

TECHNICAL REPORT

Improving the Quality of Residential Group Care: A Review of Current Trends, Empirical Evidence, and Recommendations

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Executive Summary

In 2013, an estimated 14% of the nation's child welfare cases in out-of-home care were placed in some form of residential group care (RGC).¹ Although the appropriate use of RGC has been a subject of longstanding debate, most child welfare experts, including practitioners, researchers, and advocacy groups, acknowledge that for some youth involved in the child welfare system, high quality group care is an essential and even life saving intervention^{2,3,4,5,6} (Child Welfare League of America 2013; Children's Bureau, 2015). In this report, current trends in placements and the characteristics of children and youth in RGC were reviewed. The findings report that rates of placement have declined over the past decade, both at the national level and in the state of Florida. Consistent with findings from prior research, youth placed in RGC in Florida are more often males, are older on average, and exhibit more severe behavioral problems compared to youth in family foster care. These findings suggest that more intensive and/or structured services may be warranted for this subset of the foster care population.

Despite the longstanding preference for less restrictive approaches and recent declines in placements, RGC remains an often utilized intervention for children and youth in the child welfare system. Those in favor and those who oppose the use of RGC agree that the best place for children to grow up is in nurturing families. Those who argue for the reduction or the elimination of RGC base their positions on findings from the studies that demonstrate RGC results in limited benefits to children and youth, particularly when compared with alternative interventions. Those in favor of the use of high quality RGC argue that priorities should be focused on identifying the best placement for children in the foster care system who require out-of-home care and ensuring that a full continuum of services, guided by best practices, is available to effectively meet the diverse and changing needs of all children.^{7,8} Research findings also support that for some children and youth, RGC is an effective intervention.

Findings from outcomes studies are mixed, with more recent scientific reviews concluding that, overall, youth appear to benefit from placement in RGC. Results from studies comparing RGC with alternative interventions find that for some youth, family-style RGC may be a more effective option while for others, including juvenile justice involved adolescents and younger children entering out-of-home care for the first time due to substantiated child abuse, treatment foster care and family foster care may be better options. Limitations in studies of RGC include a lack of research using rigorous designs, a failure to clearly describe programs under investigation, and the inadequate delineation of various forms of RGC. Such limitations hinder the ability to gain a complete and accurate picture of RGC and its role within the child welfare service continuum.⁹ Residential service providers are expected to apply best practices supported by research as leading to successful outcomes,

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yet not until more recently has there been a re-emergence of research focused on RGC with researchers and other stakeholder groups putting forth recommendations as a means to guide the field in efforts to build the scientific evidence-base. The empirical evidence-base for high quality models of group care is growing.

Based on reviews of current trends and issues surrounding RGC, findings from research, and reviews of recommendations proposed by child welfare experts and advocacy groups, recommendations are proposed with the goal of improving the overall quality of RGC programs in the state of Florida. Specifically, the following seven recommendations are offered:

1. Develop and implement a basic set of common quality standards for RGC.
2. Increase evaluation efforts to identify and support evidence-based RGC services.
3. Support RGC providers in strengthening efforts to engage families.
4. Explore innovative approaches, including those that are trauma-informed and relationship-based.
5. Increase efforts to identify and implement culturally competent practices that are supported by research.
6. Continue to build upon efforts to strengthen the child welfare workforce.
7. Explore flexible funding strategies that can help facilitate higher quality services and innovative uses of RGC that are consistent with systems of care principles.

What is Known?

Residential group care (RGC), in its various forms, is considered a necessary component of the child welfare service continuum (Children's Bureau, 2015), ensuring that specialized needs of the subset of children and youth requiring more intensive or structured services are met. The term group care is used broadly to represent an assortment of residential group-based placements. Children may be referred by the child welfare, juvenile justice, or mental health systems or, in some instances, they may be voluntarily placed by caregivers. This report primarily focuses on the use of RGC as a child welfare intervention; however, it is noted that children who are placed in group care settings often have a history of involvement in multiple systems.¹⁰ RGC has generally been described as an intervention reserved for children with complex behavioral and mental health needs, yet the specific structure, service components, and populations served can vary widely from one facility to the next. The lack of a universal definition and the inadequate delineation of its various forms have clouded the ability to gain a complete and accurate picture of RGC and its role within the child welfare service continuum¹¹ (Government Accountability Office, 2007).

At the federal level, the Children's Bureau identified two broad categories of RGC, group homes and institutions, which were used as reporting criteria for the Adoption and Foster Care Analysis and Reporting System (AFCARS). Both represent facilities that provide 24-hour care and/or treatment for children and adolescents who require out-of-home placement in group living. The key point of distinction is that group homes refer to facilities that serve 12 or fewer youths whereas institutions may serve 12 or more youths at a time (Children's Bureau, 2006). These two categories encompass a diverse range of facilities including community-based group homes, psychiatric residential treatment centers, family-style group homes, maternity homes, and treatment programs for youth with substance abuse or sexually offending behaviors. In Florida, residential programs are defined as agencies that are licensed by the Department of Children and Families (DCF) that provide 24-hour care to children adjudicated as dependent and who are expected to spend at least six months in foster care.¹² Florida uses two primary RGC models: shift care, in which direct care staff work in shifts, and family-style group homes with live-in staff, sometimes referred to as house parents. In FY 2013-2014 there were 96 DCF licensed RGC providers in the state with 58% using shift-care models and the other 42% were family-style group homes.¹³ Other types of facilities in the state include those licensed as emergency shelters, maternity group homes, wilderness camps, and those licensed by other state regulatory systems including Statewide Inpatient Psychiatric Programs (SIPP), therapeutic group homes, and group homes for persons with disabilities.

Placement Trends

Following the Adoption Assistance and Child Welfare Act of 1980 (P. L. 96-272), which mandated that children and youth requiring out-of-home care be placed in the least restrictive setting available, RGC has increasingly been considered a placement option of last resort only to be used after less restrictive interventions have failed. At the same time, growing emphasis has been placed on limiting the length of time spent in residential care only to that which is necessary to stabilize the child prior to expeditiously returning her or him to a family-like setting.^{14,15} Consistent with federal guidelines, family-based placements are preferred over RGC in Florida. Placement in RGC is typically only considered following an assessment to determine 1) if the child is over age 11; 2) has been in foster care for a minimum of six months; 3) has been removed from a family foster home more than once; and 4) the needs of the child.¹⁶ RGC is discouraged for children under 12 unless it helps to keep a sibling group together. Preference is given to family-style group homes over shift-care models, especially for younger children. The use of shift-care models are more often reserved for older youth with severe behavioral problems and/or a history of aggression or violence.

Nationally, the number of children in the foster care system declined by 21% over the past decade (Children's Bureau, 2015). Comparatively, the number of children in RGC declined by 37%. Declines in group care placements varied across states from 7% to 36% with five states increasing placement rates. In Florida, the total number of children in out-of-home care declined by a noteworthy 33% from 2006 to 2014. Over the same period, the percentage of children in Florida in out-of-home care that were placed in some form of RGC remained steady at 11%. Overall, the number of children placed in RGC has declined over the past decade at the national and state levels.

Characteristics of Youth in Residential Group Care

Demographics

The 2013 AFCARS data showed that the majority of youth in RGC were adolescent males (62.7%) with a mean age of 14 years old. Approximately 31% were under age 12. White youth made up 40.7% of those placed in group homes or institutions followed by 30.2% black/African American, 19.7% Hispanic, 5% multiracial, 1.6% Alaska Native/American Native, and less than 1% Asian and Hawaiian/Pacific Islander. Demographics of youth in RGC in Florida were similar. In FY 2013-2014, approximately 83% were adolescents between the ages of 11-17 and 17% were ages 10 and under.¹⁷ Among adolescents, the majority were nonwhite (64%) males (51%).

National

Children and youth served in RGC often have extensive trauma histories, including exposure to family and community violence. Using clinical data collected from 56 sites throughout the United States, one study found that 92% of youth served in residential care compared to 77% of youth receiving community-based services met criteria for complex trauma (i.e., multiple or repeated exposure to different forms of interpersonal trauma).¹⁸ The residential sample also exhibited significantly higher mean levels of functional impairment compared to youth receiving community-based services. Using the 2013 AFCARS data, the Children's Bureau (2015) reported that 36.2% of children in RGC had at least one diagnosed psychiatric disorder compared to 12.8% of children placed in non-group care settings (i.e., pre-adoptive homes, foster homes, supervised independent living, and trial home visits). Forty-five percent of children in RGC, compared to 6.9% of children in non-group care placements, had child behavior problems as an identified reason for referral.

Florida

Florida's foster care data showed similar distinctions between youths placed in RGC and family-foster homes. Compared with adolescents in family foster care, those in group care had higher rates of behavioral problems at the time of entry.¹⁹ Among early adolescents (ages 11-14), 56% in RGC had at least one identified behavioral problem compared with 40% in family foster care. Early adolescents in RGC were over twice as likely to have four or more identified behavioral problems than those in family-foster care. Seventy-one percent of older adolescents (ages 15-17) in RGC had one identified behavioral problem and 39% had four or more identified problems. Comparatively, 48% of older adolescents in family foster care had one identified behavioral problem and 21% had four or more identified problems.

The combined national and state level data show that children in RGC tend to fare worse in the areas of trauma and mental and behavioral health than those in other non-group-based placement settings that likely warrants more specialized and intensive services.

Summary of Key Issues Surrounding Residential Group Care

This is a time of unprecedented pressure for group care settings. Increased emphasis on evidence and outcomes, policy directives and class action lawsuits urging reduction of group care utilization along with a growing number of home and community-based interventions that promise to provide better care and outcomes for children with serious emotional and behavioral disorders have placed group care under renewed scrutiny.²⁰

Negative views of RGC, fueled by media coverage sensationalizing the worst cases; a lack of investment in identifying and developing best practices, along with the high costs of care; a lack of research clearly demonstrating effectiveness; and the status as a restrictive intervention, have contributed to its designation as a placement of last resort.²¹ The estimated costs of RGC are nearly six times that of family foster care and two times more than therapeutic foster care (Children's Bureau, 2015).²² In fiscal year 2013-2014, the average per diem rates of shift care and family group homes in Florida were \$124 and \$96, respectively, compared with an average per diem of \$15 for family foster care. It should be noted that these figures reflect additional required and specialized services provided to youth in RGC. Hence, caution should be taken in making lateral comparisons between the costs of RGC and family foster care or other less intensive interventions. Given that RGC is designed to provide more structured and/or intensive services to youth with higher level needs, it might reasonably be expected that the costs associated with providing quality care would be greater. Some have argued that when RGC is the most appropriate placement and of high quality, it is the most cost effective option both in monetary terms and in the overall benefits to the child.^{23,24} Similar to national trends of decreasing funds for group care placements, Florida's RGC expenditures have steadily declined for nearly a decade, with a 30% cumulative reduction reported for fiscal year 2013-2014.²⁵

The relative high cost of RGC is further called into question in light of limited scientific evidence supporting the beneficial effects,²⁶ which resulted in views that it is overused and that efforts should be made to divert resources to developing alternatives.^{27,28} Further complicating matters has been the increasingly limited benefits for extended in-patient care provided by managed care and public funding sources such as Medicaid.²⁹ Under increased scrutiny to demonstrate positive outcomes, RGC programs

are expected to provide effective treatment within increasingly shorter durations and with decreasing resources.³⁰ Additionally, as support for extended psychiatric hospitalization options faded away, children and youth with severe mental health conditions began to be more frequently admitted to RGC with the expectation of receiving comparable services, but at less cost and in less time. As part of a continuum of care, the role of RGC has been to move clients from inpatient to family and community-based care in an accelerated timeframe.³¹ In the mix of de-investment, diminishing resources, changing roles, and increased demands, RGC has struggled to maintain a clear purpose, with some facilities being reduced to 'catch-all' placements for children and youth without alternative options rather than programs with well-specified placement criteria and service protocols in which placements are made based on a suitable match to the needs of the youth. When used in this way, RGC may very well be over utilized. There has been no shortage of debate regarding what is the best use of residential programs. RGC has been viewed as a placement for treatment and management of children's mental and behavioral health issues, short-term stabilization, and more recently, as an intervention focused on helping children recover from trauma in the safety of a nurturing therapeutic environment.^{32,33}

Despite the longstanding preference for less restrictive approaches and recent declines in placements, RGC remains an often utilized intervention for children and youth in the child welfare system. In 2013, an estimated 14% of child welfare cases in out-of-home care were placed in some form of RGC.³⁴ Among the probable reasons for its continued use include the limited availability of alternative placement options,³⁵ high rates of placement disruptions in family-based settings among youth with more severe behavioral issues, and for some children it is presently the best available option to meet their needs.^{36,37,38} Arguments in support of the reduction or, in extreme cases, the elimination, of RGC are based on positions that children should grow up in family-settings and are often supported by citing those studies that found limited benefits over alternative options or international studies that found children, particularly at a younger age, are detrimentally impacted by placement in orphanage-style congregate care settings.^{40,41} Proponents of RGC tend to agree that when possible, children should grow up in nurturing family environments, but when that is not possible, quality RGC can be an optimal alternative for some children. Those in favor of RGC tend to argue that priorities should be focused on identifying the best placement for children in the foster care system requiring out-of-home care and ensuring that a full continuum of services, guided by best practices, is available to effectively meet the diverse needs of all children.^{42,43}

What is Important?

Residential service providers are expected to apply best practices supported by research as leading to successful outcomes. Negative views and the focus on placement in the least restrictive settings resulted in research priorities shifting away from RGC throughout the 1990s and, consequently, limited evidence to guide the selection of evidence-based practices and approaches.⁴⁴ Not until more recently, has there been a re-emergence of research focused on RGC with researchers and other stakeholder groups putting forth recommendations as a means to guide the field in efforts to build the scientific evidence-base.

In 1994, following a review process that entailed contacting 18 residential group care programs that had conducted program evaluations, the U.S. Accounting Office reported that RGC may be a viable option for some high-risk youth based on results that demonstrated benefits in maintaining school attendance as well as reduced drug use and involvement in criminal behavior. However, few programs used controlled or comparison designs needed to link youth outcomes with treatment or follow-up assessments, leading the U.S. Accounting Office to conclude that more research is needed in order to determine the long-term effects and which types of youth are best served in RGC. The extant research on RGC is scant and plagued with methodological limitations weakening the ability to extrapolate firm conclusions about its effectiveness as a child welfare intervention.^{45,46,47,48} Four widely recognized problems among RGC outcomes studies include:

1. a frequent absence of control or comparison conditions.
2. a lack of random assignment limiting internal validity.
3. poorly defined service units making it difficult to determine what treatment components contribute to change.
4. poorly defined outcomes.

Studies tend to vary widely in terms of scope and quality, an existing problem Pecora et al. noted as common across much of social services research.⁴⁹

Another issue of critical importance is a lack of research that adequately delineates between different RGC models.⁵⁰ Results from studies focused on widely different and often not well described programs tend to be combined, leading some to make over generalized conclusions regarding the effects of RGC. This is akin to concluding that clinical therapy is not effective, while ignoring the nuances in the effects of different models of therapy such as Cognitive-behavioral therapy, Solution-Focused therapy or Multisystemic therapy, which may be more or less effective in treating different types of problems and different types of clients. Understanding variations in RGC programs is essential to gaining a full understanding of the effects for different types of youth. Keeping the noted limitations in mind, the following sections provide a summary of findings from scientific reviews of RGC outcomes studies, studies comparing RGC with alternative interventions, and current evidence-supported models. The following research summary is intended to provide a snapshot of existing research conducted over the past two decades, highlighting the complexity of the findings. It should not be considered an exhaustive review nor what is referred to as a systematic review, as these are both beyond the scope of this report.

Summary of Findings from Residential Group Care Outcomes Studies

In more recent scientific reviews of RGC outcomes studies published in peer reviewed journals, reviewers concluded that overall the evidence supports that youth experience improvements following placement in RGC.^{51,52,53} Among the outcomes reported across studies were decreased pathology,^{54,55} externalizing behaviors^{56,57,58,59} and depression^{60,61} and improvements in prosocial behaviors^{62,63} and family functioning.⁶⁴ Results from studies that included post-discharge follow-up assessments were mixed with some finding that between 59%-75% of youth returned to care within three to seven years,^{65,66} while other studies reported sustained improvements over follow-up periods ranging from three months to 10 years.^{67,68,69,70,71} A key finding across studies was that outcomes varied according to youth and program characteristics and treatment approaches.^{72,73} To date, studies have yielded mixed results concerning which factors are most relevant to treatment effects and these differences are likely to vary across different types of RGC programs. The question of how to best match client characteristics with appropriate treatments provided in the most beneficial contexts remains to be further examined.^{74,75}

Summary of Findings from Studies Comparing Residential Group Care with Alternative Interventions

The question of whether youth are best served in RGC or alternative settings has not been definitively answered by existing research.⁷⁶ As previously noted, research shows that there are substantial differences between youth placed in RGC and those placed in other settings. Compared to youth in treatment foster care and family foster care, those in RGC are older on average, more likely to be male, and exhibit more severe behavioral and mental health problems (Children's Bureau, 2015).^{77,78} Researchers attempting to make comparisons in outcomes among youth treated in RGC versus other settings must take these differences into account in order to produce valid findings. Research in which statistical controls for group differences, such as randomization or propensity score matching, are not applied should not be used to draw conclusions about the effectiveness of less restrictive interventions compared with RGC.

Lee et al. (2008) reviewed two-group studies that compared RGC to family foster care, treatment foster care, no placement or two different models of RGC.⁷⁹ Twelve out of the 19 reviewed studies included some method of statistical control for differences between groups. Eight of the 12 studies compared RGC to treatment foster care. Findings from seven randomized clinical trials supported that Multidimensional Treatment Foster Care (MDTFC) outperformed generic models of RGC in reducing delinquent conduct and high-risk behavior among juvenile justice involved boys and girls.^{80,81,82,83,84,85,86} Using propensity score matching to control for group differences, one study compared Teaching Family (TF) models of group care and treatment foster care using a sample of 828 youth (minimum of eight years old at intake) who were involved in either the child welfare, juvenile justice, and/or mental health systems.⁸⁷ Although both models were effective in reducing later involvement in the legal system, youth in the TF group homes were significantly more likely to discharge under favorable conditions and had higher rates of return home and lower rates of subsequent placements up to six months following discharge. They concluded that family-style group care appears to be more effective in promoting positive outcomes than treatment foster care.

Two of the 12 studies compared outcomes of youth who were placed in RGC with those who avoided placement. Thompson et al. (1996) compared outcomes between youth (ages 10-16) who were treated in a TF group home or who were accepted for treatment but never admitted, finding that youth in the TF group experienced significantly greater improvements in attitudes during treatment and school performance over time.⁸⁸ Little difference was found between children and adolescents who either received in-home services or who were placed in RGC, concluding that due to the costs and restrictiveness of RGC, the results support in-home services as the more effective approach.⁸⁹

Two additional studies compared outcomes of children and youth placed in family-foster homes with those placed in a short-term shelter or a general model of group care. Using propensity score matching, it was found that children ages 3-12 who were placed in a short-term group shelter (i.e., SAFE Homes) as a first time placement were more likely to be placed with siblings but those who were placed in family foster homes fared better on a number of other outcomes including placement stability.⁹⁰ Comparing outcomes in a sample of abused children involved in the child welfare system who were either initially placed in a group care or family foster care, it was found that the relative risk for involvement in subsequent delinquency was 2.5 times greater for youth placed in RGC.⁹¹ In a later study, researchers used propensity score matching and three waves of data from the National Survey of Child and Adolescent Well-Being to compare long-term cognitive, academic, and affective well-being of youth who were first placed in either nonkinship foster care ($n = 259$) or group care ($n = 89$). Results from a hierarchical linear regression supported that both groups of youth showed improved behavior and below-average academics over time.^{92,93}

Overall, the results suggest that MDTFC may be a more effective alternative for juvenile justice involved youth, at least when compared with generic models of RGC. For more diverse samples, family style group care appears to produce more positive outcomes than treatment foster care or no placement at all. In other instances no differences were found for RGC compared to alternatives; however, placement in foster family care may be a better initial option for younger children who have been removed from the home due to child abuse.⁹⁴ In summarizing findings from their review, Lee et al. (2008) noted that outcomes appear to vary according to the sample and the type of group care and alternative intervention. In several instances group care programs were vaguely described, a previously mentioned limitation of RGC studies.⁹⁵ Differing outcomes by placement type for youth referred through different service systems or at varying points of involvement in the child welfare service continuum may indeed be indicative of a need to ensure that a full array of service options is available in order to meet the wide range of needs of children and youth that will inevitably vary over time.

Lee et al. (2008) also pointed out that the lack of consistency in the findings across studies may be a reflection of quality of the given program, a factor that is often not adequately captured in outcomes studies.⁹⁶ Barth accurately noted that, “All residential treatment programs are not created, or managed equally. The results correspond.”⁹⁷ A 2005 review of five meta-analyses of residential treatment outcomes studies for juvenile offenders, found overall small positive effects sizes but that outcomes were dependent upon program quality and implementation.⁹⁸ Several program characteristics were found to predict variations in effects including monitoring treatment implementation, treatment duration, and whether treatment was delivered by mental health professionals. In a statewide evaluation, clinical outcomes of 285 adolescents placed in RGC facilities finding that indicated overall, youth experienced significant improvement over the course of treatment, yet there were variations in outcomes across sites, with one provider whose clients got significantly worse over time.⁹⁹ Possible causes that were proposed included instability within the facility administration and an aging facility thought to contribute to low staff morale. The findings highlight that proper management and oversight is equally important in RGC as it is in all other areas of child welfare services and programs.

Summary of Evidence-Supported Models of Residential Group Care

The evidence-base for specific models of RGC is growing. Currently, four evidence-supported models of RGC are identified by the California Evidence-Based Clearinghouse for Child Welfare (CEBC), a registry of evidence-based programs for use in child welfare practice settings. Programs are rated on a scientific scale that ranges from ‘1’, indicating a practice with the strongest research evidence to a ‘5’, indicating a concerning practice that may pose a risk to children and families. The CEBC also rates programs based on whether the reviewed research demonstrates outcomes that are relevant to federal child welfare outcomes of safety, permanency, and child/family well-being. For complete descriptions of the CEBC rating scale and assessment of programs’ relevance to child welfare outcomes see <http://www.cebc4cw.org/search/advanced/>. The four evidence-supported models of RGC that have been rated by CEBC are described below. Additionally, the program principals, demonstrated outcomes, and child welfare outcomes ratings are summarized in Table 1.

TABLE 1. EVIDENCE-SUPPORTED MODELS OF RESIDENTIAL GROUP CARE

Model	Essential Components	Target Population	Demonstrated Outcomes	Manual or Training Available	Child Welfare Outcomes		
					Safety	Permanency	Child/Family Well-being
Positive Peer Culture	Address universal growth needs Therapeutic milieu approach Peer group problem-solving meetings Service learning/engagement in community projects Teamwork primacy Group sizes of 8-12 youth	Troubled adolescents ages 12-17	Decreased delinquency and recidivism up to 12 month post-discharge Improved social skills, school attendance, cognitive distortions and attitudes toward delinquency	Manual and training available			X
Sanctuary Model	Trauma theory Seven principles of nonviolence, emotional intelligence, social learning, democracy, open communication, social responsibility & growth and change Psycho-educational trauma recovery curricula for youth and families Sanctuary Tool Kit focusing on emotion regulation skills	Traumatized adolescents ages 12-20	Improved coping skills and therapeutic community environment Decreased verbal aggression	Manual and training available			X
Stop-Gap	Environment-based intervention: Token economy Academic intervention Social skills training Problem-solving and anger management skills training Discharge-based intervention: Intensive case management Behavioral parent training Community integration	Children and adolescents ages 6-17 with disruptive behavior disorders	Decreased therapeutic holds	Training Available	X		

Model	Essential Components	Target Population	Demonstrated Outcomes	Manual or Training Available	Child Welfare Outcomes		
					Safety	Permanency	Child/Family Well-being
Teaching Family Model	<p>Delivery systems:</p> <ul style="list-style-type: none"> Staff selection & training Competency-based management (consultation/supervision) Quality assurance (evaluation) Facilitative administration <p>Essential elements:</p> <ul style="list-style-type: none"> Teaching systems Self-determination Client advocacy Relationships Family-sensitive approach Diversity Professionalism 	<p>Children and adolescents ages 0-17</p> <p>At-risk, juvenile delinquents, in foster care, developmentally disabled, emotionally disturbed</p>	<p>Increased reunification and placement stability 6 months post-discharge</p> <p>Decreased involvement in delinquent offense during treatment</p>	Manual and training available		X	X

Source: California Evidence-Based Clearinghouse for Child Welfare (<http://www.cebc4cw.org/>)

Positive Peer Culture (PPC) was designed for use in shift care style RGC programs for troubled youth. The peer group is treated as the primary change agent with guidance provided by program staff. The model utilizes a strength-based approach that emphasizes social competence, responsibility, empowerment, and caring for others. Pro-social norms based in trust, respect, and responsibility for one's actions and the actions of peer group members are established and reinforced by peer leaders, peer group members, and program staff. Positive values and behavioral change are primarily achieved through a peer helping process that facilitates a sense of self-worth and concern for others while negating negative peer influences. PPC currently has a scientific rating of 2, indicating that it is supported by research. Two studies are identified and described that utilized experimental or quasi-experimental designs and lend support for PPCs designation as an evidence-supported model. A sample of 56 adolescent males ages 12-18, researchers found that compared to youth in a comparison RGC, those in the PCC group experienced significantly greater reductions in cognitive distortions and attitudes toward delinquency.¹⁰⁰ In a second randomized trial using a sample of 57 adolescent males (mean age = 16), researchers found that youth in the experimental PPC condition experienced significantly greater improvements in conduct (e.g., social skills, delinquency, and school attendance) and lower rates of recidivism up to 12 months following discharge.¹⁰¹ The combined results suggest that PPC is an effective/efficacious intervention for addressing negative attitudes and delinquent behavior in adolescents.

The Sanctuary Model was adapted for use in residential programs with adolescents and is designed to create trauma-informed organizational systems.¹⁰² Sanctuary is grounded in trauma theory and guided by seven principles (i.e., nonviolence, emotional intelligence, social-learning, democracy, open communication, social responsibility, and growth and change) that shape the culture of the treatment milieu and approach to providing services. The model includes a group-based trauma recovery curriculum and a set of practice tools to help build emotion regulation skills and protective factors into the treatment community. The goals are to create a cohesive community-oriented environment that promotes collaboration, healing and growth, decreased use of coercive practices (e.g. restraints), and that fosters high functioning multi-disciplinary treatment teams, increased staff moral and employee retention, and more effective work with traumatized clients. Preliminary findings from a non-randomized comparison group study of 158 adolescents in residential treatment showed that after six months youths in the Sanctuary units had significantly better scores on measures of coping strategies and internal locus of control and reduced verbal aggression scores on the Child Behavior Checklist and several dimensions of therapeutic community as measured by the Community Oriented Environment Scales.¹⁰³ The model is being implemented in over 150 programs nationally and internationally, including one group home in Tampa, Florida. Sanctuary currently has a rating of '3' indicating it has promising research evidence supporting the model.

A third evidence-supported model, **Stop-Gap**, is an intensive, short-term intervention for children and youth in residential group care. The overall aim is to interrupt patterns of disruptive behavior in order to prepare youth to discharge to a community-based placement in a timely manner. Stop-Gap is described as a two-tiered model that initially focuses on reducing problem behavior (Tier 1) through providing intensive ecological and skills training interventions. At the same time, discharge planning and intervention services are provided. Tier 2 services focus on maintaining stabilization post-discharge through 'function-based behavior support planning'. The goals of Stop-Gap are to reduce the length of stay in RGC, reduce disruptive behaviors that interfere with the child's ability to be maintained in less restrictive settings, and to improve the post-discharge environment. The model currently has a rating of '3' indicating promising research evidence. In a quasi-experimental comparison group evaluation, McCurdy and McIntyre (2009) compared rates of therapeutic holds between two residential units of approximately 25 adolescent females.¹⁰⁴ They found that after 12 months of implementation, the units using the Stop-Gap model experienced statistically significant reductions in rates of therapeutic holds whereas the comparison unit did not.

The **Teaching Family Model (TFM)** of group care is based on providing a family-like environment to children and youth in care. The model is unique in its use of live-in house parents who help teach children important life skills and to establish positive social relationships. The model also emphasizes involvement of members of the child’s extended support network including parents and family members, educators, and other natural supports. The chief goals are to improve mental health outcomes, reduce the restrictiveness of the living environment, to promote family reunification, and to help children and families achieve personal goals. The TFM currently has a rating of ‘3’, indicating promising research evidence supporting the model. In an early quasi-experimental investigation of the TFM, using a sample of 192 male and female adolescents involved in the juvenile courts, researchers found that rates of offending during treatment were significantly less among those in the TFM group homes compared to youth in the comparison group.¹⁰⁵ Outcomes were examined among youth in TFM group homes with those in comparison RGC using propensity score matching to reduce sampling bias, finding that youth in the TFM condition had significantly higher rates of return home and maintained placement stability at six-month follow-up.¹⁰⁶

A commitment to competent practice, coupled with increasing requirements to demonstrate service effectiveness has resulted in the widespread adoption of an evidence-based practice perspective in child welfare.¹⁰⁷ The evidence-base for different models of RGC remains somewhat limited but it continues to grow. Investigators have begun using more rigorous methods to evaluate the efficacy/effectiveness of various RGC models and are engaging in efforts to address other noted limitations in outcomes research in order to respond to increased demands to demonstrate the effectiveness of RGC through empirical evidence.

Recommendations for Research, Practice, and Policy

Drawing upon current national and state trends in residential group care, findings from research reviewed in the previous sections and a review of priority areas for RGC identified by national groups and members of the scientific community with expertise in child welfare, seven recommendations are proposed aimed at helping improve the quality of RGC in the state of Florida. The recommendations were derived by leading national groups with expertise in RGC including the American Association of Child Residential Centers, Children’s Bureau, and the Child Welfare League of America. In addition, recommendations put forth by child welfare scholars were reviewed.^{108,109} Table 2 provides a summary of priority areas for RGC that were identified by the key sources that guided the selection of recommendations offered in this report. Two topic areas, the development of quality standards and workforce development, although not as widely identified across the five key sources presented in the table, are two frequently cited issues of concern in RGC literature and are widely considered of relevance to current policy/practice decision-making identified by child welfare stakeholders. In the following section, each of the seven recommendation areas is summarized.

TABLE 2. SUMMARY OF PRIORITY RECOMMENDATIONS TO GUIDE PRACTICE AND POLICY FOR RESIDENTIAL GROUP CARE

Source	RECOMMENDATIONS						
	Quality Standards	Evidence-Based Practices	Workforce Development	Cultural Competency	Family Engagement	Explore/Expand New & Innovative Models/Approaches	Flexible Funding Strategies
AACRC (2009-2014)	X	X		X	X	X	
Bullard et al. (2014)		X	X	X	X	X	X
Children’s Bureau (2015)		X	X				
CWLA (2007)		X			X	X	X
Pecora et al. (2010)		X		X	X	X	X

1. Quality Standards

The American Association for Children’s Residential Centers recommended licensing, accreditation, and the development of practice standards as a starting place for initiatives focused on improving the quality of residential programs.¹¹⁰ Collectively, licensing and accreditation criteria, and practice standards should embody the conditions necessary to ensure children’s safety, rights, and health needs are met and a high level of competency in treatment planning and implementation. Licensing criteria tend to focus on environmental safety and health; whereas, accreditation standards may extend these criteria to focus on

ensuring youth receive competent and effective services. Residential providers must adhere to licensing requirements as part of their service contracts, but agencies are often not required to go through the accreditation process.¹¹¹ A survey of 544 children's residential facilities throughout the country, found that nearly all facilities were state-licensed and 79% were nationally accredited. States wishing to encourage increased accreditation among residential providers might consider doing so through increased contractual requirements, purchasing specifications or pay-for-performance measures.¹¹²

Despite well-established licensing requirements and an increasing number of accredited agencies, little has been done to develop quality measures in RGC.¹¹³ The development of core practice indicators and standards can be a valuable means for assessing quality. A quality indicator is a practice component whereas a standard is a measurable threshold that reflects acceptable quality in that component (APA, 2002). Practice standards should encompass and/or compliment and go beyond accreditation standards. They should reflect the perspectives of multiple key stakeholders including child care workers, administrators, youth, and families and be linked with available research informing evidence-based practices.¹¹⁴

Quality standards can be developed at the organizational, state, or national levels by building upon the framework of licensing and accreditation criteria, to identify critical values and practice foundations for achieving a broader mission.¹¹⁵ Establishment and measurement of desired outcomes and performance indicators can help assess the degree to which residential programs are meeting quality standards and can inform a process of continuous quality improvement.¹¹⁶ Examples of nationally proposed standards include the Child Welfare League of America's [Standards of Excellence for Residential Care](#) and [National Performance Standards for Residential Care: A Policy Initiative from Father Flanagan's Boys' Home](#). Whether standards are created and/or adapted at the organizational, state, or national level, establishing a basic set of common measures is recommended as a way to better monitor quality.¹¹⁷ A clear set of guidelines should be provided with any set of practice standards to facilitate greater universal interpretation, implementation, and measurement.

2. Evidence-Based and Best Practices

We encourage jurisdictions to analyze their data to understand the unique characteristics of their own populations that are in and at risk of placement in congregate care and consider these when crafting their policies, practices, and programs (Children's Bureau, 2015).

Efforts to increase the evidence-base for RGC through evaluation and research can support growth in other areas including practice and policy. The Children's Bureau encouraged states to engage in evaluation of RGC with the goals of determining how it is being used in the state, for whom it is being used and how effective it is. A frequently cited limitation in the extant literature is the tendency to aggregate RGC facilities and/or vaguely define programs and service elements when examining effectiveness.¹¹⁸ Yet, researchers have shown that program characteristics and practices are directly linked to outcomes.¹¹⁹ Proper delineation of these program elements is critical to understanding and cultivating best practices.

Lee and Barth (2011) proposed the use of reporting standards to help adequately describe RGC programs and the relevant characteristics that should be reported to improve the ability to determine the effectiveness of different programs.¹²⁰ The use of a common reporting framework has potential to address issues with existing RGC research but also could be utilized as a tool to guide efforts to understand the different RGC programs at the state level. Based on the CONSORT (Consolidated Standards of Reporting Trials) checklist, initially created to increase the usefulness of results reported from randomized clinical trials, Lee and Barth adapted a set of reporting standards for group care research that includes the following three domains: 1) Participant descriptions that include the number and characteristics of youth served and the setting and location of the program; 2) Intervention descriptions that include the program model, program activities, staff, system influences (e.g., funding, licensing, accreditation), and structure (e.g., level of restrictiveness); and 3) Program outcomes (for complete description of [An Index of Reporting Standards](#) for residential group care.)¹²¹ Evaluations of program outcomes should identify and collect specific process or performance measures to determine what elements or approaches contribute to outcomes and, conversely, what practices or approaches may be less helpful.^{122,123,124} Outcome measures should examine change over time in various attributes of youth and family functioning.¹²⁵ Suggested categories of outcomes include measures of clinical and behavioral functioning, recidivism/re-entry, and consumer satisfaction.¹²⁶ Outcomes measures should also include indicators of safety, well-being, and permanency. Finally, to determine whether the benefits of group care persist over time and the effectiveness of transition and aftercare services, programs should engage in efforts to collect long-term outcomes data.^{127,128} States or organizations using evaluation as a means to create an evidence-based catalog of RGC programs can adapt or add elements to reporting standards to meet their specific informational needs.

Although the appropriate use of RGC has been the subject of longstanding debate, most child welfare experts including practitioners, researchers, and advocacy groups readily acknowledge that for some youth involved in the child welfare system, high quality group care is an essential and even life saving intervention (Child Welfare League of America, 2013; Children's Bureau, 2015).^{129,130,131,132,133} As part of the evaluation process, data on specific characteristics of youth and families who receive RGC services can be collected and used to determine which types of youth are being treated in RGC programs and what are the effects for different youth.

3. Family Engagement

The family-centered and strengths-based perspectives represent frameworks that have become increasingly accepted standards of child welfare practice over the past two decades.^{134,135} Among the most well-supported findings from RGC research is that when

families are involved in treatment, youth experience better outcomes. For example, residential programs that encourage family involvement through visitation and that provide family therapy as a treatment component have been found to significantly increase the probability of treatment completion and discharge to a lower level of care.^{136,137} A quasi-experimental investigation comparing differences in outcomes between a standard and family-focused residential program found that youth in the family focused program were significantly more likely to be reunified at discharge compared to youth in the standard program.¹³⁸

RGC providers are encouraged to strengthen efforts to engage families and explore new ways to further involve youths' families and natural supports in the treatment process. The AACRC described the process of becoming family driven as a journey "...that involves constantly addressing the belief systems of the staff, through leadership involvement, training, ongoing dialogue with family members, and self-monitoring (quality improvement)".¹³⁹ There are countless ways in which families and natural supports can be a part of the treatment process. Among those suggested by AACRC include allowing family members to be key decision-makers in the treatment process and providing opportunities to facilitate treatment planning meetings and to work with staff in the treatment setting. Family members can serve as volunteers or, for those who have successfully come through the treatment process, become parent mentors. They can provide important feedback on program procedures; serve on boards and advisory committees or as strong advocates in the policy-making process.

Among the most well-supported findings from RGC research is that when families are involved in treatment, youth experience better outcomes.

4. Explore/Expand New and Innovative Models and Approaches

RGC providers are encouraged to integrate new and innovative models such as relationship-based and trauma-informed approaches that emphasize healing through recovery and building connections.¹⁴⁰ Given the extensive trauma histories and heightened risk for re-traumatization that characterizes youth served in residential treatment programs, trauma-focused interventions are increasingly being considered as a critical component to effective treatment.^{141,142} Trauma-informed care involves delivering services and creating a culture within the agency or treatment setting that is designed to facilitate recovery from prior trauma while minimizing risks for re-traumatizing clients.¹⁴³ Trauma-informed approaches that promote a safe and supportive therapeutic community are thought to be potentially promising for reducing the use of coercive behavior management practices through a focus on youth empowerment versus compliance and control.

Children in group care often have few and/or weak interpersonal connections. RGC providers, who are in the role of key agents of change, recognize the centrality of their relationships in the lives of children. Forming what has been referred to as a strong working or therapeutic alliance based in trust and positive regard is an essential pre-condition for youth and families to achieve stability and positive change. For many youth, connections made with direct care staff in RGC are meaningful and long-lasting. The Teaching Families, Sanctuary, and Positive Peer Culture models each emphasize change through relationships with others, whether it is family, treatment staff/house parents, or peers. Increased emphasis on building quality relationships and strengthening youths' natural support network as a cornerstone of effective treatment, already fully a part of the approach within many RGC facilities, may help to change the perspective of RGC as cold institutional environments and encourage providers to increase efforts to build upon this foundation.

Recommendations also include the exploration of approaches that soften the boundaries between in-home and out-of-home services such as weekday placement programs or shared care models suggested by Pecora et al.¹⁴⁴ Increased flexibility of funding that allows for simultaneous RGC and family support services and increased provision of transition and after care services could also help expedite permanency and prevent future placement disruptions and/or the need for services.¹⁴⁵

5. Culturally and Linguistically Competent Practice

RGC providers should renew their commitment to culturally and linguistically competent practices, both through evaluation of services and exploring new approaches.¹⁴⁶ Researchers found that while training on cultural and linguistic competency was nearly universal across RGC facilities, the application of training elements differed substantially.¹⁴⁷ Little empirical evidence exists that demonstrates the implementation and effectiveness of specific culturally and linguistically competent practices. Efforts to ensuring effective interventions for youth with diverse cultural backgrounds should include testing evidence-based practices with diverse populations and increased, in the use of culturally competent services and models.¹⁴⁸ Current policies should also be evaluated to determine how they may be contributing to disparities for certain cultural subgroups.

6. Workforce Development

Workforce issues have long plagued the field of child welfare, detrimentally impacting the effectiveness of services. Workforce development is an area of high priority for the field as a whole and has important implications that extend to the effectiveness of RGC as well. Workforce development and training is a frequently identified challenge among residential care providers (Children's Bureau, 2015). Sixty-four percent of RGC program directors identified difficulty with hiring staff, particularly child care workers and RNs due to a shortage of applicants and an inability to offer competitive wages, which also impacts retention.¹⁴⁹ Fifty-six percent of survey respondents indicated that they felt their staff did not receive adequate training, which may also exacerbate retention issues. Addressing workforce development and retention issues are central to insuring youth in RGC are receiving quality, evidence-based care.¹⁵⁰ Efforts to strengthen the child welfare workforce should focus on providing adequate training, oversight,

and support for those in direct care and supervisory roles.

7. Flexible Funding Strategies

Efforts to identify and implement best practices in RGC cannot proceed without adequate funding.^{151,152} In addition to allocating funds to support evaluation, exploring alternative payment options such as case capitation versus the per diem approaches or providing reimbursement that covers costs associated with providing quality care, treatment, and services should be considered.^{153,154} Such approaches could make it more possible to receive payment for out-of-home care for children while providing services to caregivers to work toward reunification and other permanency options when needed.

Summary

All children should grow up, not only in families, but in a nurturing environment in which they can prosper and develop long-lasting, meaningful connections. However, for some children, temporary placement in RGC may help address issues that interfere with their well-being and ability to achieve safety and permanency. Prior to making any decisions that will inevitably impact children and families who are involved in the children welfare system, the full range of benefits and consequences should be carefully weighed. Possible consequences of intensified efforts to dramatically reduce the use of RGC at the present time could result in the following:

Increased expectations on foster families and treatment foster care providers to care for youth with increasingly severe challenges. Research does not conclusively demonstrate that foster families or treatment foster homes are more adequately equipped to respond to the diverse range of needs identified among youth currently treated in RGC. Even with proper training and supports, which also need further research, this could result in further loss of foster families due to an increased burden and an increase in placement disruptions.

A continued disincentive to invest in resources needed to develop high quality group care programs. A lack of resources and political support will continue to undermine evaluation/research focused on ensuring that children with high-level needs are receiving the best possible care and on gathering information to inform the best and most cost-effective uses of RGC.

Stakeholders and legislators are encouraged to oppose any initiatives geared toward eliminating the use of RGC. Empirical research does not support such initiatives. In light of limited placement options and evidence that for some youth RGC is a critical service, the potential consequences of such initiatives are too great and may negatively impact those children and families who are already among the most vulnerable.

Resources

Cultural Competency

[Child Welfare Information Gateway: “Group and Residential Care”](#)

Provides access to print and electronic publications, websites, databases, and online learning tools for improving child welfare practice.

- [Cultural Competence in Out of Home Care](#) page provides information regarding cultural issues for foster/adoptive parents.

Evidence-Based Practices

[California Evidence-Based Clearinghouse for Child Welfare](#)

CEBC provides a searchable database of programs that can be utilized by professionals that serve children and families involved with the child welfare system.

- [“What Works in Group Care? – A Structured Review of Treatment Models for Group Homes and Residential Care”](#) (Sigrid, 2011).

[Child Welfare Information Gateway: “Group and Residential Care”](#)

Provides access to print and electronic publications, websites, databases, and online learning tools for improving child welfare practice.

- [Evidence-Based Practices](#) resource page, involves identifying, assessing, and implementing strategies that are supported by scientific research.

Children’s Bureau

CB focuses on improving the lives of children and families through programs that reduce child abuse and neglect, increase the number of adoptions, and strengthen foster care.

- [A National Look at the Use of Congregate Care in Child Welfare](#)
- [Adoption and Foster Care Analysis and Reporting System \(AFCARS\)](#)
AFCARS collects case-level information on all children in foster care and those who have been adoptions with title

IV-E agency involvement.

[Chapin Hall at the University of Chicago](#)

Policy research that benefits children, families, and their communities.

- [The Center for State Child Welfare Data](#)
Knowledge-based investments and improved outcomes for children and families.
 - [Foster Care Dynamics 200-2005: A Report from the Multistate Foster Care Data Archive](#)

Explore/Expand New & Innovative Models/Approaches

[Children and Residential Experiences \(CARE\) Model Overview](#)

The CARE model, developed by Cornell University, is used to create conditions for change to support safe environments, strong programmatic elements and wide-variety of treatment programs and interventions that are trauma-sensitive and developmentally appropriate.

[Moving Forward](#)

Tool for informing and inspiring practitioners, organizations, and governments across the globe who are seeking to provide the best possible rights-based care for children who are, or may be, in need of alternate care.

[Midwest Trauma Services Network](#)

MTSN provide training and consultation in the use of trauma-informed interventions for agencies that work with children, youth, and their caregivers.

Family Engagement

[Child Welfare Information Gateway: "Group and Residential Care"](#)

Provides access to print and electronic publications, websites, databases, and online learning tools for improving child welfare practice.

- [Engaging Families](#) page, provides resources on how to understand and fully engage families in child welfare services and includes state and local examples.
- [Residential Treatment for Children and Youth](#)
- [Official Journal of the American Association of Children's Residential Centers](#)
- [The Future of Family Engagement in Residential Care Settings](#) (Levison-Johnson & Affronti, 2009).

Flexible Funding Strategies

[Child Welfare Information Gateway: "Group and Residential Care"](#)

Provides access to print and electronic publications, websites, databases, and online learning tools for improving child welfare practice.

- [Funding Strategies](#) page, provides information on how child welfare services can be funded as well as examples of how agencies structure funding for their programs.

Quality Standards

[Child Welfare League of America](#)

CWLA promotes best practice in child, youth, and family services. They also provide blueprints and standards of excellence for out-of-home care services such as residential group care.

- CWLAs "[Standards of Excellence for Residential Services](#)"

[National Association of Social Workers \(NASW\)](#)

NASW Standards for Social Work Practice in Child Welfare.

[Child Welfare Information Gateway: "Group and Residential Care"](#)

Provides access to print and electronic publications, websites, databases, and online learning tools for improving child welfare practice.

- [Standards for Out-of-Home Care Services](#) resource page includes state and local examples.

Workforce Development

[Center for Workforce Studies](#)

The NASW Center for Workforce Studies conducts studies to enhance social work professional development through innovation training programs in emerging practice areas.

[Child Welfare Information Gateway: "Group and Residential Care"](#)

Provides access to print and electronic publications, websites, databases, and online learning tools for improving child welfare practice.

- [Child Welfare Workforce Development and Workplace Enhancement Institute](#) report sponsored by the Children's Bureau.
- [Practice Issues in Residential Care](#) page provides information to assist child serving agencies in working with children and youth in residential care and with their families.

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