Elements of
Effective Practice
for Children and Youth Served by Therapeutic Residential Care

Historically, group homes and residential treatment centers have been an important but controversial part of the child welfare continuum of services. These facilities, plus shelter care, maternity homes and juvenile justice facilities, are referred to as "congregate care."

Group homes and residential treatment centers have been challenged to better define their intervention models and the youth they are best suited to serve within a context of child welfare values that include serving children in the least restrictive alternative settings with the most effective interventions.

EFFECTIVE PRACTICE ELEMENTS

safe children | **strong** families | **supportive** communities

casey family programs

Elements of Effective Practice for Children and Youth Served by Therapeutic Residential Care is a research brief that focuses on a subset of congregate care services, which we refer to as therapeutic residential care (TRC), that includes group homes, residential treatment centers, and psychiatric residential treatment facilities that serve seven or more children. Here you will find a summary of key elements of effective TRC — serving the right youth, with the most appropriate interventions, for the shortest amount of time necessary to achieve key safety, therapeutic, and permanency goals. The full research brief, including reference citations, is available at **casey.org/residential-care/**.

Considerations for TRC policies and programs

The following **questions** can guide the examination of policies and program design:

- Who is being placed in therapeutic residential care and other forms of congregate care, and why?

- What service gaps, if addressed, would prevent some children from being placed in TRC?

- What child and family interventions and other supports to shorten length of stay and ensure an adequate supply of step-down placements are needed but not available in your community?

- What TRC program models and interventions are available for the groups of youth most commonly needing TRC? Is there a good fit between needs and available services?

Program and legislative **reform provisions** for therapeutic residential treatment and group care must be comprehensive because reductions in the use of residential treatment and group care are dependent upon other system reforms and services. These reforms go beyond the walls of TRC agencies, and thus we have identified what some of these reforms should be:

Data and assessment

- Understand your community's data about who is being served in TRC and why. A number of experts caution that use of TRCs for different purposes may involve distinctly different strategies. Improve multi-dimensional assessment for intervention targeting.

- Use multi-disciplinary teams and team decision-making to carefully assess child needs and make child placement decisions.

Services array redesign

- Increase the availability of "up-stream" community-based prevention services, including in-home parent coaching and interventions for families in crisis such as Functional Family Therapy (FFT), Intensive Home-Based Services, and Multi-Systemic Treatment (MST).

- Improve kinship care licensing by offering rent deposits, house modifications, transportation supports, and other strategies to ensure timely availability of relative caregivers. Provide those kinship parents with the clinical supports they need to parent effectively.

- Expand the supply of treatment foster homes, including those involving kinship caregivers.

- Provide foster parent supports, as well as interventions designed to prevent a child's behavior problems from escalating, such as FFT, HOMEBUILDERS, MST or Project KEEP, because some youth escalate and go into TRC after a placement disruption.

- Refine the array of clinical interventions in TRC to better meet the needs of the children, including careful use of psychotropic medications.

- Make assertive permanency planning efforts for children in TRC.

- Train juvenile court judges about key values and the most effective community and TRC strategies, because some judges order TRC or other forms of congregate care placements without full consideration of other options.

- Provide more timely aftercare services from TRC staff for parents, families, relatives, and other caregivers after reunification and for adoptive families. A small but significant proportion of youth served in TRC are from adoptive and kinship care families, and more work is needed to create supportive pathways for leaving care.

Performance targets, incentives and measurement

- Reinforce the philosophy that children belong with families, and shift workers are never sufficient — even if a child is "safe" and "stable." Consider "down-stream" implementation side-effects and barriers that may undermine the best-intentioned reform efforts if foster parents or essential after-care services become overwhelmed.

- Set aggressive targets for reducing the number of children placed in shelter care and TRC by shortening length of stay whenever clinically possible. Distinguish dosage and intensity from length of treatment or level of restrictiveness.

- Use refined performance metrics and redesigned performance-based contracting fiscal incentives to achieve reform targets.

- Offer financial incentives and support to help TRC agencies become providers of aggressive family finding, wraparound, family team decision-making, youth emancipation, respite care, and other key services.
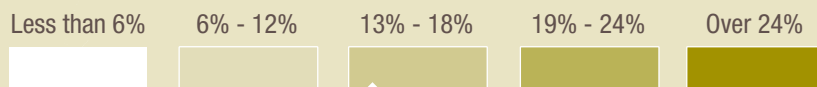
FACTS: Youth in foster care

Children in congregate care
September 30, 2013
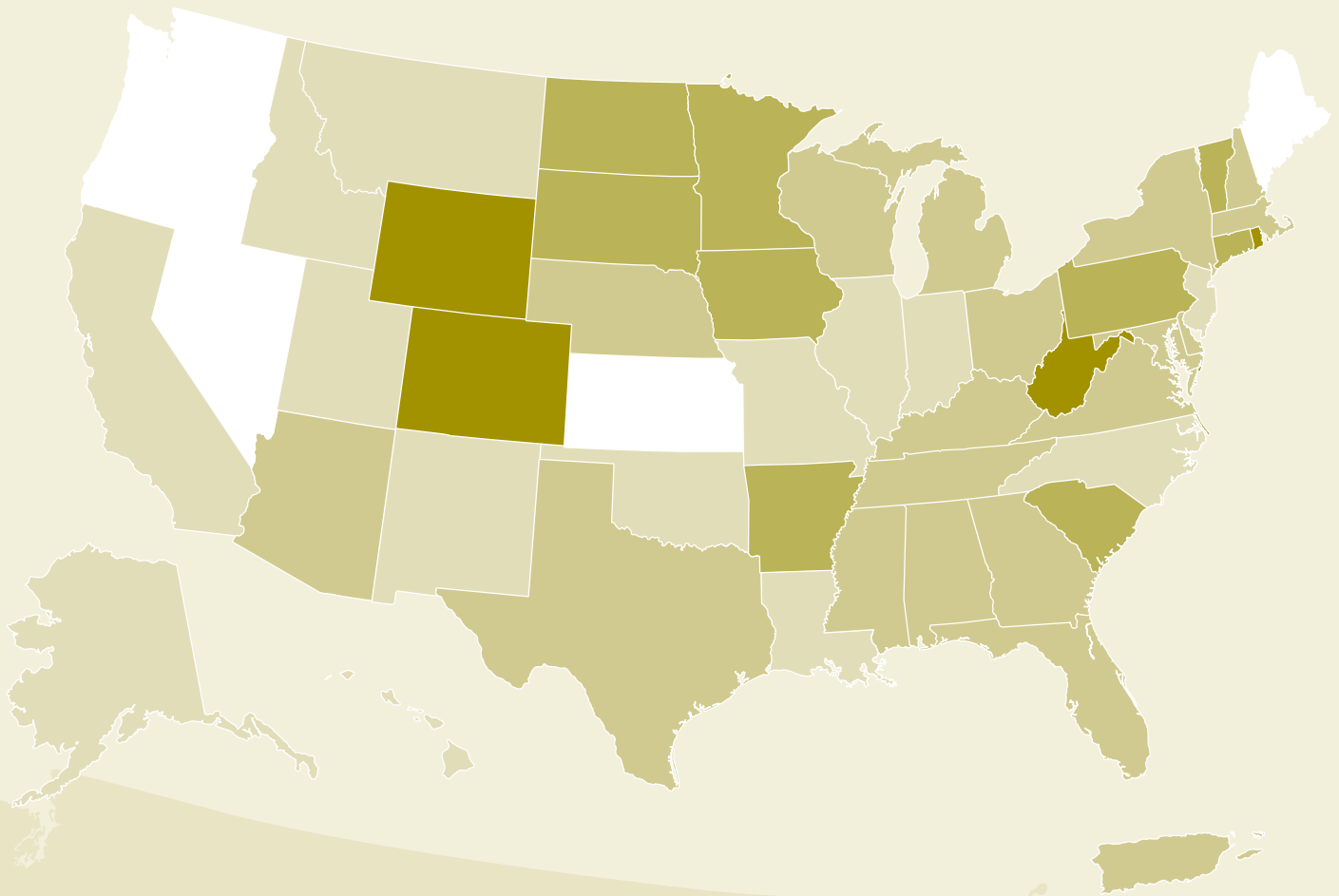
Percentage of all foster children in congregate care by state, FY 2013

Less than 6%   6% - 12%   13% - 18%   19% - 24%   Over 24%

national average (14%)

Few states have developed specific, assessment-based criteria for use of TRC nor measured their effectiveness at improving youth outcomes. In fact, use of congregate care varies significantly by state. While child welfare practice is moving toward more limited use of congregate care, the depth of improvement is not consistent across states.

Source: GAO analysis of data states reported to HHS. GAO-16-85

Nearly **1** in **7** youth

in care reside **in congregate care** (over 56,000).

31
PERCENT

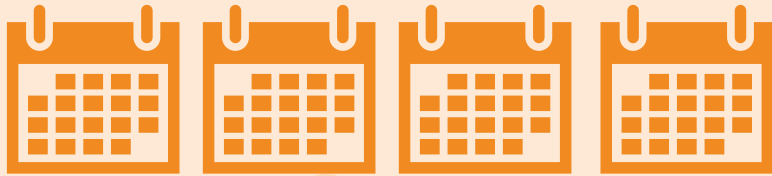of youth in congregate care are **under age 13**.

6x
MORE LIKELY

3x
MORE LIKELY

Compared to other types of out-of-home care, youth in congregate care are 6 times more likely to have behavior problems and 3 times more likely to have a DSM-V classification.

8

MONTH STAY

Youth in congregate care average an eight-month stay

34

PERCENT

DECREASE

The percentage of children placed in congregate care settings has decreased by 34% from 2004 to 2013.

More than 4 in 10

youth 13 years and older entered congregate care for a behavior issue (with no other clinical condition).

21

PERCENT
of them stayed less than a week.

Externalizing disorders

Internalizing problems

CONGREGATE CARE

Youth with internalizing problems, such as depression or anxiety, are less likely than youth with externalizing disorders to be placed in congregate care settings and more likely to be placed in therapeutic foster care.

1/2 of youth 13 years and older who entered care in 2008 spent time in congregate care.

ABOUT **1/4** of youth 13 years and older entered a congregate care setting as their first placement.

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