LITERATURE REVIEW:
ALTERNATIVES TO CONGREGATE CARE

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I. INTRODUCTION

California's Continuum of Care Reform (CCR)[1] began in September 2012 and is a large-scale effort among advocates, legislators, and the Department of Social Services to revise and reform the current child welfare system, specifically addressing the state's current rating system, service provision, and programs serving youth and their families in the continuum of Aid to Families with Dependent Children-Foster Care eligible placement settings. A goal of California's CCR is to reduce long-term congregate care placements and increase home-based placements for better outcomes for youth.

CCR is supported by research that underpins the notion that children fare better emotionally, physically, and educationally, in the short and long run, when placed in home-based family settings. Congregate care settings may contribute to higher levels of emotional and behavioral problems, higher risk for poorer educational outcomes, and do not provide children with an appropriate long-term placement setting. Residential centers and other forms of congregate care have been put in place to accommodate especially high risk children who require a level of care that was not available in the family home. However, research supports the notion that congregate care is not only less effective at achieving safety, permanency, and well-being outcomes than other less restrictive settings, but can also be more costly at providing that care.[2,3,4]

At the request of the Southern Area Consortium of Human Services' (SACHS) Directors, literature from various sources was compiled to present alternatives to placing children in congregate care, especially those with high needs, which are often the population that end up in residential/group home settings.

For the purpose of this report, the term congregate care is defined as a residential facility in which a dependent child of the child welfare system resides as an out-of-home placement. This can be a residential treatment center, group home, emergency shelter, or in-patient hospital setting. This report will use the umbrella term *congregate care* unless otherwise specified.

California's response to this problem is the Continuum of Care Reform which will, over time, reduce congregate care by replacing it, amidst other reform components, with Short Term Residential Treatment Centers (STRTCs). Not intended to provide a long-term placement, these facilities will provide children a home when they cannot be served in a less restrictive setting. These facilities will provide services to stabilize children, connect them to community-based resources, and will require reviews of the placement for each child in order to assess their need to continue in that setting.

States and child welfare agencies across the country have been addressing the need to reduce congregate care for decades. Through systematic reforms, targeted evidence-based interventions, innovative promising practices, additional foster family homes, supportive programs for foster

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[1] California Department of Social Services. (2015). California's child welfare continuum of reform. Retrieved from http://www.cdss.ca.gov/cdssweb/entres/pdf/CCR_LegislativeReport.pdf
[2] Fisher PA, Chamberlain P. Multidimensional treatment foster care: A program for intensive parenting, family support, and skill building. *Journal of Emotional and Behavioral Disorders.* 2000;8:155–164
[3] Dozier, M., Kaufman, J., Kobak, R., O'Connor, T., Sagi-Schwartz, A., Scott, S.,…Zeanah, C. (2014). Consensus statement on group care for children and adolescents: A statement of policy of the American Orthopsychiatric Association. American Journal of Orthopsychiatry. 84(3), 218-225. Retrieved from https://www.apa.org/pubs/journals/features/ort-0000005.pdf
[4] Ryan, J., Marshall, J., Herz, D., Hernandez, P. (2008). Juvenile delinquency in child welfare: Investigating group home effects. Children and Youth Services Review. 30(9), 1088-1099. Retrieved from http://www.sciencedirect.com/science/article/pii/S0190740908000418

caregivers and children, policy changes, consistent and accurate analysis of the needs of the children in the system, and appropriately collaborating with community agencies to provide as much of the continuum of services to children and youth in the system in their homes with their families, child welfare agencies are changing the continuum of services, reducing congregate care, and promoting better outcomes among children and youth.

The following are the alternatives and/or strategies for reducing congregate care presented in this report:

- Evidence-Based Behavioral Health Interventions
- Services and Support for Home-Based Caregivers
- Foster Family Recruitment, Support, and Retention
- Treatment Foster Care
- Time-Limited Placements
- System Reform Strategies in the United States

Congregate Care Use in the Foster System

Congregate care was designed to provide children with high emotional and behavioral needs a placement option that addressed their needs in a highly restrictive placement. Research overwhelmingly points to congregate care producing adverse effects for children and that congregate care no longer holds the same value on the foster care continuum. The trend to move away from congregate care has been discussed nationwide, but the need to find ways to appropriately provide services to these children, youth, and families in the system still remains.

Key Findings on Trends in Congregate Care Use[5]:

- The overall use of congregate care has decreased by 20% since 2009, but there is substantial variation among states even in this trend (suggesting detailed analysis is needed to understand local trends).
- Some states rely heavily on congregate care as a first placement (suggesting capacity building for foster homes is needed).
- Youth placed in congregate care and treatment foster homes have significantly higher levels of internalizing and externalizing behaviors than those placed in traditional foster care (suggesting that increased access to services that effectively address internalizing and externalizing behaviors are essential to safely reducing the use of congregate care).
- Compared to youth whose clinical needs are met through treatment foster care, youth placed in congregate care are more likely have externalizing problems (suggesting that strategies for serving these youth in home-based setting should focus on preparing those homes to respond by de-escalating difficult behaviors).
- 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 (suggesting that support is needed for

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[5] Chadwick Center and 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.chadwickcenter.org/Documents/CC_Research_vF.PDF

implementation and evaluation of interventions that may stabilize foster care placements).

II. OVERALL PATTERNS OF CONGREGATE CARE USE[6]

Two patterns of congregate care use have to be addressed to reduce the use of congregate care for children and youth in the child welfare system.

1. Youth without clinical impairment who experience emergency shelter care as an initial placement.
2. Youth with clinical mental health needs to enter congregate care either as an initial placement or after home-based placements have been disrupted.

High Needs of Youth Placed in Congregate Care[7]
Using the Child Behavior Checklist and the National Survey of Child and Adolescent Well-Being (NSCAW II), a sample of youth data was analyzed to assess the level of clinical problems present in children not placed in out of home care, placed in out of home care (but not congregate care), Emergency Shelter Care, Therapeutic Foster Care, and Group or Residential Treatment (Congregate Care). The data showed that youth placed in emergency shelter care more closely resemble their home-based counterparts in terms of mental health need, and youth in congregate care settings are clinically similar to youth in therapeutic foster homes. The lower level of clinical problems among youth in emergency shelter care, paired with the frequency of congregate care as their first placement suggest the need for ***front door strategies that build capacity for initial home-based placements.*** Also, similar clinical profiles among congregate care and therapeutic foster care youth suggest the ***potential for intensive intervention provided in home-based settings that are prepared to support and address the needs of youth with complex and challenging diagnostic profiles as either an alternative to the use of congregate care altogether or as a back door, step-down approach.***

Like youth placed in therapeutic foster care youth residing in group homes or residential treatment centers are predominantly older (age 11 and older) and likely to exhibit externalizing behaviors. However, several NSCAW II findings underscore the idea that youth with comparable clinical characteristics are more likely to be placed in congregate care than therapeutic foster care to manage their behavioral risk. These youth are more likely to exhibit externalizing behaviors (such as aggressive behavior, oppositionality, and conduct problems). Among those youth requiring higher levels of care, those with internalizing problems (e.g. depression and anxiety) are more likely to be placed in therapeutic foster homes than congregate care settings. ***This suggests that investments in interventions focused on stabilizing affect and behavior, de-escalating conflict, and promoting mindfulness and stress reduction could be used to make more home-based placements available to youth with externalizing behaviors.***

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[6] Ibid.
[7] Ibid.

III. ADDRESSING BEHAVIORAL HEALTH NEEDS

Addressing youth mental health in order *to reduce congregate care utilization* will require a two-pronged approach:[8]

1. Evidence-based interventions to target the needs of youth
2. Services and support for their home-based caregivers

The United States Children's Bureau analyzed data from the Adoption and Foster Care Analysis and Reporting System and provided a summary in the report *A National Look at the Use of Congregate Care in Child Welfare.[9] **The Children's Bureau asked states to describe promising practices that they have adopted to reduce their reliance on congregate care and to best match services with the clinical needs of the children under their care and responsibility***. Common approaches include:

- Using 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.
- Using early trauma screening, assessments, and treatment that enables the implementation of tailored mental health services.
- Increasing efforts to find family (kin) placements immediately following a child's removal from home.
- Working with congregate care providers to change the service array.
- Effective leaders that engage and secure buy-in from agency staff at multiple levels as well as external community partners and stakeholders.
- Developing highly skilled, clinically informed casework staff to work with all children, but particularly for those working with children who may be at risk of congregate care.
- Data collection systems that allow administrative staff to examine the demographic characteristics of children being placed in congregate care, mental and behavior diagnoses, lengths of stay, placement stability, crisis stabilization, and resource availability.
- Creating an assessment and review process in the care of children with complex needs (cited by all of the states interviewed as being critical).
- Developing a multidisciplinary committee process that reviews assessments and placement recommendations.
- Monitoring facilities through their licensing departments and their contract review processes.

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[8] Ibid.

[9] Children's Bureau. (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. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/cbcongregatecare_brief.pdf

Researchers are working to identify common elements of programs that have ***proven effective at preventing out-of-home placements across child welfare, juvenile justice and mental health settings.*** A review of evidence-based programs suggests that such programs have common components, including that each:[10]

- is intensive in nature, often involving several contacts per week, at least initially, between provider and family;
- includes some form of 24/7 support for families during the intervention;
- provides the majority of their services in home or in the community;
- includes a significant focus on the family, particularly on empowering parents to manage and guide their children's challenges more effectively, and on improving communication within the family;
- draws on family and youth strengths as protective factors;
- works with families to more effectively address their interactions with the multiple systems, such as schools and courts, that may affect youth and family success;
- seeks to help families take better advantage of natural supports, such as extended family and the community;
- provides individualized treatment toward specific key outcomes set in conjunction with the youth and family and based on a structured set of principles, tools and/or curriculum;
- are intended as a short-term intervention, most with specified lengths of service of approximately three to four months;
- includes significant staff training and supervision/monitoring components to ensure model fidelity and quality assurance;
- keeps caseloads small;
- fits generally into a cognitive-behavioral theoretical framework.

Assessing Behavioral Health Needs[11]

There are high rates of clinical needs present in children who are involved with the child welfare system. It is critical that every child who enters the system is screened for mental health needs, included screening for Post-Traumatic Stress Disorder symptoms, and referred for a thorough assessment when indicated. A thorough, trauma-informed assessment should be performed by a licensed mental health professional and should happen before the initiation of mental health services. The assessment should drive the treatment plan and interventions which should clearly align with the mental health needs of the child.

The National Survey of Child and Adolescent Well-Being (NSCAW II) findings indicated that an estimated 2 in 5 children in congregate care settings do not have elevated scores on the Child Behavior Checklist (CBCL) when compared to the general population. These youth may be able to be immediately deflected or discharged from congregate care. *Periodic reassessment should occur to children who are in care to ensure they are in their most appropriate, least restrictive level of care.*

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[10] Annie E. Casey Foundation. (2015). Too many teens: Preventing unnecessary out of home placements. Retrieved from http://www.aecf.org/m/resourcedoc/aecf-TooManyTeens-2015.pdf

[11] Chadwick Center and 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.chadwickcenter.org/Documents/CC_Research_vF.PDF

Program Highlight:[12,13] The Return Home Early Project, a program of Kids Oneida in New York, found substantial outcomes when addressing their youth in congregate care. They assessed each child in a Residential Treatment Center or Group Home (commonly placed there due to high need behavioral issues), for their potential to move to a less restrictive level of care (foster home), closer to home, or back home with their families. They used a Child Readiness Assessment tool created by the agency. They found that in the first full year (2008), the Return Home Early project identified 43 children who could be discharged early from placement, which saved Oneida County 4,755 days of care. In one year, it was estimated that 1.6 million dollars were saved. In first year, 10 children were moved to a lower level of care, seven moved to a facility closer to home, and institutional placements had gone from 140 to 109 children in the county. After five years of the program being implemented, Return Home Early project identified and returned 169 children from Oneida County who benefited from discharge from placement. This saved the county 16,000 days of care. Residential Treatment Center and Group Home occupancy decreased by 50%. From 2009-2013, a total cost avoidance of $4.9 million dollars.

Evidence-Based Interventions to Address Behavioral Health Needs[14]

Utilizing evidenced-based mental health interventions treats children's needs while aiming to reduce the use of congregate care. In general, the mental health treatments presented by The California Evidence-Based Clearinghouse for Child Welfare (CEBC) show that mental health treatments can be delivered in a family home with children living with their parents or other caregivers and do not require out-of-home placement.

Treatments for disruptive behaviors are recommended by the Chadwick Center and Chapin Hall (2016) report as likely being appropriate for consideration for those children in congregate care, given their higher prevalence of externalizing behaviors.

The following are treatments for disruptive behaviors for children, youth, and their families in order to address clinical issues that could allow children to step down or completely avoid congregate care. *Each of these interventions has a CEBC Rating of 1: Well Supported by Research Evidence (with two or more randomized controlled trials showing it as being effective):[15]*

- Coping Power Program, ages 8-14, child and parent components
- Multi-Systemic Therapy, ages 12-17, family-focused intervention
- Parent-Child Interaction Therapy (PCIT), ages 2-7, parent-focused intervention
- Parent Management Training, Oregon Model (PMTO), ages 2-18, parent-focused intervention
- Positive Parenting Program (Triple P) Level 4, ages birth -12, parent-focused intervention

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[12] Kids Oneida. (2013). Keeping families together. Kids Oneida Annual Report. Retrieved from http://www.kidsoneida.org/assets/Documents/AnnualReports/KO2013AR.pdf

[13] Kids Oneida. (2013). The Kids Oneida Return Home Early Project: Keeping Families Together. Retrieved from http://cmhconference.com/files/2013/cmh2013-52.pdf

[14]Chadwick Center and 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.chadwickcenter.org/Documents/CC_Research_vF.PDF

[15] Ibid.

- Problem Solving Skills Training (PSST), ages 7-14, child-focused intervention with some parent involvement
- Promoting Alternative Thinking Strategies (PATHS), ages 4-12, often conducted in a school setting
- The Incredible Years (IY), ages 4-8, parent-focused intervention with child component
- Treatment Foster Care Oregon- Adolescents (TFCO-A), ages 12-18, parent and child components

IV. SERVICES AND SUPPORTS FOR HOME-BASED CAREGIVERS

The most beneficial alternative to congregate care is for a child to reside in the home of their family while receiving the appropriate, trauma-informed, culturally-competent services. The examples shown here of behaviorally-focused interventions are mechanisms for keeping, or moving children, into the home of their birth family.[16]

Building Capacity for Home-Based Care[17]

It is important to provide additional services and support for the home-based caregiver of the youth whose needs are being addressed in order to prevent the disruption of placement or the movement to congregate care, and also to help move youth to lower levels of care. Services able to improve the caregiver's sense of competency in parenting the child typically have focus in the following areas:

- managing difficult behaviors
- encouraging positive caregiver-child interactions
- helping the caregiver develop proactive and reactive responses that reinforce positive behaviors
- providing a safe and nurturing environment for the child

The CEBC defines Placement Stabilization Programs as those which aim to reduce the number and frequency of disrupted out-of-home placements. There is one program rated by the CEBC with a rating of 1 (Well Supported by Research Evidence) and that is Treatment Foster Care Oregon-Adolescents (TFCO-A), previously referred to as Multidimensional Treatment Foster Care-Adolescents. This program can be used as a first step in reducing entries into congregate care, or as a back-door approach to step down from congregate care. Treatment Foster Care Oregon-Preschool is rated as a 2 on CEBC, which is Supported by Research Evidence.

The following four programs are rated with a 3 (Promising Research Evidence) in regards to Placement Stabilization Programs:

- Family Group Decision Making (FGDC): Several controlled studies have shown effect on placement stability

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[16] Annie E. Casey Foundation. (2015). Every kid needs a family: Giving children in the child welfare system the best chance for success. Policy report. Retrieved from http://www.aecf.org/m/resourcedoc/aecf-EveryKidNeedsAFamily-2015.pdf

[17] Chadwick Center and 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.chadwickcenter.org/Documents/CC_Research_vF.PDF

- Keeping Foster and Kin Parents Supported and Trained (KEEP): Several randomized controlled trials have been conducted and showed effect on placement stability
- Neighbor to Family Sibling Foster Care Model: One comparison study showed effects on placement stability
- Wraparound: One randomized controlled trial, with no post-intervention follow-up, showed effect on the rate of placement change

These treatment models are only effective when appropriate for the population being served which means that communities have to examine the needs of their unique population of youth by analyzing the characteristics of the youth in congregate care and assessing to see what mix of services will best serve them. An assessment of the availability and accessibility of these treatment models in the community is also necessary, with the introduction of new practices to be data driven to ensure success.

Respite Care

- Respite care with children, youth, and their families provides both parties with an opportunity to spend time away from each other safely, and to effectively address issues surrounding barriers to them positively residing together. Some states utilize respite care programs/facilities for parents who submit Person in Need of Supervision (PINS) requests and/or for children with high needs.[18] Some programs and states have used respite care as a preventative measure to moving a child into the child welfare system and placing them in a foster care setting.[19,20,21]
- Research has demonstrated that respite services can:[22]
  - Reduce risk of maltreatment and *risk of an out-of-home placement*
  - Achieve statistically significant reductions in reported stress levels of caregivers and improvements in the quality of their relationships
  - Improve caregivers' positive attitude toward their children
  - Improve family functioning
  - Help caregivers meet their children's special needs
  - Improve relationships between parents and children
  - Decrease the risk of child abuse
  - Prevent placement disruptions
  - Increase families' ability to provide care at home for children with disabilities

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[18] Center for the Study of Social Policy. (2004). Policy matters: Setting and measuring benchmarks for state policies: Encouraging strong family relationships: Recommendations for state policy. Retrieved from http://www.cssp.org/publications/public-policy/policy-matters-encouraging-strong-family-relationships.-setting-and-measuring-benchmarks-for-state-policies.pdf

[19] Quraishi, F., Segal, H., Trone, J. (2002). Respite care: A promising response to status offenders at risk of court-ordered placements. Vera Institute of Justice. Retrieved from http://www.vera.org/sites/default/files/resources/downloads/IIB_Respite_care.pdf

[20] Chadwick Center and 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.chadwickcenter.org/Documents/CC_Research_vF.PDF

[21] Weingartner, E., Weitz, A. (2002). Respite care: An alternative to foster care for status offenders in New York City. Vera Institute of Justice. Retrieved from http://www.vera.org/sites/default/files/resources/downloads/Respite_care_and_foster_care.pdf

[22] AdoptUSKids. (2012) Creating and sustaining effective respite services: Lessons from the field. Retrieved from http://adoptuskids.org/_assets/files/ausk/respite-program/creating-and-sustaining-effective-respite-services.pdf

- Facilities offer respite care services to youth at risk for placement in the child welfare system. Services in many respite care programs include: [23]
    - individual and group counseling;
    - work to address family relationships;
    - substance abuse counseling;
    - medical care;
    - vocational training for older youth;
    - linking the child and family to appropriate community services;
    - assisting in developing stable living conditions;
    - parenting training;
    - referrals to other programs;
    - after-crisis services for children and parents.
- Rigorous research documents the success of crisis respite services in protecting children and keeping families together. Control group studies show that children receiving short-term crisis respite services experience fewer substantiated incidents of maltreatment, fewer placements in foster care, and fewer out-of-home placements due to emotional and behavioral disturbance.[24]

V. TREATMENT FOSTER CARE

Treatment foster care (TFC), also known as therapeutic foster care, is a foster family-based intervention designed to meet children with high needs (behaviorally, emotionally, and/or medically) whose difficulties may put that at risk for multiple placements and/or more restrictive placements such as congregate care settings. Youth in treatment foster care reside with foster caregivers who are specially trained in stabilizing or treating the youth's behavioral, emotionally, and/or medical issues and addressing the needs that arise from them. During this time, the child's permanent caregivers are also being prepared on how to care for the child and meet their needs through caregiving and access to resources in their community. Different jurisdictions utilize treatment foster care and call it by other names (with slight variations in program components) such as Multidimensional Treatment Foster Care (MTFC) and Intensive Treatment Foster Care (ITFC). Under any name, the intent of this type of care is to treat the child's mental, emotional and/or physical health needs in a home-based setting for a limited amount of time until the child is ready to move to a permanent setting with caregivers who can continue to address their needs. Brief summaries of (MTFC) and Intensive Treatment Foster Care models are below.

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[23] Center for the Study of Social Policy. (2009). Policy matters: Setting and measuring benchmarks for state policies. Promoting child safety, permanence, and well-being through safe and strong families, supportive communities, and effective systems. Retrieved from http://www.cssp.org/publications/public-policy/top-five/2_policy-matters-setting-and-measuring-benchmarks-for-state-policies.pdf

[24] Ibid.

Multidimensional Treatment Foster Care (MTFC)[25, 26,27]

- A specific evidenced-based program model that works with children and families who need a high level of support due to the child having a high level of need due to: severe abuse and neglect, severe mental and/or behavioral problems, and/or problems with juvenile delinquency. MTFC serves as an alternative to group homes/residential congregate care by delivering services which children are in the care of highly trained and supervised foster parents and with school supervision.
- While the child is foster care, the child's long-term caregivers (biological family, relatives, or others with whom the child will be living with after treatment) will be instructed with the same sort of parenting strategies that the child is receiving in the foster home.
- Outcomes:
    - Several randomized trials have shown the effectiveness of this model. In one randomized trial, youth were assigned to MTFC or group care, and those in MTFC had significantly fewer arrests, fewer self-reported delinquent activities, less frequent runaways, and less time spend in incarceration than youth in group care.

Intensive Treatment Foster Care (ITFC)[28]

- Intensive in-home therapeutic and behavior-management services are provided in a foster home setting for children/youth with serious emotional and/or behavioral issues.
- The goal is to move the child/youth out of group homes care (level 9-14) and into family-based care.
- Foster parents must meet minimum requirements for foster care and complete a 60 hour certification training.
- Targeted population of emotional disturbed children do not have to currently reside in a group home, they may also be at risk from entering a level 9-14 group home to be appropriate for this program.
- This program has the following components:
    - places one youth at a time with a family;
    - matches the foster family and child with care;
    - uses a team approach to treatment, with the foster parents as part of the treatment team along with program staff;
    - utilizes a unique Support Counselor to offer individualized counseling & emotional support, mentoring and modeling skills for both child and foster parent;
    - employs case managers with low caseloads for frequent on-site consultation for individualized problem-solving & treatment planning;
    - uses Trauma-focused Cognitive Behavioral Therapy as its treatment model;

[25] Fisher, P., Gilliam, K. (2012). Multidimensional treatment foster care: An alternative to residential treatment for high risk children and adolescents. *Psychosocial Intervention*. 21(2), 195-203. Retrieved from http://www.sciencedirect.com/science/article/pii/S1132055912700765

[26] Multidimensional Treatment Foster Care is now called Treatment Foster Care Oregon (TFCO) in many jurisdictions.

[27] Leve, L., Fisher, P., Chamberlain, P. (2009). Multidimensional treatment foster care as a preventative intervention to promote resiliency among youth in the child welfare system. Journal of Personality. 77(6), 1869-1902. Retrieved from http://www.mtfc.com/2009%20MTFC%20as%20a%20Preventive%20Intervention%20Leve_Fisher_Chamberlain_2009_JoP.pdf

[28] Social Services Agency, County of Santa Clara. (2016). Intensive Treatment Foster Care Program. Retrieved from https://www.sccgov.org/sites/ssa/dfcs/foster/itfc/Pages/itfc.aspx

    o offers a more normalizing living environment and better opportunities for permanence.

VI. FOSTER FAMILY RECRUITMENT, SUPPORT, AND RETENTION
Building Capacity for Initial In-Home Placements

Many children and youth can return home to their birth families with the right support and services. Those who cannot should live with relatives or kin if possible. If relatives are not available, systems should maintain a strong network of non-relative foster families, including TFC families who are equipped to handle more severe needs.[29] Building capacity for initial home-based placements can likely include the following strategies:[30]

- Emergency foster homes with short term needs addressed during that time (e.g. going to school, health care needs)
- Recruitment of a larger pool of regular foster care homes
- Effective identification and screening of kinship caregivers

In a research summary prepared by Karissa Hughes (2015), *Supporting, Retaining & Recruiting Resource Families*, research is presented that highlights evidence-based practices around support models for resource families, best practices for developing retention programs for resource families, and promising practices around recruitment, including for harder to place children (e.g. sibling groups, older youth, and children with higher behavioral, mental, and/or medical needs). Page 55 of the report highlights targeted recruitment techniques for children with severe emotional, behavioral, or medical challenges. This research may support efforts to build upon existing networks of resource families or assist in recruiting additional families who can best support the high needs of particular children and potentially reduce placement in a group home setting.[31]

Recommendations from the Annie E. Casey Foundation are that recruiting, supporting, and retaining foster caregivers should be a top priority for child welfare agencies. Forty percent of families who end up discontinuing their foster parenting duties do so primarily due to inadequate agency support. Support services such as implementing components of evidence-based and promising practice interventions can assist in this way. **The beds available inside foster family caregiver homes are not only alternatives to congregate care, but can be more effective in producing better outcomes for the child.** Public agencies should be required by legislators to have an active and updated list of current foster parents and a tracking system for comparing the

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[29] Annie E. Casey Foundation. (2015). Every kid needs a family: Giving children in the child welfare system the best chance for success. Policy report. Retrieved from http://www.aecf.org/m/resourcedoc/aecf-EveryKidNeedsAFamily-2015.pdf

[30] Chadwick Center and 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.chadwickcenter.org/Documents/CC_Research_vF.PDF

[31] Hughes, K. (2015). Research summary: Supporting, retaining, and recruiting resource families. Public Child Welfare Training Academy. Retrieved from http://theacademy.sdsu.edu/wp-content/uploads/2015/10/pcwta-research-support-retention-recruitment-oct-2015.pdf

capacity of foster homes with the needs of the children who need placement. This should also track the need for emergency foster care beds.[32]

Agencies should have ongoing training for foster families to build capacity for them to care for youth with high needs to keep them out of congregate care and with families who are equipped with the knowledge, skills, and resources to appropriately address their needs. San Diego utilized an evidence-based program, Project KEEP, to train and support foster parents and to develop their skills. Programs like this have been found effective at reduce child problematic behavior while supporting the families who care for them.[33]

The Quality Parenting Initiative (QPI)[34] is a foster care rebranding effort aimed change and implement the core elements underlying foster care including: To define the expectations of caregivers, to clearly articulate these expectations, and then to align the system so that those goals can become a reality. Some agencies using QPI have reported reduced use of congregate care through this initiative.

VII. TIME-LIMITED PLACEMENTS
Short Term Emergency Foster Homes
Expanding capacity for short term emergency foster homes allow children to be placed in families as an alternative to group home care. Emergency foster homes meet the immediate needs of children and are prepared to care for them with short notice. It can be difficult to place children with high emotional, behavioral, or medical needs in these types of placements without the caregivers having proper training. Recommendations from the Annie E. Casey Foundation are to increase support for these families to take children on an emergency basis, strengthen licensing processes, and secure efficient funding for families to support children in this way and keep them out of congregate care.[35] Recruitment strategies mentioned in the previous section are also effective means to consider for recruiting families as emergency foster homes.

Assessment Centers[36]
Some counties are utilizing assessment center for children removed from their homes. Commonly called "23-hour Assessment Centers," these facilities allow children to stay for up to 23-hours and receive a mental health screening and a safe place to sleep while caseworkers search for an appropriate placement for the child. This may serve as an alternative to congregate care as a first placement option. Assessment Centers also recognize the need for a mental health screening so that the child's needs may be appropriately addressed when developing a plan for placement. Some Assessment Centers will provide a more in-depth mental health assessment

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[32] Annie E. Casey Foundation. (2015). Every kid needs a family: Giving children in the child welfare system the best chance for success. Policy report. Retrieved from http://www.aecf.org/m/resourcedoc/aecf-EveryKidNeedsAFamily-2015.pdf

[33] Ibid.

[34] Youth Law Center. (n.d.) Quality parenting initiative. Retrieved from http://www.ylc.org/our-work/action-litigation/quality-foster-care/quality-parenting-initiative/

[35] Annie E. Casey Foundation. (2015). Every kid needs a family: Giving children in the child welfare system the best chance for success. Policy report. Retrieved from http://www.aecf.org/m/resourcedoc/aecf-EveryKidNeedsAFamily-2015.pdf

[36] Payne, C. (2014). Literature Review: 23 Hour Assessment Centers. Academy for Professional Excellence. Retrieved from http://theacademy.sdsu.edu/wp-content/uploads/2015/02/23-hour-Assessment-Center-Final1.pdf

after the screening or include it as a follow-up for the case worker. A child should not stay in the Assessment Center for longer than 23 hours in compliance with Community Care Licensing.

Emergency Shelters

Emergency shelters are not seen as ideal placements but are sometimes the last resort and only option for children entering out-of-home placement or transitioning between placements, or for hard to place, "high-risk" youth. Emergency shelters are to be used while a permanent placement is sought, should be time-limited, and provide appropriate assessment and treatment services to youth. There is an array of differences in how shelters are set up. Some are simply facilities with beds and limited services while others are cottage, home-like settings with access to mental health services and other support services for the youth residing there.

Program Highlight: [37,38] Child Haven Emergency Shelter in Clark County, Nevada converted their emergency shelter into a 23-hour Assessment Center. The shelter implemented several systematic practice and policy changes beginning in 2006. A large part of the changes were the creation of an Emergency Response Team (Command Post), an Emergency Receiving Team, and an Emergency Reception Center. Some of the outcomes associated with the new system changes were a significant reduction in the use of congregate care, children under 6 no longer placed in congregate care, and better transition process for kids moving from shelter to foster care placements.

VIII. PLACEMENTS FOR COMMERCIALLY SEXUALLY EXPLOITED CHILDREN (CSEC)

Commercially Sexually Exploited Children (CSEC) have needs that are best met in stable, long-term environments where they can transition to a healthy independent life. This can be difficult to provide among foster parents who are unprepared or unequipped with the knowledge and resources to aid in their recovery. According to the U.S. Department of Justice, CSEC victims require specialized recovery programs that offer "shelter, nutrition, and appropriate medical treatment, as well as psychological evaluation, counseling, alcohol and drug treatment programs, education programs and life skills training."[39]

Residential facilities for CSEC survivors, while licensed as group homes, should be tailored to meet the needs of this specific population. A National Survey of Resident Programs for Victims of Sex Trafficking retrieved data on the number of residential programs available for trafficking victims, including the number of beds available, locations of these facilities, and resources offered.

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[37] Hammack, P. (2016). Emergency shelter: Lessons learned. Department of Family Services, Clark County. Unpublished PowerPoint Presentation.

[38] A recorded version of the February 18, 2016 webinar on the successes and challenges of converting an emergency shelter into a 23-hour Assessment Center is available through the Public Child Welfare Training Academy's Continuum of Care Reform website: http://theacademy.sdsu.edu/programs/pcwta/continuum-of-care-reform/

[39] Reichert, J. & Sylwestrzak, A. (2013). National survey of residential programs for victims of sex trafficking. Chicago, IL: The Illinois Criminal Justice Information Authority. Retrieved from http://www.icjia.state.il.us/assets/pdf/researchreports/nsrhvst_101813.pdf

- Key findings (as of October 2013):
    - Of the 37 total residential programs in the U.S., 73% were long-term residential and group homes, 12% were shelters, and 15% were transitional living program
    - California had the most programs- 10 residential programs and 371 beds (54% of all beds in the country located in CA)
    - 75% of the beds in the programs were designated for victims under the age of 18
    - 28 of the 37 programs offered aftercare services for those leaving the program
- Summary of services
    - Many of the existing residential facilities for CSEC are in undisclosed locations for the purpose of protecting outside persons from contacting youth and potentially inflicting harm or harassment.
    - Services may include individual and group trauma therapy, case management, classes in social and life skills, onsite schools, arts and culture based classes, job placement services, and aftercare services including linkages to community resources. There are a variety of tools, resources, and interventions available for those working with this population.[40]
    - Facilities vary in the length of time and age for the youth residing there. Some facilities only allow youth to stay until age 18, while others will allow stays into adulthood.

IX. SYSTEM REFORM EFFORTS BY OTHER JURISDICTIONS

Several large statewide entities have attempted reform of their child welfare agencies in hopes of reducing congregate care use for both improvements in child and family outcomes, and to produce cost-saving benefits. These large scale efforts involved the participation of multiple departments and organizations, with collaboration and adjustments made in multiple arenas in order to address the problems each state/jurisdiction were presented with, much in the same way the California Continuum of Care Reform is structured.

Tennessee Department of Children Services (DCS)[41]

- *Background/Problem*: Reform in the state of Tennessee started with the Brian A. class action litigation that, by use of federal court order, forced DCS to reform their system to address the overuse of congregate care. Routine placement of children in congregate care settings were contributing to poor outcomes for the children behaviorally, developmentally, and academically. In addition, the state's lack of available foster homes and failure to keep children safe in the shelters were deemed unacceptable.
- In-depth interviews with 51 Tennessee child welfare stakeholders were conducted in order to provide other jurisdictions a closer look at the policies, practices, and organizational structures that led Tennessee DCS to accomplish their reform and reduce its use of congregate care.

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[40] Foster Family-based Treatment Association. (2014). Domestic minor sex trafficking/commercial sexual exploitation of children.

[41] Children's Rights. (2011). What works in child welfare reform: Reducing reliance on congregate care use 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

- The following changes were implemented as part of the reform, information gathered by in-depth interviews with 51 Tennessee child welfare stakeholders:
    - *Closed the state's largest congregate care facility-*Tennessee Preparatory School, a residential school serving children in the state for longer than a century.
        - Within four months, almost all of the youth residing in the school were placed in family-based placements either with their own family or family members, friends, or others willing to take them in.
    - *Required new organizational structures*
        - foster home recruitment and retention plans
        - a system for reviewing the cases of children placed in group care for extended periods of time)
    - *Mandated improvements to parts of service delivery*
        - limit stays in emergency shelters to 30 days
        - require approval before placement in congregate care
        - prohibit placement of dependent children in correctional/ detention facilities
    - *Recruitment of foster parents who had the skills to care for children with unique or high-level needs*
        - children with special needs and teenagers were their highest need populations
    - *Higher use of treatment foster homes*
    - *Used existing foster parents as recruiters for new foster homes*
    - *Provided intensive foster parent training and staff support for foster parents*
    - *Changes in infrastructure and frontline practice*
        - Development of a practice model
        - Identifying the least restrictive placements using the Child and Adolescent Needs and Services (CANS) assessment tool to align with strength-based, culturally responsive, and family-focused casework by suggesting the intensity of services needed for the child but leaves it to the caseworkers to meet that level of care in the least restrictive setting
        - Limiting entries into and lengths of stay in congregate care by implementing a gatekeeper policy of having a Regional Administrator approve all group care placements
        - Building a supportive infrastructure by improving upon pre-service and in-service training, focusing on dangers of institutionalization, barriers to permanency associated with placement in congregate care, and importance of placement in family settings
    - *Changing relationships with private providers by instituting the Continuum model and performance-based model of contracting:*
        - Continuum model entails DCS paying providers a rate that is based on the level of services a child needs, and only for the days that the child is in the care of that provider. Providers get paid the same rate for every type of placement, and with congregate care being more expensive than serving a child in a foster home, providers can save money by placing a child with foster families and then use saved money to reinvest in other types of programs for children and families.

- ▪ Performance-based contracting rewards providers for achieving the following goals: reducing the number of days children spend in foster care, increasing permanent exits from care, and reducing re-entries.
- *Outcomes:*
  - o During the period of reform, indicators of safety, permanency, and well-being were improving, however due to the number of possible influences, and the fact that that study did collect quantitative data, it is not possible to solely contribute improvements to the reduction in congregate care usage. Respondents to qualitative survey data suggested that reducing congregate care played a critical role in the positive outcomes that came from Tennessee's reform.
  - o In 2000, 28 percent of children entering foster care were placed directly into congregate care settings. By 2003, that figure had dropped to 13 percent, and it has remained around that level or lower ever since.
  - o On January 1, 2001, 22 percent of Tennessee's foster children were placed in congregate care. On January 1, 2009, only nine percent were living in congregate care settings.

Connecticut Department of Children and Family Services (DCFS)[42]

- *Background/Problem*: After determining an overreliance on congregate care, in 2011 Connecticut DCFS assessed their system and found that there was an underutilization of the alternatives to congregate care including the use of current foster, kinship, and relative families for placements. They also found that their foster families were not receiving the same level of support- financially or therapeutically, as their congregate care providers were.
- *Goals for Rightsizing and Redesigning Congregate Care Goals:*
  - o Reduce the numbers of children ages 12 and younger in congregate care and eliminate, to the greatest possible extent, congregate placements for children ages six years and younger.
  - o Gradually reduce the length of stay in congregate placements through DCFS's Voluntary Services Program to a period of six to nine months, aligned as much as possible to the school year. Approval of Voluntary Placements will also require family involvement, and the application of a financial means test. In addition, DCFS will seek insurance payment where available.
  - o Review and repurpose any existing therapeutic group homes.
  - o Implement a system of performance management, built upon the principles of Results Based Accountability and the literature of "Implementation Science." This involves a heavy focus on training as well as data collection, use and reporting.
- Levers of Change Addressed:
  - o *Policy Changes*
    - ▪ Children 12 or younger to be served in family settings and removed from congregate care and placed in family settings.

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[42] Connecticut Department of Children and Families. (2011). Congregate care rightsizing and redesign: young children, voluntary placements and a profile of therapeutic group homes. A report in the "fostering the future" series. Retrieved from http://www.ct.gov/dcf/lib/dcf/latestnews/pdf/cc_right_sizing_report__young_children_and_voluntary_placements_8_4_11.pdf

- No children age six or younger will placed in congregate care without formal authorization by the commissioner.
- Length of stay in congregate care will be reduced to six to nine months and align with children's needs.

o *Practice Changes/Modifications*
  - Internal team to provide system oversight for all congregate care systems.
  - Establish a multi-stakeholder partnership that meets regularly to frame strategies for redesigning congregate care settings and development of strategies for achieving these goals.
  - Partner with Connecticut institutions of higher education and the private provider sector to implement joint trainings for DCFS staff, foster families, and community and congregate care providers. In conjunction with these partners address the following: family-centered care; trauma-informed practice; the neuroscience of child and adolescent development; strategies for building partnerships with communities; and improvements in leadership, management, supervision and accountability.

o *Improved Access to Child-Specific and Family Supportive In-Home and Community Services*
  - Support the expansion of community-based autism services and respite programs for families seeking voluntary services and placements from DCFS.
  - Increase the use of foster family settings as an alternative to congregate care.
  - Increase evidence-based wraparound model components to assure effective supports for families.

o *Performance Management*
  - Develop and implement evaluation strategies to gauge policy and practice changes effectiveness.
  - Establish guidelines for Therapeutic Group Homes to abide by.
  - Evaluate clinical intervention services to see what can be implemented in a community-based setting.
  - Congregate care providers to measure family engagement, length of stay, planning and activities to support return of a child to her home, and number of children discharged to families.
  - Regularly analyze data, leveraging various data reporting systems and datasets.

o *Financing*
  - Explore a cost model for therapeutic group homes that would allow a child's clinician to continue to provide transitional services when the child transitions to home-based care.
  - Fund training services to be utilized across providers for consistent, family-centered, trauma-informed practice and training.
  - Develop and monitor a feedback system for congregate care providers.

Annie E. Casey Rightsizing Congregate Care

The following information is compiled research on reform efforts by the Annie E. Casey Foundation who used its intensive embedded consulting approach to help systems find the best way to reduce the use of congregate care placements for children and youth. The approach was embodied in the Casey Strategic Consulting Group, which in 2009 became part of the Foundation's Child Welfare Strategy Group (CWSG).[43]

- The Annie E. Casey Foundation's strategic consulting group worked with several public child welfare systems to improve the use of congregate care, and reduce the reliance on it in order to *improve outcomes for youth and families, increase support for community-based services, and reinvest savings into providing additional effective supports for families.*
- The overall strategy implemented through these reform efforts was termed "rightsizing" congregate care and was thought to be the best starting point to reforming child welfare services, given the fact that congregate care did not show any promise of providing better care for children than a family environment. Rightsizing congregate care was structured into a bigger reform context of long-term system change.
- There were five levers of system change addressed when rightsizing congregate care, and the research found that system change occurred when at least two of the following five levers were targeted:
    - **Composition of Services:** Reduce congregate beds, increase community foster homes, increase community-based services, increase use of kinship placements for children.
    - **Front-Line Practice:** Engage young people in talking about their placement preferences, increase engagement of parents and family, identify potential kinship homes earlier.
    - **Finance:** Create financial disincentives for congregate care (e.g. require local contributions for institutional placements) and redirect savings from decreased use of congregate care to community-based services.
    - **Performance Management:** Use permanency and well-being outcomes to evaluate congregate care providers and phase out contracts with providers that have poor performance.
    - **Policy:** Mandate family-based concurrent planning for all children and youth, limit use of independent living as a case goal, identify potential kinship homes earlier, encourage youth to consider open adoption arrangements that permit birth-family contact, and require prior authorization and utilization reviews for entry into congregate care.
- Casey's strategy was to target one or two of these levers of change, and then expand to others as the reform moved forward. All of the initiatives included Front-Line Practice as a targeted change, but not all other levers were included in all initiatives.

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[43] Annie E. Casey Foundation. (2010). Rightsizing congregate care. A powerful first step in transforming child welfare systems. Retrieved from http://www.aecf.org/m/resourcedoc/AECF-RightsizingCongregateCare-2009.pdf

The following jurisdictions are those who have been reformed through the Casey Rightsizing Initiative.

New York City Administration for Children's Services
- *Background/Problem:* Number of teens in the system was increasing and two-thirds of teens were ending up in congregate care and aging out of the system with limited prospects.
- *Two levers of change targeted:* performance management and frontline practice
  - Elimination of the weakest group home providers.
  - Improved engagement with teenagers, working with them to identify possible families.
- *Implemented the following new policies:*
  - Designed an innovative case review process to find family placements for teens.
  - Mandated family-based concurrent planning for youth in foster care.
  - Limited the use of independent living as a case goal.
  - Encouraged teens to consider open adoption to allow contact with their birth families.
- *Outcomes:*
  - The number of congregate care beds was reduced to 2,192 in December 2008 from 4,174 in 2002, a 47 percent decrease.
  - Reducing congregate care saved more than $41 million, a portion of which was reinvested in supportive and aftercare services.
  - Initial placements for two-thirds of teens entering the ACS system were now in family settings, compared to 2003, when the number was one-third.

Maine Office of Child and Family Services
- *Background/Problem:* The agency was put under legislative review and in the spotlight of national media coverage and public outcry when a child fatality highlighted the need for Maine's faulted system to undergo reform. Their strategy was to focus on reducing congregate care placements, which would encourage more home-based placements and also free up system resources and funding to provide more support for community based resources for children in home-based placements.
- *Three levers of change were targeted*: frontline practice, policy, and finance
  - It was decided that the best way to support these levers of change was through the elimination of congregate care placements with the *goal of moving 10 percent of congregate care residents to permanent families or home-based placements.*
  - The following strategies were used:
    - *Permanency teams* used to evaluate cases for moving children out of congregate care.
    - *Policy changes* that *redefined congregate care as a treatment rather than a placement* and required authorization and review before placing a child in a group home setting.
    - *Shifting resources to services in the community* which meant working with providers to shift from residential care to community-based services.
    - Casey negotiated with the state governor to redirect funding saved from removing some congregate care facilities into expanding community-based resources.

- *Outcomes:*
    - 200 children were in residential placements in 2009, compared to 747 in 2004, a 73 percent decrease.
    - 30 percent of children were living in kinship care placements in 2009, compared to 12 percent in 2003.
    - 40 percent of children discharged to adoption spent less than two years in care, compared to 26.8 percent of children in similar circumstances nationwide.
    - $4 million was invested into community programs from the $10.4 million saved overall.

Louisiana Department of Children and Family Services

- *Background/Problem:* Foster homes were limited, facilities were overcrowded, and congregate care numbers were too high. The agency was given a one-time federal funding opportunity to address their overwhelmed system.
- *Two levers of change were targeted:* frontline practice and composition of services.
- *Surveyed youth in congregate care and discovered the following:*
    - Youth stated the main reason they stayed in congregate care (average length of stay was two years) was because no one assessed whether they could live in a family setting.
    - Youth felt they were not given enough support to strengthen ties with families yet even upon aging out, said they planned to return home to their families.
- *Implemented the following changes:*
    - Agency implemented and expanded community and family resources so that children leaving congregate care for family-based placements could have more support (i.e. utilized evidence-based clinical services such as Multisystemic Therapy).
    - Developed an alternative response system.
    - Provided access to substance abuse programs for parents.
    - Gave grants to kin caregivers and instituted an evidence-based parenting program, Nurturing Parent, to caregivers.
    - Strengthened foster home recruitment strategies, streamlined licensure, and worked to improve retention rates.
- *Outcomes:*
    - 411 children were in residential care in 2008, down from 611 in 2006, a 33 percent decrease.
    - The increase in new foster homes intensified: In 2008, there were 700 new homes in the state compared to 496 in 2006.

Virginia Department of Social Services

- *Background/Problem:* Teenagers were the largest group of youth in congregate care.
- *Three levers of change were targeted*: finance, performance management, frontline practice.
- Developed a Council on Reform (CORE) to serve as a steering committee comprised of 100 volunteers from various state departments to lead the development and implementation of reform.

- *Financial changes*:
  - Despite a deficit in the budget, reallocated $1.8 million over two years to recruit, train, and support foster and adoptive families.
  - Provided a 23 percent increase over two years for foster care and adoption subsidies.
  - Allocated $800,000 to train foster care and adoption caseworkers.
  - Developed a new state-local funding formula with incentives for community-based placements.
    - Increased matching funding for community-based placements and decreased matching funding for residential and group home placements.
- *Performance management and frontline practice changes*:
  - Implemented Team Decision Making (TDM) for all cases which removed a child from congregate care. In the pilot city, 250 TDMs were held in five months, leading to a 30 percent decrease in the number of youth in congregate care in that city.
- *Outcomes:*
  - 1,399 children were in congregate care in 2009, down from 1,922 in 2007, a 27 percent decrease.
  - The 14 CORE localities saw a 14 percent drop in the overall foster care population between 2007 and 2009, while statewide the numbers dropped 11 percent.
  - Family-based placements increased 9 percent in CORE localities between 2007 and 2009 and 5 percent statewide.
  - Discharges to permanent families were up 14 percent in CORE localities between 2007 and 2009 and 5 percent statewide.

X. FEDERAL EFFORTS TO REDUCE RELIANCE ON CONGREGATE CARE

Senate Finance Committee Chairman Orrin Hatch (R-UT) and Senator Ron Wyden (D-OR) convened two hearings in 2015 to address congregate care use in child welfare: *No Place to Grow Up: How to Safety Reduce Reliance on Foster Care Group Homes* (May 19, 2015) and *A Way Back Home: Preserving Families and Reducing the Need for Foster Care* (August 4, 2015). The following are key highlights from each hearing.

- **Hearing: No Place to Grow Up: How to Safety Reduce Reliance on Foster Care Group Homes**[44]
  Joo Yeun Chang, Associate Commissioner of the Children's Bureau for the United States Administration for Children Youth and Families, presented the outline of a proposal in the FY 2016 President's Budget that would "reduce congregate care by increasing monitoring of congregate care use and supporting family-based care as an alternative to congregate care." The proposal would:
  - Require justification of a congregate placement setting based on the documented

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[44] No place to grow up: How to safely reduce reliance on foster care group homes, United States Senate Committee on Finance. (2015). Retrieved from http://www.finance.senate.gov/hearings/no-place-to-grow-up-how-to-safely-reduce-reliance-on-foster-care-group-homes

assessment of a child's medical and behavioral needs, along with the specific goals the child must achieve to move to a lower level of care and a family-based setting, including the time frame in which they can achieve this.

- o Require the continued justification of the appropriateness of the congregate care placement at six months in the placement and every six months thereafter.
- o Reimburse child welfare agencies with 60 percent match in federal funds for specialized casework (instead of the 50 percent match) and an 80 percent match for specialized caseworker training.
- o Provide foster parent training and support through training and compensation for serving as a treatment foster care home (therapeutic foster home). It would also provide Title IV-E reimbursement for supervision costs of children who may need specialized services during the day.

- **Hearing: A Way Back Home: Preserving Families and Reducing the Need for Foster Care**[45]

  During this hearing, individuals presented *alternatives to group foster care*, along with suggestions to reallocate finances to be able to provide services that keep children with their families and out of foster care.

  - o The premise of the hearing can be summarized with the following quote: "Whenever possible, children should grow up in a home with their family. When problems arise, attempts should be made to keep children safely at home. If a child cannot be kept safely at home, efforts should be made to place them with fit and willing relatives. Children and youth should only be placed in group homes for short periods of time and only when efforts to place them in a safe family setting have been exhausted. Too many children and youth spend years isolated and confined in foster care group homes. ***However, it is not sound public policy to work to reduce the reliance on group homes without addressing the need to support a family placement for children and youth currently in or at risk of entering one of these facilities***."
  - o Alternatives to group foster care include allowing states to use their federal foster care funds for the purpose of providing services and interventions that can result in allowing children to stay safely at home (i.e. continuing to fund the Title IV-E waiver programs).
    - ▪ Donna Butts, Executive Director, Generations United, presented the following recommendations at the hearing:[46]
      - • Continue to fund flexible Title IV-E waiver funds to be used to support kinship caregivers, giving them the support and resources they need to adequately care for their child relatives and keep them out of the foster care system.
      - • Promote evidence-based support programs that aim to enhance kinship care to be more fully evaluated for effectiveness in a statewide or county child welfare program.

[45] A way back home: Preserving families and reducing the need for foster care, United States Senate Committee on Finance. (2015). Retrieved from **http://www.finance.senate.gov/hearings/a-way-back-home-preserving-families-and-reducing-the-need-for-foster-care**
[46] Butts, D. (2015). A way back home: Preserving families and reducing the need for foster care. Written Testimony. Retrieved from http://www.finance.senate.gov/imo/media/doc/04aug2015-ButtsTestimony.pdf

- Relative foster families should have access to the same therapeutic services that non-relative therapeutic foster care families have.
    - This can be achieved by requiring states to have a kinship care ombudsman or a primary kinship resource liaison who provides kinship caregiver with information about benefits, resources, and services available to them.
        - Charles Nyby, Oregon's Differential Response and Safety Operations and Policy Analyst for the Child Welfare Program in the state, provided a presentation highlighting the effectiveness of Oregon's Differential Response program, a Title-IV-E demonstration project that has shown progress in reducing congregate care. He also argued that financial policies and budgetary considerations should be made to continue to allow states to sustain projects through the Title IV-E Waiver Demonstration Projects, set to expire in 2019.[47,48]

Program Highlight: The program HomeWorks, was presented in the hearing from the state of Utah as an example of an effective Title IV-E program that has been shown to reduce the use of out-of-home and congregate care.[49,50]

- A Title IV-E Demonstration Project with the following in-home practice model components:
    - Structured Decision Making (SDM) at intake
    - Advanced approach to caseworker training
    - Consistent use of the child and family assessment
    - Increased frequency and length of staff time with the family in addition to community support for sustained family resiliency
- HomeWorks works with families to achieve long-term behavioral change to reduce risk of repeat maltreatment and ongoing involvement with public child welfare services.
- Financial benefits of HomeWorks:
    - For the average cost of serving one child in a foster care home for one year, HomeWorks can serve 11 families.
    - For the average cost of serving one foster care child in a residential group setting for one year, HomeWorks can serve 34 families.
- Outcomes:
    - Increased capacity for parents to care for and protect children and increased availability for parents to access community resources to support their children while in their home.
    - Reduced use of foster care, including fewer cases from in-home to foster care.

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[47] Oregon Department of Human Services. (n.d). Oregon's vision for differential response. Retrieved from http://www.oregon.gov/DHS/CHILDREN/DIFFERENTIAL-RESPONSE/Documents/DR-Vision-Statement.pdf

[48] Nyby, C. (2015). A way back home: Preserving families and reducing the need for foster care. Written Testimony. Retrieved from http://www.finance.senate.gov/imo/media/doc/04aug2015-NybyTestimony.pdf

[49] Silverberg Williamson, A. (2015). A way back home: Preserving families and reducing the need for foster care. Written Testimony. Retrieved from http://www.finance.senate.gov/imo/media/doc/04aug2015-WilliamsonTestimony.pdf

[50] Utah Department of Human Services. (2014). HomeWorks. Social Services Appropriations Subcommittee Update. Retrieved from http://le.utah.gov/interim/2014/pdf/00005436.pdf

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