

Working with Children and Youth with Complex Clinical Needs: Strategies in the Safe Reduction of Congregate Care



Capacity Building
CENTER FOR STATES



Suggested citation:

Capacity Building Center for States. (2017). *Working with children and youth with complex clinical needs: Strategies in the safe reduction of congregate care*. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services



This product was created by the Capacity Building Center for States under Contract No. HHSP233201400033C, funded by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

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Introduction

“Congregate care is not a destination, it is an intervention for children and youth with complex clinical needs.”¹

High-quality and customized congregate care can be lifesaving for children and youth who have been removed from their homes and have such complex clinical or behavioral needs that a short-term stay in a residential treatment facility is essential.² Although research has illuminated the potentially negative effects of congregate care, especially for young children, residential care does have its place on the placement continuum.³ Congregate care is designed to provide children and youth with a “viable placement alternative” that addresses their specific emotional and behavioral health needs within a highly restrictive placement.⁴

Definition

The term congregate care represents a wide array of out-of-home placement settings, including group homes, child care institutions, residential treatment facilities, emergency shelters, and in-patient hospitals. This Guide uses the umbrella term “congregate care” unless otherwise indicated.⁵



Current Trends and Population Profile

In the past, widespread use of congregate care placement prompted examination of and debate over its effectiveness in achieving safety, permanency, and well-being as well as its cost.⁶ The dynamic landscape of the child welfare field, changes in policies and priorities, and current research have encouraged a shift away from congregate care use to less restrictive, more family-like or home-like settings.⁷ Current trends indicate a significant decrease in the number of children placed in congregate care over the past decade. For example, between 2004 and 2013, the proportion of children in congregate care decreased from 18 percent of

¹ Blau, G.M., Caldwell, B., & Lieberman, R.E. (Eds.). (2014). *Residential interventions for children, adolescents, and families: A best practice guide*. New York, NY: Routledge Taylor & Francis Group.

² The Annie E. Casey Foundation. (2015). Every kid needs a family: Giving children in the child welfare system the best chance for success. *Policy Brief: KIDS COUNT*. Retrieved from <http://www.aecf.org/resources/every-kid-needs-a-family/>.

³ Wulczyn, F., Alpert, L., Martinez, Z., & Weiss, A. (2015). Within and between state variation in the use of congregate care. Chicago, IL: The Center for State Child Welfare Data, Chapin Hall at the University of Chicago. Retrieved from https://fcda.chapinhall.org/wp-content/uploads/2015/07/Congregate-Care_webcopy.pdf.

⁴ Chadwick Center & Chapin Hall. (2016). Using evidence to accelerate the safe and effective reduction of congregate care for youth involved with child welfare. San Diego, CA and Chicago, IL: Collaborating at the Intersection of Research and Policy. Retrieved from <http://www.chapinhall.org/pages/using-evidence-accelerate-safe-and-effective-reduction-congregate-care-youth-involved-child>. Payne, C. (2016). Literature review: Alternatives to congregate care. Southern Area Consortium of Human Services, Academy for Professional Excellence, San Diego State University of Social Work, San Diego, CA.

⁵ Payne, 2016.

⁶ Ibid.

⁷ Children's Bureau (CB). (2015). A national look at the use of congregate care in child welfare. U.S. Department of Health and Human Services, Administration for Children and Families. Washington, D.C. Retrieved from <http://www.acf.hhs.gov/programs/cb/resource/congregate-care-brief>; Chadwick Center & Chapin Hall, 2016.

the foster care population to 14 percent. Additionally, the number of children and youth in the child welfare system declined by 21 percent, from 507,555 in 2004 to 402,378 in 2013.⁸ These trends indicate that child welfare agencies are changing the continuum of services to promote better outcomes for children and youth with complex clinical needs.

In the Children's Bureau (CB) review of Adoption and Foster Care Analysis Reporting System (AFCARS) data, it was found that approximately 63 percent of children and youth in congregate care were male and 37 percent were female. Children and youth in this setting were: 41 percent white; 30 percent black/African American; 20 percent Hispanic; 5 percent two or more race/ethnic groups; 2 percent undeterminable/missing; 2 percent American Indian/Alaska Native/non-Hispanic; <1 percent Asian, Native Hawaiian/other/Pacific Islander.⁹



According to CB's brief, "A National Look at the Use of Congregate Care in Child Welfare" (2015), a significant proportion of children and youth who experience time in congregate care comprise those with a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, behavioral health issues, or clinical disabilities other than a DSM diagnosis. From this, CB developed and analyzed these children and youth through four subgroups, which were identified using information on clinical disabilities and circumstantial information associated with children's/youth's removal and placement in foster care called the "Child Behavior Problem (CBP)": *Subgroup 1–No Clinical Indicators, Subgroup 2–DSM Indicator, Subgroup 3–Child Behavior Problem/"CBP" Indicator, and Subgroup 4–Disability Indicator.*¹⁰ Each subgroup is associated with different types of interventions to reduce the reliance on congregate care, ranging from early trauma screening and treatment to kinship care.

There is great variation, however, between and within States regarding the use of congregate care.¹¹ The likelihood of youth directly entering congregate care ranges anywhere from 4 to 44 percent.¹² Thus, while national trends suggest a decrease in the use of congregate care, some States have actually increased its use.¹³

In a recent policy brief, "Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare," from Chadwick Center and Chapin Hall (2016), key findings on trends in congregate care reveal:

- The overall use of congregate care has decreased by 20 percent since 2009, but there is substantial variation among States even in this trend. *This suggests a need for detailed analysis to understand local trends.*
- Some States rely heavily on congregate care as a first placement. *This suggests a need to build capacities for foster home care.*
- Youth placed in congregate care and therapeutic foster homes have significantly higher levels of internalizing and externalizing behaviors than those placed in traditional foster care. *This suggests that increased access to services that effectively address such behaviors are essential if congregate care use is reduced.*
- Compared to youth whose clinical needs are met through therapeutic foster care, youth placed in congregate care are more likely to have externalizing problems. *This suggests that strategies for serving these youth in home-based settings should focus on preparing those homes to respond by de-escalating difficult behaviors.*

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Wulczyn, Alpert, Martinez, & Weiss, 2015.

¹² Ibid.

¹³ CB, 2015.

- The California Evidence-Based Clearinghouse for Child Welfare (CEBC) contains tested strategies for disruptive behavior problems; however, many of them have not been tested for use with the child welfare population. *This suggests a need for intervention implementation and evaluation support that may stabilize foster care placements.*

As the findings suggest, if States want to successfully reduce their use of congregate care to conform to emerging trends, they should employ a two-pronged approach: (1) use evidence-based interventions to target the complex mental health needs of youth and (2) provide additional services and supports for their home-based caregivers.¹⁴

Partnerships with Private Agencies

In order to safely reduce the use of congregate care, partnerships with private agencies are necessary to provide children, youth, and families with ample support, especially given the complex clinical needs of this population. A prominent example of this type of partnership is the national Building Bridges Initiative. This program works to identify and promote practice and policy that will create strong and closely coordinated partnerships and collaborations between families, youth, community- and residentially-based treatment and service providers, advocates, and policymakers to ensure that comprehensive mental health services and supports are available to improve the lives of young people and their families.¹⁵

Group care providers are placed in a position to examine their intervention models, current practices, and how to better meet the needs of the people they serve, as there is greater focus on the usage of congregate care by States. To enhance the specificity and targeting of care to children, youth, and families, providers have made improvements in intervention design, implementation, staff development, evaluation, and the increased provision of after-care services.¹⁶



The provider community has also expanded its array of services to include therapeutic or treatment foster care. Treatment foster care evolved in the 1970s, providing an alternative to institutionalizing children with severe emotional and behavioral disorders through combining the best qualities of both mental health residential treatment and child welfare foster care programs. Therapeutic/treatment foster care is now one of the widely used forms of out-of-home placement for children and adolescents with severe emotional and behavioral disorders.¹⁷

¹⁴ Chadwick Center & Chapin Hall, 2016.

¹⁵ Building Bridges Initiative. Retrieved from <http://www.buildingbridges4youth.org>.

¹⁶ Casey Family Programs. (2016). *Elements of effective practice for children and youth served by therapeutic residential care: Research brief*. Retrieved from <http://www.casey.org/media/Group-Care-complete.pdf>.

¹⁷ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2014). *What does the research tell us about services for children in therapeutic/treatment foster care with behavioral health issues? Report of the SAMHSA, CMS and ACYF Technical Expert Panel, September 27–28, 2012*. HHS Publication No. (SMA) 14-4842.

Strategies for Safely Reducing Congregate Care

In the U.S. Children’s Bureau report (2015), “A National Look at the Use of Congregate Care in Child Welfare,” CB synthesized qualitative information into common themes that embody the two-pronged approach and suggest additional strategies. Those themes are divided into two strategies: practice and program.

Practice Strategies

The practice level strategies are designed to assist agencies in the provision of services to youth and families with complex clinical needs.

► Expanding services to avoid removal and support the safe return home

- Evidence-based interventions and strategies help to build capacity in both preventing removal and supporting reunification. Evidence-based treatments designed to address the clinical issues of children/youth with disruptive behaviors and their families could allow for step-down or complete avoidance of congregate care. Each of the following interventions has the California Evidence-Based Clearinghouse for Child Welfare Rating of 1: Well Supported by Research Evidence:¹⁸
- **Coping Power Program (CPP):** A cognitive-based intervention for aggressive and disruptive children ages 8–14 who are at risk for later delinquency, particularly during the transitional period to middle school, as well as their parents/caregivers. The program’s child component focuses on anger management, social problem solving, and practicing skills to resist peer pressure. The focus of the parent component is on supporting their involvement and consistency in parenting.¹⁹
- **Multi-Systemic Therapy (MST):** An intensive family-focused and community-based intervention for youth ages 12–17 with possible substance abuse issues whose antisocial or delinquent behaviors place them at risk of out-of-home placement and/or youth involved with the juvenile justice system. The primary goal of MST is to decrease criminal behavior and out-of-home placements of youth. Program goals for parents include empowering them to independently address challenges in raising children and empowering their children to cope with various problems they may face regarding family, peers, school, and their neighborhood.²⁰
- **Parent-Child Interaction Therapy (PCIT):** A family-centered dyadic behavioral intervention for children ages 2–7 and their parents/caregivers. This parent-focused intervention teaches traditional play therapy skills and focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent–child attachment relationship.²¹



¹⁸ Chadwick Center & Chapin Hall. (2016). Using evidence to accelerate the safe and effective reduction of congregate care for youth involved with child welfare. San Diego, CA & Chicago, IL: Collaborating at the Intersection of Research and Policy. Retrieved from http://www.chapinhall.org/sites/default/files/effective%20reduction%20of%20congregate%20care_0.pdf.

¹⁹ National Institute of Justice. (2012). Program Profile: Coping Power Program. Retrieved from <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=241>; The California Evidence-Based Clearinghouse for Child Welfare. (2009). Coping Power Program. Retrieved from <http://www.cebc4cw.org/program/coping-power-program/>.

²⁰ The California Evidence-Based Clearinghouse for Child Welfare. (2009). Multisystemic Therapy (MST). Retrieved from <http://www.cebc4cw.org/program/multisystemic-therapy/>; Multisystemic Therapy. (2015). Retrieved from <http://mstservices.com>.

²¹ Pennsylvania Recovery and Resiliency. *Parent-Child Interaction Therapy* [PowerPoint slides]. Retrieved from http://www.parecovery.org/documents/PCIT_Webinar_042815.pdf; The California Evidence-Based Clearinghouse for Child Welfare. (2006). Parent-Child Interaction Therapy (PCIT). Retrieved from <http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed>.

- **Parent Management Training, Oregon Model (PMTO):** This parent-focused intervention, which can be used as a preventative program and treatment program, is targeted toward parents of children ages 2–18 with disruptive behaviors such as conduct disorder, oppositional defiant disorder, and antisocial behaviors. Parents are taught effective family management strategies and parenting skills to address specific clinical problems youth may have, such as externalizing and internalizing problems, school problems, antisocial behavior, conduct problems, deviant peer association, theft, delinquency, substance abuse, and child neglect and abuse.²²
 - **Positive Parent Programs (Triple P), Level 4:** The fourth level of the Triple P program—is targeted for parents/caregivers of children and adolescents from birth to 12 years old with moderate to severe behavioral and/or emotional difficulties and motivated parents who wish to gain in-depth understanding of positive parenting. This parent-focused intervention helps parents to learn strategies promoting social competence and self-regulation and reducing problem behavior in their children. Parents/caregivers are encouraged to develop and practice a parenting plan with their child, during which they track, reflect, and modify as needed.²³
 - **Problem-Solving Skills Training (PSST):** A child-focused intervention for youth ages 7–14 with behavioral problems that includes some parent involvement. It is aimed at decreasing inappropriate or disruptive behavior in children, helping them to learn to slow down, stop and think, and generate multiple solutions to any problem through utilization of a cognitive-behavioral approach.²⁴
 - **Promoting Alternative Thinking Strategies (PATHS):** PATHS is a classroom-based social emotional learning program for children ages 4–12. It is designed to reduce aggression and behavior problems and increase emotional and social competencies by teaching skills in five domains: self-control, emotional understanding, positive self-esteem, relationships, and interpersonal problem solving.²⁵
 - **The Incredible Years (IY):** IY is a series of three separate curricula for parents, teachers, and children ages 4–8. It is a parent-focused intervention with a child component aimed at promoting emotional and social competence and preventing, reducing, and treating behavioral and emotional problems in young children.²⁶
 - **Treatment Foster Care Oregon-Adolescents (TFCO-A):** With dual functionality in preventing entry into and facilitating step-down from congregate care, this model of therapeutic foster care was designed for children ages 12–18 with severe emotional and behavioral disorders and/or severe delinquency. TFCO-A contains both parent and child components where youth have the opportunity to live in families while simultaneously preparing and supporting caregivers to provide youth with effective parenting.²⁷

²² The California Evidence-Based Clearinghouse for Child Welfare. (2009). Parent Management Training- Oregon Model (PMTO). Retrieved from <http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/>; Blueprints for Healthy Youth Development. (n.d.). Parent Management Training. Retrieved from <http://www.blueprintsprograms.com/factsheet/parent-management-training/>; Implementation Sciences International, Incorporated. (n.d.). PMTO, Parent Management Training-Oregon Model. Retrieved from <http://www.isii.net/2015SITEFILES/Implement.html>.

²³ The California Evidence-Based Clearinghouse for Child Welfare. (2013). Triple P- Positive Parenting Program- Level 4 (Level 4 Triple P). Retrieved from <http://www.cebc4cw.org/program/triple-p-positive-parenting-program-level-4-level-4-triple-p/>.

²⁴ The California Evidence-Based Clearinghouse for Child Welfare. (2009). Problem Solving Skills Training (PSST). Retrieved from <http://www.cebc4cw.org/program/problem-solving-skills-training/>.

²⁵ The California Evidence-Based Clearinghouse for Child Welfare. (2014). Promoting Alternative Thinking Strategies (PATHS). Retrieved from <http://www.cebc4cw.org/program/promoting-alternative-thinking-strategies/>; Blueprints for Healthy Youth Development. (n.d.). Promoting Alternative Thinking Strategies (PATHS). Retrieved from <http://www.blueprintsprograms.com/factsheet/promoting-alternative-thinking-strategies-paths>.

²⁶ The California Evidence-Based Clearinghouse for Child Welfare. (2006). The Incredible Years (IY). Retrieved from <http://www.cebc4cw.org/program/the-incredible-years/>.

²⁷ Chadwick Center & Chapin Hall, 2016; The California Evidence-Based Clearinghouse for Child Welfare. (2007). Treatment Foster Care Oregon- Adolescents (TFCO-A). Retrieved from <http://www.cebc4cw.org/program/treatment-foster-care-oregon-adolescents/>.

- Using crisis mobilization teams to stabilize children and prevent out-of-home placements or moves to more restrictive placements.
- Using wraparound services to stabilize placement. This program is rated 3 (Promising Research Evidence) by the California Evidence-Based Clearinghouse for Child Welfare (CEBC). Wraparound is a team-based, family-driven planning process aimed at children/youth ages 0–17 with severe emotional, behavioral, or mental health difficulties who are in or at-risk of out-of-home placement, as well their parents/caregivers. Children/youth targeted by this program have complex needs and are involved with multiple child and family-serving systems. Team members of the wraparound process include families, providers, and key members of the family's social support network. They work collaboratively on developing an individualized plan and implementing the plan, meeting regularly to monitor progress and make alterations as needed. This process should be grounded in a strengths-based approach that is culturally competent and community-based.²⁸

► **Using early trauma screening and assessments to enable the implementation of tailored mental health services**

- **Treatment Outcomes Package (TOP).** TOP is a validated mental health assessment tool adapted for child welfare to provide a real-time snapshot of whether children across a system are improving (Ohio, Cuyahoga County).²⁹
- **Child and Adolescent Needs and Strengths (CANS) Assessment.** CANS assessments “evaluate strengths, concerns and service needs of children with mental health disorders, developmental disabilities, emotional and behavioral health care needs, and family issues, including children entering the child welfare system.”³⁰ It is currently “the most widely used common assessment strategy for monitoring well being in the child serving system in North America.”³¹ As of 2014, CANS was used in 37 States to support decision-making related to “level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.”³² State-wide usage of CANS occurs in the following locations: Alabama, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New York, Nevada, Oregon, Rhode Island, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

FEATURED RESOURCES

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

(March 2016)

Casey Family Programs

Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare

(January 2016)

Chadwick Center and Chapin Hall

Literature Review: Alternatives to Congregate Care

(February 2016)

Chelsea Payne, M.S.W., Southern Area Consortium of Human Services (SACHS)

A National Look at the Use of Congregate Care in Child Welfare

(May 2015)

U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau

²⁸ The California Evidence-Based Clearinghouse for Child Welfare. (2007). Wraparound. Retrieved from <http://www.cebc4cw.org/program/wraparound/>; Payne, C. (2016). Literature review: Alternatives to congregate care. Southern Area Consortium of Human Services, Academy for Professional Excellence, San Diego State University of Social Work. Retrieved from <http://theacademy.sdsu.edu/wp-content/uploads/2016/03/alternatives-congregate-care-feb-2016.pdf>.

²⁹ The Annie E. Casey Foundation. (2015). *Every kid needs a family: Giving children in the child welfare system the best chance for success.* KIDS COUNT Policy Report. Retrieved from <http://www.aecf.org/resources/every-kid-needs-a-family/>.

³⁰ Cordell, K.D., Snowden, L.R., & Hosier, L. (2015). Patterns and priorities of service need identified through the Child and Adolescent Needs and Strengths (CANS) assessment. *Children and Youth Services Review*, 60, 129-135.

³¹ Lyons, J.S. (2014). Use of the Child and Adolescent Needs and Strengths (CANS) in child welfare in the United States. Retrieved from <http://www.oacca.org/cans-report/>.

³² Ibid.

- **Youth Connections Scale (YCS).** YCS is used to help young people in foster care strengthen and build supportive safety nets and achieve relational permanence with caring adults. Youth's perceptions about their level of connectedness and the strength of their emotional, financial, and social safety nets are captured in the YCS, which can be used for a range of functions from guiding the case planning process to facilitating discussions with youth around rebuilding connections. Four sections of the YCS measure (1) the number of meaningful connections/relationships with supportive adults; (2) strength connections between the youth and adult, including frequency of contact and consistency of support provided by the adult; (3) specific types of support indicators—for example, a home to go to for the holidays, emotional support, help with school, and so on; and (4) overall level of connectedness to caring and supportive adults. The YCS is available in the public domain and used nationwide in a number of States, including New York, Wisconsin, and Minnesota as part of case planning, ongoing supervision, and program evaluation efforts.³³ It can be used in conjunction with other evidence-based assessments.

Voices from the Field: Colorado Department of Human Services

Colorado uses trauma-informed screenings with all children in IV-E waiver counties who have an open child welfare case and refers those who screen positive for symptoms for additional assessment at community mental health centers in order to initiate appropriate trauma-informed treatment by a clinician, if needed. The Southwest Michigan Children's Trauma Screening Checklist is used to screen for signs and symptoms of trauma in children and youth, while the Trauma Symptom Checklist for Young Children (ages 3–7) and the Child Post-Traumatic Stress Disorder (PTSD) Symptom Scale (ages 8–18) are used to track children's progress for trauma screening penetration and fidelity measures.³⁴

► Increasing the availability of family-based placement options

- *Implementing Family Finding immediately following a child's and/or youth's removal from home.* Family Finding is rated by the CEBC as having a high level of relevance to the child welfare system.

Arizona Department of Child Safety's IV-E waiver includes enhancing their current kinship search procedures.

- *Implementing family group decision making (FGDM) involving all relevant parties in removal and placement decisions.* FGDM is rated by CEBC as a level 3 (Promising Research Evidence):

Some States have policies requiring that family team conferences take place prior to a youth's change in placement.

A promising new framework known as youth conferencing is used in this process as a general term to describe the myriad of models being implemented as decision-making forums for vulnerable youth. At the core, these models bring together youth and those personally connected to them to engage in a process of relationship building and collaborative planning around key decisions. It is designed for youth over the age of 15 who are or soon will be transitioning into more permanent living arrangements as they age out of the foster

³³ The Center for Advanced Studies in Child Welfare (CASCW) & Anu Family Services. (2012). *Measuring relational permanence of youth: The Youth Connections Scale implementation guide*. CASCW at the University of Minnesota School of Social Work & Anu Family Services. Retrieved from <http://cascw.umn.edu/wp-content/uploads/2013/12/YCSImplementation.pdf>.

³⁴ Human Services Research Institute, Social Work Research Center at Colorado State University & Chapin Hall at the University of Chicago (2016). *Colorado Title IV-E Waiver interim evaluation report covering the period from July 1, 2013 – June 30, 2015*. Retrieved from <https://sites.google.com/a/state.co.us/cdhs-dcw/collaborations-initiatives/committees-groups/iv-e-steering-committee>.

care system. In the study, “Connected and Cared For: Family Group Conferencing for Youth in Group Care,” researchers found that children and youth who had a family group conference had their needs met relative to safety, kinship support, cultural connections, and less restrictive placement. Youth have an opportunity to lead their own conferences, giving them practice in taking ownership for their life’s course or direction and begin making decisions, with assistance and guidance from caring adults.³⁵

Voices from the Field: Minnesota and Hawaii

Olmsted County, Minnesota, adapted the New Zealand Family Group Conference (FGC) model to use specifically with older youth in foster care. Youth work with the coordinator/facilitator to identify individuals in their lives who may have a significant role in their futures.

Hawaii: E Makua Ana Youth Circles model—EPIC ‘Ohana is contracted with the State of Hawaii to work with youth in the foster care system or youth who have aged out between ages 14–26 in this transition planning process. Approximately 300 circles are held each year for youth and young adults, with the goals of creating tangible transition plans and empowering youth to develop their own unique voice and take control of their lives. Before the youth circle can begin, facilitators conduct a “surface assessment” of youth to identify their strengths and highlight their value. In this youth-driven, solution-focused, strengths-based model, the process moves forward with an additional person who is neither a service provider nor professional. Facilitators work with youth to identify this individual should they be unable to identify someone. At least five goals and a list of invitees are developed by youth, and youth identify how the meetings will open and close.

- *Utilizing permanency roundtables (PRT) to expedite permanency outcomes*

PRTs are utilized for youth in congregate care settings for more than 12 months with a focus on achieving permanency, which includes stepping down to a less restrictive setting and finding relatives who may serve as placement options and/or lifelong connections. Additionally, this strategy can assist in breaking down barriers to adoption and/or legal guardianship.

- *Individualizing transition planning to ensure positive placement outcomes*



³⁵ Howard, M.D. (2013). Youth conferencing: Implementation experiences and future directions. The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect. Retrieved from http://www.ucdenver.edu/academics/colleges/medicalschoo/department/s/pediatrics/subs/can/FGDM/Documents/FGDM%20Web%20Pages/Resources/Issue%20Briefs/Youth_Conf_IssueBrief.pdf.

Voices from the Field: Michigan

The iCare365's guided transition permanency model—"Planning a Transition with Hope Home (PATH Home)"—was designed to improve permanency outcomes for youth in residential treatment settings and piloted as an essential component of the Diligent Recruitment Project iCARE 365 in the State of Michigan. The PATH Home model consisted of three phases: selection, training/preparation, and service integration/transition. It was designed to build cross-system partnerships for the transition planning process. PATH Home enhanced the focus of individualized transition planning for youth leaving residential care. Agency staff were trained in transition planning and given opportunities to demonstrate their skills with the youth on their caseloads. The model was developed in collaboration with youth, community mental health providers, agency staff, caregivers, and residential treatment facilities. Foster parents were given an enhanced curriculum, which included training on how to care for youth with mental health needs, sexual offender history, and educational needs. Quarterly family team meetings were held to plan for the transition of youth; monthly meetings were held to review case progress for those who were receiving enhanced adoption services. Extensive case mining was used to locate permanency resources. A key learning from the project is that important factors in successful placement were a planned progression to placement and the integration of mental health and educational services into the plan prior to discharge of the youth.

The steps in the process are as follows:

- Convened "home teams" that developed, clarified, and refined transition plans for youth in residential settings; the plans were reflective of the various service providers and informal support providers that were engaged or that would be engaged with the youth and family
- Developed a uniform transition planning process for the youth's exiting residential services
- Provided training to all pilot staff involved in transition planning to ensure some degree of consistency in the implementation of the model
- Coordinated child-specific recruitment activities for the identified youth
- Coordinated activities to recruit families who could someday be enhanced resource families and foundation families
- Reviewed current transition and aftercare policy and procedures and assessed whether they were appropriate and in need of revision
- Provided community and "practice" family experiences for youth transitioning from residential/hospital settings and preparing for permanency
- Enhanced the ability to conduct information exchange across service settings
- Developed project evaluation and reporting mechanisms
- Anticipated the common barriers and issues that could potentially arise during the transitional process and developed contingency plans to respond to those issues
- Actively prepared enhanced resource families for the new placement through trainings, observations, and support provided by community service providers
- Focused (in the plan) on identifying the skills youth need for successful transition as well as opportunities for practicing those skills as part of their preparation
- Created back-up contingencies (Plan A and Plan B) for critical facets of the plan
- Included sufficient time for the family to observe the youth in placement and made adjustments to possible interventions and understanding of the youth

- *Recruiting, developing, and supporting relative and resource families*

Quality Parenting Initiative (QPI) is Youth Law Center’s approach to strengthening foster care, including kinship care, using branding and marketing principles. Their core premise is that the primary goal of the child welfare system is to ensure that children have effective, loving parenting. The major successes of the project have been in systems change and improved relationships. Sites have also reported measurable improvement in outcomes such as reduced unplanned placement changes, reduced use of group care, reduced numbers of sibling separation, and more successful improvements in reunification. The Quality Parenting Initiative is currently implemented in 18 counties in California, Washoe and Clark Counties in Nevada, and all counties in Florida, and Connecticut.³⁶

Voices from the Field: San Luis Obispo County, California

“One of the ways the Quality Parenting Initiative (QPI) has changed the way we do business is by encouraging transparency for all parties. The partnership plan, which is included in all of our placement packets, has helped underline that there are expectations both for foster parents and for social workers. We’ve also had the opportunity to have our judge come and address our social work staff and confirm that foster parents can attend court. One benefit of QPI is that it has brought more focus on the important role that foster parents play in our county. It is sometimes easy to gloss over the difficult work they do, and they may often feel unrecognized. QPI has brought their important role more into the spotlight and has helped our department shape policies that are more supportive of foster parents. In this process, we’ve also had more direct input from foster parents about how to improve department policies and practices. Another benefit is the increased focus on placement transition planning and increased collaboration with all community partners who work with our foster children.”

Keeping Foster and Kin Parents Supported and Trained Project (KEEP)—rated by CBECE as a 3 (Promising Research Evidence).

The objective of **KEEP** is to give parents effective tools for dealing with their child’s externalizing and other behavioral and emotional problems and to support them in the implementation of those tools. Curriculum topics include framing the foster/kin parents’ role as that of key agents of change with opportunities to alter the life course trajectories of the children placed with them. Foster/kin parents are taught methods for encouraging child cooperation, using behavioral contingencies and effective limit setting, and balancing encouragement and limits. There are also sessions on dealing with difficult problem behaviors, including covert behaviors, promoting school success, encouraging positive peer relationships, and strategies for managing stress brought on by providing foster care. There is an emphasis on active learning methods, and illustrations of primary concepts are presented via role-plays and videotapes.³⁷

- *Increasing recruitment efforts and training treatment foster care (MTFC)*

The Foster Family-based Treatment Association (FFTA) defines TFC as a distinct, powerful, unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centers. In TFC, the positive aspects of the

³⁶ Youth Law Center. (2012). Quality Parenting Initiative. Retrieved from <http://www.ylc.org/our-work/action-litigation/quality-foster-care/quality-parenting-initiative/>.

³⁷ The California Evidence-Based Clearinghouse for Child Welfare. (2007). KEEP (Keeping Foster and Kin Parents Supported and Trained). Retrieved from <http://www.cebc4cw.org/program/keeping-foster-and-kin-parents-supported-and-trained/>.

nurturing and therapeutic family environment are combined with active and structured treatment. Treatment foster programs provide, in a clinically effective and cost-effective way, individualized and intensive treatment for children and adolescents who would otherwise be placed in institutional settings.³⁸

The following are programs supported by research:

Treatment Foster Care Oregon - Adolescents (TFCO-A), formerly known as *Multidimensional Treatment Foster Care (MTFC)*—TFCO-A is a model of therapeutic foster care for children ages 12–18 with severe emotional and behavioral disorders and/or severe delinquency. TFCO-A creates opportunities for youth to successfully live in families rather than in group or institutional settings and simultaneously prepares their caregivers to provide them with effective parenting. TFCO-A can be used as a front door approach to facilitate step-down from congregate care. TFCO-A has a strong caregiver component involving regular contact and support of the caregiver in individual and group formats. This model has been implemented in California, New York City, and Ohio.

Together Facing the Challenge—Together Facing the Challenge is rated by the CEBC as a 2 (Supported by Research Evidence). This training/consultation approach is designed for treatment foster parents of children/youth ages 3–17 and for agency staff. Its train-the-trainer approach seeks to improve practice in TFC through training on practical parenting and supervisory skills and techniques.³⁹

Voices from the Field: KidsPeace

KidsPeace, a multiservice agency providing therapeutic foster care in eight States, uses Together Facing the Challenge (TFTC) as an essential element of its clinical model. An evidence-based approach, TFTC emphasizes practical training on effective interventions; for example, everyone has heard of “time outs” and “family meetings,” but not everyone knows how and when to use these interventions most effectively. Further, TFTC aligns seamlessly with treatment goals based on resiliency theory and trauma-informed care, the other fundamental elements of the model. KidsPeace currently uses the Strengths and Difficulties Questionnaire at intake and discharge to track outcomes and guide practice refinements. Possibly the greatest challenge to implementation with fidelity to this model is the different regulatory and funding environments found across States.

- *Using respite care to support resource family retention by providing families with relief from daily stressors and serving as a protective strategy against burnout.*

Some benefits of respite services include the reduced risk of child maltreatment and out-of-home placement, prevention of placement disruptions, as well as the improvement of family functioning, quality of relationships, and positive attitudes toward children. The continuum of formal and informal respite care provides relief in the form of after-school activities, after-school jobs (for teenagers), summer camp, planned respite with a worker or other resource parent, or crisis respite. In California, respite care is one of the most fre-

³⁸ Foster Family-based Treatment Association (FFTA). (2008). Implementing evidence-based practice in treatment foster care: A resource guide. Retrieved from https://ncwwi.org/files/Evidence_Based_and_Trauma-Informed_Practice/Implementing_Evidence-based_Practice_in_Treatment_FC.pdf.

³⁹ The California Evidence-Based Clearinghouse for Child Welfare. (2011). Together Facing the Challenge. Retrieved from <http://www.cebc4cw.org/program/together-facing-the-challenge/>.

quently requested supports by resource families, and most agencies already have respite policies in place; however, accessibility is often a challenge.⁴⁰

- *Creating an alternative placement program* that pays family foster homes to keep beds available on an emergent basis to care for children while their needs are assessed and other appropriate foster family home placements can be identified.

Program Strategies

The program strategies assist agencies in building infrastructure to support service delivery to youth and families with complex clinical needs.

► Working with congregate care providers to change the service array and practices

- Working in partnership with residential care providers to improve intervention design, implementation, staff development, and evaluation, as well as the increase the provision of after-care services

Voices from the Field: The Plummer Home

The Plummer Home is a group residence for adolescent males ages 14–18. With a traditional approach to group home placement since 1855, Plummer staff were disheartened by youth discharged to “independence” and experiencing homelessness, loneliness, lack of connectedness, and poor outcomes in adulthood. Five years ago, a strategic planning process resulted in significant transformation. Today, Plummer uses a strategic intervention model and outcome-focused approach to achieve the vision that every young person will have a family unconditionally committed to nurture, protect, and guide them to a successful adulthood.



The interventional model has three domains and is applied to each youth regardless of age, level of need, or complexity of family circumstances:

- Permanency: a safe, emotionally secure parenting relationship in a lifelong legal family
- Preparedness: skills and support to meet emotional, educational, and economic needs
- Community: a safe place to live, a sense of belonging, and a chance to positively contribute to community.

The permanency domain innovatively blends:

- Family search and engagement to identify, engage, or recruit safe and caring parents and family to make and sustain a lifelong commitment
- Permanency preparation/readiness to increase opportunities for successful and lasting family relationships
- Youth-guided, family-driven teaming for planning and decision-making that is guided by youth voice and youth needs and driven by family involvement and toward a family outcome

⁴⁰ Hughes, K. (2015). *Research summary: Supporting, retaining & recruiting resource families*. Public Child Welfare Training Academy: Academy for Professional Excellence at San Diego State University School of Social Work. Retrieved from <http://theacademy.sdsu.edu/wp-content/uploads/2015/10/pcwta-research-support-retention-recruitment-oct-2015.pdf>; Payne, 2016.

CANS and YCS are standardized assessments that inform each youth's intervention plan. A customized intervention strategy blends the evidence-based practice of Think: Kids Collaborative Problem Solving with evidence-informed practices adapted from Darla Henry's 3-5-7 Model of Preparing Children for Permanency and Annie E. Casey Foundation's Lifelong Families Model.

The Plummer Intervention Model Matrix is an in-house tool measuring progress against individual goals and fidelity to the intervention model. A custom-designed, cloud-based case management and outcomes reporting system collects, analyzes, and reports data. Data measure a variety of indicators related to the outcome areas of permanency, preparedness, and community. Post intervention follow-up surveys are designed to measure satisfaction and success related to number, strength, and longevity of permanent relationships established or strengthened during the Plummer intervention; education and employment success; and overall satisfaction with the Plummer services.

- Restructure contracting with providers from a structure with a set number of beds and service levels to a contract for an array of services, which could be delivered in multiple settings such as congregate care, treatment foster homes, regular foster homes, and family or relative homes.



► **Developing a highly skilled, clinically informed workforce to work with children and youth who are likely candidates of congregate care**

The following strategies can build workforce capacity:

- Staff are trained in the use of trauma-informed assessments that enable the implementation of tailored mental health services
- Staff provide hands-on support to resource families to maintain children with highly challenging behaviors in family foster homes
- Staff prepare complex transition plans that engage family members, resource families (as appropriate), congregate care providers, and community support systems
- Reduced caseload to develop and maintain engaged relationships with youth, biological and kinship family members, treatment providers, and community stakeholders involved in the child's case
- Detailed knowledge of placement resources and ability to prepare resource families for children with behavioral health challenges
- Organizational infrastructure with congregate care and family foster care under the same leadership team

► **Supporting data collection to inform practices and ensure better outcomes**

- Institute data collection systems to analyze data at the jurisdictional level, allowing for better resource development and allocation strategies that reflect the needs of particular communities.

Voices from the Field: Arizona Department of Child Safety

The Arizona Department of Child Safety uses data to better inform its resource family recruitment and increase foster family options for children. Since 2007, maps and reports have been developed using Geographic Information Systems (GIS) technology every six months. These products identify areas of the state with the highest number of children entering out-of-home care and the lowest number of licensed resource families, providing a graphic representation of communities with the highest need for new foster families.

The maps are designed to show both the total number of children in each area who need a foster family as well as the percentage of children who need a foster family compared to the total number of children removed from the area. By mixing these two variables, the maps allow foster home recruiters to compare need between urban and rural areas. In addition, the maps and related reports summarize various demographic information about the children removed from each neighborhood and school district, including age, gender, race, and ethnicity. These GIS products are regularly shared with foster home recruiters and assist them in recruiting families who live in the same neighborhood from which the children are removed.

These map products were expanded in 2015 to include a market segmentation analysis of successful family foster homes. The analysis uses Tapestry™, a product of ESRI, Inc., to develop a profile of foster homes based on common demographic and socioeconomic behaviors. This profile can help target foster home recruitment efforts in specific areas and customize marketing strategies towards specific family profiles.

- Use State data to identify children/youth currently in congregate care settings.
- Use data to identify staff capacity building needs to ensure its workforce is adequately prepared to meet the array of needs of children in its particular communities.
- Use data to work with congregate care providers to ensure that the available service array meets the needs of specific populations.

► Developing a multidisciplinary committee review process

- Institute a placement review process prior to placing youth in a congregate care setting and review the placement every six months. Reviews should be led by system leaders and include representation from the provider community.

Voices from the Field: Connecticut and Maine

Connecticut has instituted removal team meetings and an approval process that requires the commissioner to personally approve any new congregate care placements. Maine's Office of Child and Family Services (OCFS) requires prior authorization and utilization review by APS Healthcare of all children and youth in high-end placements. Congregate/residential placement was redefined as temporary treatment and is now referred to as intensive temporary residential treatment (ITRT). OCFS clinical staff review children and youth in ITRT placement over 18 months through a record review process and meetings with providers to discuss barriers and develop strategies to ensure safe return to family.

► **Monitoring facilities to ensure quality service**

- Use a self-assessment tool to ensure best practices by congregate care providers.

Voices from the Field: The Building Bridges Self-Assessment Tool

The Building Bridges Initiative (BBI) has developed the Building Bridges Self-Assessment Tool (SAT) and Instructional Guides. The SAT is an instrument that was purposefully designed to be used with groups of residential and community staff, advocates, families, and youth to assess their current activities against best practices consistent with the BBI Joint Resolution Principles.

- Rank providers based on their success (or failure) with youth placed in their care, and use the ranking to make future placement decisions.
- Use performance-based contracting to reduce congregate care by contracting for results and rewarding providers for achieving specific outcomes.

Voices from the Field: Tennessee Department of Children’s Services

Tennessee fully implemented performance-based contracting (PBC) to expedite permanency for children in congregate care. Under PBC, contracted congregate care providers are evaluated annually on three main outcome standards: (1) decreasing length of stay; (2) increasing permanent exits (e.g., reunification, adoption, or guardianship); and (3) reducing reentries into foster care. Providers are rewarded financially if they show a reduction in the number of days that they serve children in State custody and receive a percentage of the amount saved by the State to use at their own discretion. If providers show outcomes worse than the baselines established, they must return money to the Department of Children’s Services. They are also mandated to demonstrate additional evidence of high-quality services.⁴¹



41 Children’s Rights. (2011). *What works in child welfare reform: Reducing reliance on congregate care in Tennessee*. Retrieved from http://www.childrensrights.org/wp-content/uploads/2011/07/2011-07-25_what_works_reducing_reliance_on_congregate_care_in_tn_final-report.pdf.

Appendix: Organizational Assessment

This assessment is designed to assist child welfare agencies in a systematic review of their policies and practices and help to identify areas for improvement. The assessment provides a framework for identifying and assessing agency strengths and challenges in implementing child welfare practices pertaining to congregate care.

Completing the assessment should be a collaborative effort within organizations and involve external partners wherever appropriate. Child welfare agencies should designate a team leader to spearhead the assessment and include team members representing the expertise of agency representatives and key stakeholders. Different team members may be assigned to complete specific sections of the assessment, with the team leader compiling all results. The collaborative effort will help to ensure that the organizational assessment is as accurate, comprehensive, and current as possible.

Results of the assessment can be used to develop implementation plans with clear outcomes and target dates to ensure positive results, as well as be incorporated into current CQI (Continuous Quality Improvement) efforts.

Administrative Policies and Procedures

What policies and procedures are in place to ensure children and youth with complex clinical needs are placed and monitored in the most appropriate setting?

Does the agency leadership demonstrate a strong commitment to placement of children with complex clinical needs in the most appropriate setting? __Yes __No

If yes, how is this commitment communicated to staff?

How is serving children and youth with complex clinical needs supported at the various levels of the organization?

Does your agency have a multi-disciplinary committee process that reviews assessments and placement recommendations?

How often are cases reviewed?

Are reviews led by agency leadership to ensure adherence to process and procedures?

What type of professional development has your staff and the provider community received to assist in meeting in the needs of children and youth with complex clinical needs?

Has there been any cross training? Yes __ No__
If yes, what type of training has taken place _____

Review of Current Data

How many children are currently in congregate care settings? _____

What types of congregate settings are youth currently placed in?

- Group home
- Residential treatment facility
- Psychiatric hospital

Age Distribution:

Birth - 1
2 - 5
6 - 12
13 -15
16 - older

What is the average length of time that they have been in out-of-home care?

What is the average length of time that they have been in a congregate care setting?

What is the average number of placement changes have that they had?

Are there identifiable patterns in the levels of care (step up, step down) resulting from placement changes?

What are their permanency goals?

Reunification____
Adoption_____
Guardianship_____
APPLA_____

What are the types of circumstances that led them to be placed in congregate care settings?

No Clinical Indicators
DSM mental health diagnosis
Child behavior problems
Disability diagnosis (visual, hearing, or cognitively impaired; physically disabled; or having other conditions requiring special medical care)

How is your data used to identify and track children and youth with complex clinical needs?

How is your data used to recruit and support family-based options?

Has there been any analysis of the available service array as compared to the needs of children and youth with complex clinical needs?

Is your data collection system used to identify children and youth currently in congregate care setting?

Does the case management system (or other data collection system) support placement decision making and placement resource identification? (E.g. is a worker or resource specialist able to search for an available foster home that serves children with specific medical or mental health needs?)

Continuous Quality Improvement (CQI)

Does part of your agency's overall QA/QI or CQI system include the monitoring of experiences and outcomes of this population? Yes ___ No___

Are conversations related to congregate care regularly occurring between data, IT, and program staff?

Are practice-related conversations regularly informed and supported by administrative and/or case review data?

How has the case review data been shared with staff?

Assessment and Intervention

What types of early trauma screening and assessment tools are currently used to assist in the placement of children with complex clinical needs?

How are the screening tools used to plan for service interventions?

What types of evidence-based interventions are implemented to work with families with children who have complex clinical needs to prevent out-of-home placement?

What types of practices are used to increase permanency for children and youth once placement occurs?

- Family Finding immediately upon placement
- Family Group Decision Making
- Permanency Roundtables
- Targeted recruitment, development, and support of kin and resource families
- Individualized transition planning

What types of supports and services are available for parents and family members to maintain placement stability? (Check all that apply)

- Financial support
- Medicaid or other state-financed health care coverage
- Mental health services for youth
- Mental health services for adults
- Crisis intervention services
- Respite care
- Wraparound services
- Formalized support groups
- Other _____

Rate your current relationship with the following supports and services

	Very Strong			Very Weak	
Financial support	5	4	3	2	1
Medicaid or other state-financed health care coverage	5	4	3	2	1
Mental health services for youth	5	4	3	2	1
Mental health services for adults	5	4	3	2	1
Crisis intervention services	5	4	3	2	1
Respite care	5	4	3	2	1
Wraparound services	5	4	3	2	1
Formalized support groups	5	4	3	2	1

Engaging Community Stakeholders

How have you engaged the provider community in changing their array of services to meet the needs of children and youth with complex clinical needs?

How have you engaged the provider community to reduce the length of stay in congregate care settings?

How do you monitor facilities through their licensing process and contract review?

Overall Strengths and Challenges in Congregate Care Practices

Based on the above self study, what do you see as your organization's strengths in congregate care practice?
Check all that apply.

Agency Strengths

- Practice model
- Organizational culture
- Policies and procedures
- Use of data to inform policy, program and practice
- Strong Continuous Quality Improvement (CQI) system
- Multi-disciplinary review process for children and youth with complex needs
- Recruitment, development and support of resource families for children and youth with complex clinical needs
- Evidenced-based trauma-informed screening tools
- Inclusive case planning honoring youth and family voice
- Use of evidenced-based interventions
- Culturally responsive services
- Professional development of staff
- Collaboration between cross systems partners
- Recruitment and support of family-based placement options
- Other

Agency Challenges

Which of the following stand in the way of implementing practices?

- Organizational culture
- Use of data
- Recruitment and support of family-based options for children and youth with complex needs
- Implementation of evidence-based assessments and interventions
- Staff turnover
- Unsupportive collaboration between cross systems partners
- Professional development
- Cultural competence
- Lack of willingness to involve constituents in improving service delivery
- Supervisory role
- Lack of support/involvement by provider community
- Other (please specify) _____

What do you need to overcome these challenges?

What resources are currently available to you to overcome these challenges?

How are you using your data to recruit and support family-based options?