providers and conduct an assessment of the current service array
- ◆ Survey congregate care facilities for willingness and readiness to serve as QRTPs
- ◆ Read the Center for States' "[Change and Implementation in Practice: Problem Exploration](#)" brief and related resources to gain a clearer understanding of the challenges related to congregate care that agencies may encounter

## Explore Other States' Approaches

Many states have begun successfully reducing congregate care. When beginning an exploration of successful strategies and lessons learned, give consideration to:

- ◆ Working with a Center for States capacity building team to understand successful approaches to congregate care reduction; visit the [Child Welfare Capacity Building Collaborative Liaisons](#) website to find your state's Tailored Services Liaison
- ◆ Reviewing FFPSA implementation approaches taken by other states (you can find some useful resources at [www.familyfirstact.org](http://www.familyfirstact.org))

## Create a Plan

When working collaboratively to develop an implementation plan:

- ◆ Use data analysis to determine gaps and resources, and determine where there are opportunities to build on successes and fill gaps
- ◆ Develop a collaborative plan with clear, measurable steps for implementation: consider the use of S.M.A.R.T. (Specific, Measurable, Assignable, Relevant, and Time-Based) goals

# Conclusion

An important goal of the FFPSA is to ensure each child and youth engaged with the child welfare system has a permanent connection to a safe, stable, and nurturing family. The FFPSA's increased focus on prevention services is designed to keep children at home with their families and incentivize kinship care and family foster care when necessary. As states increase the availability of prevention services, kin connections, and family foster homes, the number of children experiencing congregate care will decrease. Trauma-informed and skilled QRTPs should meet the needs of the small number of children who require specialized, short-term residential care.

Understanding the FFPSA provisions and their impact on congregate care usage should help states ensure access to necessary clinical care for children and youth with serious emotional and behavioral disorders, while fostering family connections for all children and youth in child welfare.

"I started living in a group home at the age of 10. I had a really bad temper. I was fighting people and getting restrained. Living there was hard for me because there were too many people and I always had to be with staff. I didn't have any privacy. I couldn't even watch TV shows that I wanted to watch on my own. Group homes were so tough for me that I ran away from every program I went to.

Now I live in a house with just one other youth and Ms. E, which is really helpful. I feel like I can be normal here. Ms. E has been consistent and has taught me the ropes of life. She has taught me how to channel my anger, have respectful relationships, work in the community, and has shown me how to be responsible."

*- Young person formerly in foster care*



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# **Appendix A:**

## **Sample Qualified Residential Treatment Program Assessment**

This sample assessment is intended to support state agency staff and residential treatment programs in planning and developing QRTPs that meet the requirements of the FFPSA. It uses information compiled from existing assessments and serves as an example but not official guidance. Each state and jurisdiction must determine which tool best meets their needs. Links to state examples can be found at the end of appendix A.

**1. Has the agency adopted a formal policy on trauma-informed care?**

- Yes
- No

If yes, please attach or insert the policy below.

**2. Is there a written family involvement policy?**

- Yes
- No

If yes, please attach or insert the policy below.

**3. Is there a grievance procedure that is shared in writing with youth, families, and staff?**

- Yes
- No

If yes, please attach or insert the procedure below.

**4. Are trauma competencies identified in personnel policies and performance evaluations?**

- Yes
- No

If yes, please attach or insert the competencies below.

**5. Do all staff and board members receive trauma training?**

- Yes
- No

If yes, please describe the frequency and content of training.

**6. Do staff receive training on:**

- Agency policies and procedures
- Use of seclusion and restraints
- Confidentiality
- Personal and professional boundaries
- Implementation science
- Family involvement
- Secondary trauma

**7. Please describe other types of trainings provided on a regular basis.**

**8.** Does the organization have a written policy describing the circumstances under which the organization uses seclusion and restraints?

- Yes
- No

If yes, please attach or insert the policy below.

**9.** Does the organization have a written policy on use of psychotropic medication?

- Yes
- No

If yes, please attach or insert the policy below.

**10.** Is a screening used to assess exposure to trauma?

- Yes
- No

**11.** Is a functional assessment used to inform treatment?

- Yes
- No

**12.** Do staff and residents have access to a clinician with demonstrated skills in trauma treatment?

- Yes
- No

**13.** What evidence-based trauma treatment interventions does the organization currently implement?

**14.** Please document the number and type of clinicians trained and certified in each intervention.

**15.** How does the agency ensure fidelity to the model?

**16.** Does the agency have 24/7 availability of licensed or registered nursing staff?

- Yes
- No

If yes:

Are they employees of your program?

How many hours are they on site?

How are they accessed on call?

**17.** Does the agency have 24/7 availability of licensed clinical staff?

- Yes
- No

If yes:

What type of licensure do they have?

Are they employees of your program?

Which days and hours are they on site?

Which days and hours are they on call?

**18.** Does each child in care have a written safety plan?

- Yes
- No

**19.** Does the agency provide any type of aftercare following discharge?

- Yes
- No

If yes:

How long is aftercare provided?

What aftercare services are provided?

What criteria are used to determine the need for or type of aftercare?

**20.** How are family members included in the assessment process?

**21.** How are family members included in the child's treatment program?

**22.** How does the agency conduct and document outreach to family members?

**23.** How does the agency maintain sibling connections?

**24.** How does the agency maintain contact information for family and fictive kin?

**25.** Does the agency have a continuous quality improvement (CQI) or quality assurance (QA) plan?

- Yes
- No

Check which of the following components are included in the plan:

- Client outcomes
- Practice expectations and requirements
- Regulatory requirements
- Data processes, including collection, analysis, and reporting
- Performance improvement processes

**26.** Describe how staff, families, and youth are involved in CQI or QA.

**27.** Does the agency have a data management system?

- Yes
- No

Check which of the following components are included in the system:

- Demographic data
- Screening and assessment results
- Services and treatment provided
- Progress and outcomes data
- Family contact information
- Reporting function
- Other (please describe)

**28.** Are data used to monitor children's progress and inform treatment?

- Yes
- No

**29.** Are data used for performance improvement?

- Yes
- No

**30.** Describe internal review processes.

**31.** Describe external review processes.

**32.** Is the agency currently accredited?

- Yes
- No

If yes, please list the type, accrediting body, and expiration date.

If no, is the agency considering accreditation?

- Yes
- No

If yes, please list the type and accrediting body.

### **State Examples**

- ◆ [Colorado QRTP Trauma-Informed Care Model](#)
- ◆ [Virginia QRTP Application](#)
- ◆ [Maine Qualified Residential Treatment Program \(QRTP\) Readiness Assessment Tool for Existing Residential Treatment Programs](#)
- ◆ [Kentucky Provider Readiness Assessment Survey](#)

# Appendix B: Additional Resources

The following resources can help states as they work to build equitable child welfare systems and reduce disproportionality in congregate care.

- ◆ [Child Welfare Information Gateway: Strategies for Reducing Inequity](#)
- ◆ [Achieving Race Equity: Child Welfare Policy Strategies to Improve Outcomes for Children of Color](#)
- ◆ [Center for the Study of Social Policy: "Seizing the Opportunity: Ten Ways to Advance Equity and Promote Well-Being through the Family First Prevention Services Act \(FFPSA\)"](#)
- ◆ [Center for the Study of Social Policy: Alliance for Racial Equity in Child Welfare](#)
- ◆ [National Child Welfare Workforce Institute: Racial Equity Resources](#)
- ◆ [The Annie E. Casey Foundation: "Measuring Disparities in Child Welfare Systems – Five Lessons"](#)
- ◆ [The Annie E. Casey Foundation: Race Equity and Inclusion Action Guide](#)

The following resources can help states develop targeted prevention services and increase family-based placements.

- ◆ [Center for States Change and Implementation in Practice Series](#)
- ◆ [A Data-Driven Approach to Service Array Guide](#)
- ◆ ["It's All Relative: Supporting Kinship Care Discussion Guides and Video Series"](#)
- ◆ ["Strategies for Authentic Integration of Family and Youth Voice in Child Welfare"](#)
- ◆ [Building Bridges Initiative](#)
- ◆ ["How did New Jersey safely reduce congregate care?"](#)

The following resources can help states as they consider trauma-informed and evidence-based approaches.

- ◆ [Children's Bureau Express: Selecting Evidence-Based Practices](#)
- ◆ [Youth Engagement Blueprint Series](#)
- ◆ [Family Empowerment Leadership Academy](#)
- ◆ ["Becoming a Family-Focused System: Assessing Organizational Culture and Climate"](#)
- ◆ [Recommendations for Trauma-Informed Care Under the Family First Prevention Services Act](#)
- ◆ [SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach](#)
- ◆ [The California Evidence-Based Clearinghouse for Child Welfare](#)
- ◆ [SAMHSA TIP 57: "Trauma-Informed Care for Behavioral Health Services"](#)
- ◆ [National Child Traumatic Stress Network](#)

The following are examples of functional assessments used in different jurisdictions.

- ◆ [Children's Functional Assessment Rating Scale \(CFARS\)](#)
- ◆ [Child and Adolescent Functional Assessment Scale \(CAFAS\)](#)
- ◆ [Child and Adolescent Needs and Strengths \(CANS\)](#)