



## **Position Statement on Residential Services**

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# CWLA's Position on Residential Care

To promote better services and outcomes for children, youth and their families, the Child Welfare League of America (CWLA) strongly endorses a system of care that includes residential services as an integral component of the continuum of services.

## Issue

The original use of “continuum of care” used least restrictive *and* most appropriate as the accepted standard. The continuum included services such as prevention/diversion, family preservation, counseling, in-home services, day care, day treatment, foster care, adoption, residential treatment, family reunification, transitional care, and aftercare. In the last 20 years, however, child welfare practice has created a linear notion of “continuum of care” as a case management blueprint governing most decisions. Currently, the child welfare field widely accepts that the most humane and efficient approach to allocating services to children and families is to provide those services from least to most restrictive, as this stepwise intervention is presumed to cost less and keep families together. This practice has resulted in residential services being used as the intervention of last resort, often after multiple failures in other services, rather than as the most appropriate intervention based on a thorough assessment of the individual child and family's current needs.

## Support for Residential Services in the Continuum

Residential services are an important and integral component within the multiple systems of care and the continuum of services. Residential services include supervised/staffed apartments, group homes, residential treatment, intensive residential treatment, emergency shelter, short-term diagnostic care, detention, and secure treatment.

Residential care's primary purpose is to address the unique needs of children and youth who require more intensive services than a family setting can provide. Either on site or through links with community programs, residential services provide educational, medical, psychiatric, and clinical/mental health services, as well as case management and recreation (CWLA, 2004). Within residential settings, children and their families are offered a variety of services, such as therapy, counseling, education, recreation, health, nutrition, daily living skills, pre-independent living skills, reunification services, aftercare, and advocacy (Brazier, 1996).

A number of studies have identified positive outcomes associated with residential care. A Canadian study of 40 children in residential care found that for the majority of children, functioning was severely impaired at admission, moderately impaired at discharge, and normal at one and three years post-discharge (Blackman, Eustace, & Chowdhury, 1991). A study of children diagnosed with conduct disorder in residential care found that the number of concerns expressed by caregivers decreased between admission, discharge, six-month, one-year, and two-

years post-discharge (Day, Pal, & Goldberg, 1994). Finally, a retrospective study of 200 children served at group homes in the Midwest found that, as adults, 70% had completed high school, 27% had some college or vocational training, and only 14% were receiving public assistance (Alexander & Huberty, 1993).

Family-centered residential care has shown considerable success. Landsman, Groza, Tyler, and Malone (2001) found that youth in family-centered care had shorter lengths of stay, were more likely to return home at discharge, and had better long-term stability than youth in traditional residential care. Similarly, at 6-, 12-, 18-, and 24-month follow-up, 58% of youth discharged from family-focused, community-oriented residential programs had been involved in no new illegal activity, had continued to participate in educational endeavors, and had not been moved to a more restrictive level of treatment. Ninety percent of the youth accomplished two of the three aforementioned outcomes (Hooper, Murphy, Devaney, & Hultman, 2000).

One of the most promising studies demonstrating the efficacy of residential care with young children emerged from a 23-year longitudinal study from Israel. There, Weiner and Kupermintz (2001) found that 268 children initially placed as preschoolers in well-designed residential care settings, some of whom spent long periods of time in care before being placed in adoptive homes, functioned “adequately or as well as young adults.” The finding was contrary to the researchers’ initial hypothesis and led them to conclude that “neither preschool institutional care, nor long-term institutional care was found to be harmful for these young people in terms of normative living... In fact, the majority of those who were functioning well have significantly improved since their teenage years.”

Characteristics of residential care that have been correlated with long-term positive outcomes include high levels of family involvement, supervision and support from caring adults, a skill-focused curriculum, service coordination, development of individualized treatment plans, positive peer influences, enforcement of a strict code of discipline, a focus on building self-esteem, a family-like atmosphere, academic support, presence of community networks, a minimally stressful environment, and comprehensive discharge planning (Pecora, Whittaker, Maluccio, & Barth, 2000; Curtis, Alexander, & Lunghofer, 2001; Whittaker, 2000; U.S. General Accounting Office, 1994; Curry, 1991; Lazelere, Dinges, Schmidt, Spellman, Criste, & Connell, 2001; Barth, 2002). Age, gender, intelligence, length of stay, and presenting problems are all weakly correlated to outcomes (Curry, 1991; Pecora et al., 2000).

Unfortunately, outcome studies of residential services vary widely in scope and suffer from an absence of control conditions, poorly defined service units, limited samples, improper selection of outcome criteria, and utility by practitioners (Whittaker & Pfeiffer, 1994). Those studies that do identify a comparison group often fail to control for the initial level of problems that the children present, making causality especially difficult to determine. Such gaps in research have posed a barrier to identifying best practices in residential services, which are exacerbated by the relative inattention by federal agencies and private foundations to new models of residential provision as compared to other types of out-of-home placement (Whittaker & Maluccio, 2002).

## Recommendations

To achieve more effective and efficient systems of care for children, youth, and families, both the agencies developing and controlling public policy and the service providers delivering the services need to work cooperatively. The following action steps are recommended:

### Public Policy

- Conduct initial and ongoing coordinated assessments where the operative question is not where does the child and family fit into the system, but rather which services in the system best fit the child's and family's strengths, needs, and permanency plan at the time. This would include assessing 1) the *supervision* required to ensure the safety of the child and those with whom the child interacts; 2) the *interventions* and *supports* necessary to ensure treatment needs are met; and 3) the *developmental needs* of the child and family system. Residential treatment would be used as the "treatment of choice" if so indicated by this comprehensive assessment.
- Promote the choice of *most appropriate and least restrictive* service for children and families, investing in time-limited intensive interventions at the outset and throughout the course of care if assessment dictates this is the best choice for dealing with trauma and/or keeping families together over the long haul.
- Revise policy and practice to acknowledge that some children and families will require services at various levels of intensity over time, and that this may be a decidedly nonlinear process. The goal is to provide appropriate (including appropriately limited) interventions at various points in time; to design each intervention as part of a continuous strategy of family stabilization so that past, present, and future interventions shape each other; and to manage helping resources for each family over time rather than seek quick-fix solutions.
- Retain an emphasis on family empowerment and family connections at all levels of service, with recognition that optimum connections may not mean that every parent and child lives together full-time or without ongoing support.
- Ensure the provision of care and support to families after the course of intensive services as a way of preventing costly future interventions as much as possible.
- Blend services so there are step-up, step-down, and wraparound options at all levels of intervention, and in particular so that the boundaries between home-based and out-of-home services are eliminated.
- Develop outcomes, including cost-benefit measures, not limited solely to discrete services but to long-range family stabilization and the real cost of services across time.

- Develop rate reimbursement methodologies that include *all* direct and indirect costs associated with providing quality care, treatment, and services.

## Service Providers

- Implement programs and practices that actively support family-centered services that maintain permanent family connections for all children.
- Develop new, structural partnerships among providers of residential services, referral and funding agencies, foster care and postadoption services, public schools and educational collaboratives, and inpatient and outpatient mental health providers to allow for greater access by all children, youth, and families to all of the services along the continuum at any given point.
- Increase capacity to provide services to those children and families with the most intensive needs.
- Commit resources to postdischarge continuity of care and provision of family supports for at least one year after children exit residential programs. Resources could include new professional opportunities for campus-based child care workers to learn how to be available to families in the community both during and after treatment.
- Develop more flexible methods of providing services and the duration of residential placement with much more of a presence in family homes, local schools, and other community resources.
- Develop universal outcomes to measure the effectiveness of residential services, including areas such as:
  - Clinical—Difficulty of the Child; Difficulty of the Family; GAF; Child Needs Checklist; and Family Needs Checklist.
  - Functional—Education; Employment; Recidivism – court and re-abuse.
  - Effectiveness of Placement—Restrictiveness of Placement; Nature of Discharge; Permanency Planning.
  - Consumer Satisfaction—Child over 12 years; Parent; Referring Entity

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