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

Executive Summary

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Introduction and background

Historically, group homes and residential treatment centers have been an important but controversial part of the child welfare continuum of services. As of September 30, 2014, 415,129 youth were in out-of-home care, with 23,233 (6%) placed in group homes and 32,955 (8%) placed in residential treatment and other institutions of some kind.[1] Note that sometimes some or all of these facilities are referred to as "congregate care."

States vary substantially in how extensively they use congregate care and for which groups of children and youth. Many states are focusing on more carefully using congregate care, including some as part of their Title IV-E waiver (e.g., Arizona, Delaware, Massachusetts, Rhode Island, and West Virginia). Group homes and residential treatment centers have been challenged to better define and standardize their intervention models and the youth they are best suited to serve. They have been asked to "right size" lengths of stay and to involve family members more extensively in treatment. Further they have been asked to do more than manage problem behaviors, including help youth heal and learn skills for managing their emotions and behaviors that they can use in the community. Lastly, child welfare needs to conduct more extensive evaluation studies of these programs.[2] This is a call to be more specific and targeted in order to better meet the needs of the children, youth, and families that receive services at this level of care.

The congregate care field has responded by improving many aspects of intervention design, implementation, staff development, and evaluation, including providing more after-care services — support services that follow youth into the community during the transition out of care.[3] But these agencies need funding to make some of these transformations, and states are working to determine what kinds of program models, funding mechanisms, and performance monitoring will make that reform possible.[4]

There has been a significant decrease in the percentage of children placed in congregate care settings in the past decade (34% from 2004 to 2013), and this reduction is at a greater rate than the overall foster care population (21%).[5] According to the most recent data available, children spend an average of eight months in congregate care (34% spent more than nine months). While these trends suggest that child welfare practice is moving toward more limited use of congregate care, the depth of improvement is not consistent across states, and some cohorts of children and youth have fared better than others.[6]

The full Casey Family Programs research brief summarizes key elements for effective therapeutic residential treatment and group home care — serving the right youth, with

the most appropriate interventions, for the shortest amount of time necessary to achieve key therapeutic and permanency planning goals.

The Research Brief begins with a national overview of who is being served in congregate care, including the behavioral health profiles and treatment needs of those children and adolescents. It then focuses on describing what interventions (including their duration) are associated with effective services for different kinds of youth needs. This is intended to help suggest what might be ideal lengths of stay for certain groups, recognizing that every family is unique. This executive summary includes a summary of the interventions and also describes key reforms for improving congregate care.

Rather than "congregate care," in parts of this executive summary and the full Research brief we will use a more precise term for a sub-group of these services*:* **therapeutic residential care (TRC)**. By this we mean group homes serving seven or more children, residential treatment centers, and psychiatric residential treatment facilities (PRTFs). PRTFs provide non-acute inpatient facility care for recipients who have a mental illness and/or substance abuse/dependency and need 24-hour supervision and specialized interventions.[7] We will not focus on shelter care because it is designed to serve as temporary housing for children and it has few therapeutic components, and because some states intend to significantly reduce shelter care by using other strategies to care for children in crisis situations. Psychiatric hospital programs will also not be a focus because they are a very intense and restrictive use of congregate care, limited to a very small group of youth with acute and severe problems. The brief also does not focus on secure detention and other forms of juvenile corrections placements.

Who is being served in congregate care and TRC? Youth characteristics

Using the National Child Traumatic Stress Network data set, Briggs et al. found that in a sample of 11,076 children who had experienced at least one traumatic event, (Mean X age: 10.6 years), the children served in residential treatment had greater functional impairment in all eight of the functional impairment areas they had examined (behavior, academic, attachment, running away, substance abuse, self-injury, suicidality, criminal activity).[8] In a recent landmark study, the U.S. Children's Bureau compiled key statistics to describe the youth being served in various forms of group care (including shelter care and maternity homes).[9] (See Figure 1.)

Figure 1. Cohort Trends in Congregate Care Use

Three cohorts of youth were followed for five years from the time they entered foster care for the first time in FFY 2006, 2007, and 2008 and were examined using our four-subgroup divisions. Of those who experienced some time in congregate care, on average about 41% were in Subgroup 1 (No Clinical Indicators), 20% in Subgroup 2 (DSM Indicator), 32% in Subgroup 3 (CBP Indicator), and 7% in Subgroup 4 (Disability Indicator). Given these similarities among cohorts, additional congregate care analyses only are reported for the most recent cohort (children and youth followed from 2008 to 2013).

The majority of the children in the 2008 cohort did not spend long periods of time in congregate care. Thirty-six percent spent 60 days or less in congregate care; 5% spent 61 to 90 days; and 35% spent 91 days to one year in that setting. Close to one-quarter (24%) spent more than one year in congregate care. On average, they spent nine months in congregate care (close to the average of eight months seen below); more than one-third (34%) spent more than nine months.[10]

In another examination, Point in Time (PIT) analyses enabled the Children's Bureau to see how congregate care was being used for all children in care on September 30, 2013 (i.e., the last day of the federal fiscal year (FFY) 2013). They used those analyses to answer the question: "What is the difference between children who do and do not experience congregate care?" They found that:

- Children in congregate care settings are almost 3 times as likely to have a DSM diagnosis compared to children in other settings.
- Children in congregate care settings are more than 6 times more likely than children in other settings to have "child behavior problem" as a reason for removal from home.
- On average, children spent a cumulative eight months in a congregate care setting compared to an average time in a particular placement type of 11 months for children in other settings.[11]
- The overall time in foster care was longer for children who spent some time in congregate care, with an average of 28 months compared to 21 months total time in foster care.[12]

The PIT analyses can over-represent youth who have been in care for longer time periods and youth who enter care toward the end of the federal fiscal year. Therefore, the Children's Bureau followed three cohorts of youth for five years from the time they entered foster care for the first time in FFY 2006, 2007, and 2008. This allowed for a better understanding of how many "new" entries into congregate care occur in a given year. (See Figure 1 above.)

The Children's Bureau also examined groups of youth by age and found that:

- Children 12 and younger made up an unexpectedly high percentage (31%) of children who experienced a congregate care setting. This concerning percentage of younger children in congregate care underscores the need for careful examination of this special group of children.
- Use of congregate care varies by state, and additional information on state practices, policies, and state-specific definitions of congregate care would provide important missing information. Twenty-one states had percentages of children 12 and younger in congregate care that were above the national average of 31%. States ranged from 6% to 69% of the 2008 cohort who were age 12 or younger and who experienced a congregate care episode.[13]

For children ages 13 and older, the findings below are troubling:

- Of the approximately 51,000 children age 13 years and older who entered foster care in 2008, about half (25,535) entered congregate care at some point. These older youth represent 69% of the children in congregate care.
- Among those, more than 4 in 10 entered due to a reported child behavior problem and no other clinical or mental health condition.
- About one-quarter (24%) entered a congregate care setting as their first placement.[14]

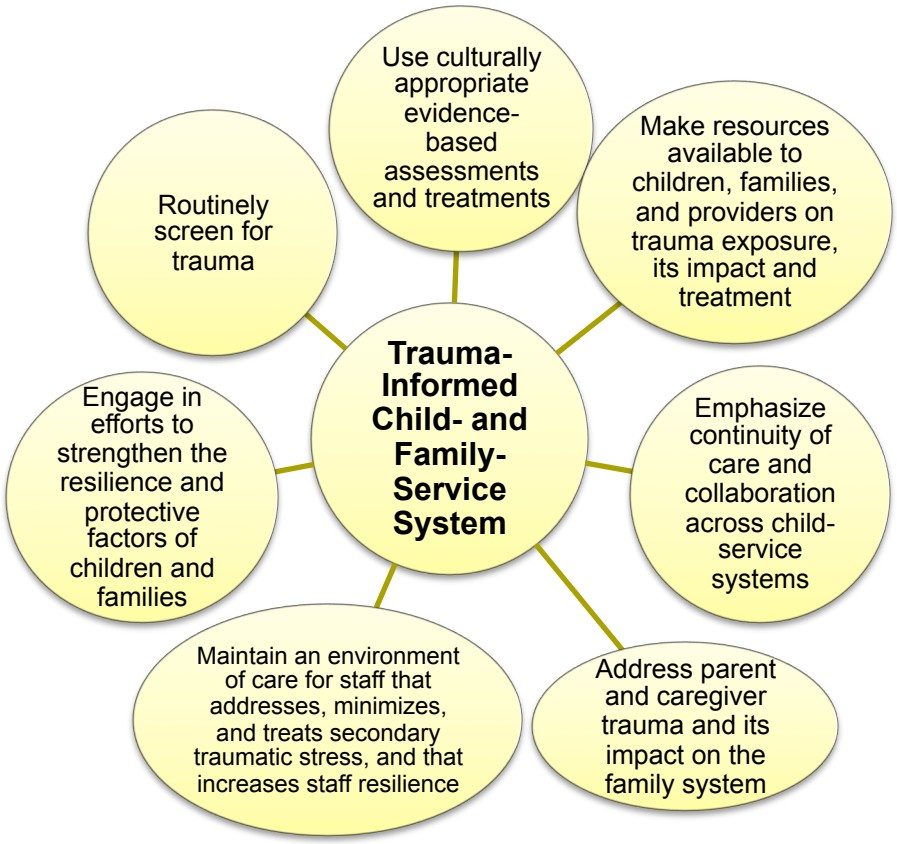
Trauma-informed care and other interventions

All areas of child welfare and behavioral health services (not just TRC) should more fully implement trauma-informed care approaches, including those addressing trauma caused by system factors such as poorly handled initial child placement and maltreatment by foster parents, and complex trauma as a specialty area. (See Figure 2.) Typically, complex trauma exposure involves the simultaneous or sequential (long-term) occurrence of child maltreatment; it may include psychological maltreatment, neglect, physical and sexual abuse, poly-victimizations,[15] and witnessing domestic violence. The factors associated with complex trauma include:

- Chronic exposure
- Early childhood occurrence, and
- Occurrence within the child's primary caregiving system and/or social environment

Exposure to these initial traumatic experiences, the resulting emotional dysregulation, and the loss of safety, direction, and the ability to detect or respond to danger cues may impact a child's development over time and can lead to subsequent or repeated trauma exposure in adolescence and adulthood without supports that might buffer the negative effects.[16]

Figure 2. Elements of a Trauma-Informed Child- and Family-Service System According to the National Child Traumatic Stress Network



Source: National Child Traumatic Stress Network (NCTSN) (undated). *What is a Trauma-Informed Child- and Family-Service System?* Accessed online on 8/31/2015 at http://nctsn.org/resources/topics/creating-trauma-informed-systems

Interventions that are effective or relevant for TRC

Based on a review of the literature and selected conversations with experts from the U.S. and overseas, the interventions highlighted in Table 1 are especially effective or relevant for therapeutic residential care (TRC). We also indicate how each of these interventions were rated by the California Evidence-Based Clearinghouse for Child Welfare (CEBC) according to their established criteria using the three highest levels of effectiveness for the CEBC classification system as follows:[17]

1. **Well-Supported by Research Evidence**: Sample criteria include multiple-site replication and at least two randomized control trials (RCTs) in different usual care or practice settings that have found the practice to be superior to an

appropriate comparison practice. The RCTs have been reported in published peer-reviewed literature. (Marked with three asterisks below Table 1.)

2. **Supported by Research Evidence**: Sample criteria include at least one RCT in usual care or a practice setting that has found the practice to be superior to an appropriate comparison practice. The RCT has been reported in published peer-reviewed literature. In at least one RCT, the practice has shown to have a sustained effect at least one year beyond the end of treatment. (Marked with two asterisks.)

3. **Promising Research Evidence**: Sample criteria include at least one study utilizing some form of comparison (e.g., untreated group, placebo group, matched wait list) that has established the practice's benefit over the comparison, or found it to be equal to or better than an appropriate comparison practice. In at least one RCT, the practice had a sustained effect for at least six months beyond the end of treatment. (Marked with one asterisk.)

In the full Brief, for each intervention, we cite the problem area addressed, age range and the length of treatment. The next section presents information to help answer this question: *For what kinds of youth needs are certain interventions most effective?* For some intervention ratings, we drew from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Effective Programs (NREP), where the quality of the research studies reviewed is rated on a 4-point scale, the "BLUEPRINTS" intervention registry, or the Office of Juvenile Justice and Delinquency Prevention (OJJDP).[18] Interventions that were not able to be rated due to a lack of evaluation data are marked as such (NR: Not able to be rated).

In some cases, the evidence base for the effectiveness of a particular intervention within a TRC environment is sparse, so we rely on the research evidence indicating that the intervention is effective for a particular problem or area of functioning that youth in TRC typically have, and various meta-analyses that have reported intervention effect sizes.[19] Brief descriptions of each of these interventions are included in the full research brief in Appendix A. Recent reviews by Sigrid James and her colleagues have highlighted many of the same interventions.[20] A list of skill domain areas and intervention types that are recommended for them are contained in Appendix B in the full research brief. With the exception of Multi-Systemic Therapy (MST) for sexual aggression or the more general MST intervention used to help facilitate family reunification,[21] we did not include interventions that use a home-based or in-home intervention strategy or are focused on attachment issues in children ages birth to 5 because nearly all children in that age range can and should be provided for in an outpatient, birth family, kinship family or treatment foster home setting. These home and community-based interventions include

programs such as *Circle of Security Parenting (COS-P), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Coping Power Program, imagery rehearsal therapy, life story intervention, Parent-Child Interaction Therapy (PCIT), Parent Management Training – Oregon Model (PMTO), Positive Parenting Program (Triple P), prolonged exposure therapy for adolescents, Problem-Solving Skills Training (PSST), Promoting Alternative Thinking Strategies (PATHS), risk reduction through family therapy, Seeking Safety, The Incredible Years (IY), the 3-5-7 Model, therapist web-assisted treatment, trauma-focused art therapy,*[22] and *Treatment Foster Care Oregon – Adolescents (TFCO).* Some of these programs were recently highlighted as effective "disruptive behavior treatments" for youth with externalizing behaviors.[23]

What this rich array of interventions offers the TRC field is the ability not only to focus on controlling youth behavior but also to address their underlying therapeutic treatment issues. Caution needs to be exercised in using Table 1 and the longer reference table in Appendix A in the full research brief because a child's intervention must be tailored to the needs of that child and his or her family. An intervention designed for one treatment stage or setting may not be appropriate for another. For example, Real Life Heroes (RLH) was specifically developed to help traumatized children who were not improving with cognitive behavioral therapies and other trauma-informed interventions that focused primarily on the child's development of self-regulation skills and desensitization to traumatic memories and reminders.[24]

Table 1. Program models and interventions that appear to be effective or relevant for therapeutic residential treatment and group care (References are included in the full Research Brief.)

TRC Program Models	
Supported	• Positive Peer Culture (PPC)
Promising	• Boys Town Family Home Program℠ and Teaching Family Model (TFM) • The Sanctuary Model • The Stop-Gap Model
Not Able to Be Rated Because of Insufficient Research Evidence At This Time	• Menninger Clinic Residential Treatment Program Model (RTAP) • Multifunctional Treatment in Residential and Community Settings (MultifunC) • Re-ED (originally called Re-Education of Children with Emotional Disturbance)

TRC Interventions (CEBC, Blueprints, OJJDP or SAMHSA NREP Ratings)	
Well-Supported	
• Attachment Biobehavioral Catch-up (ABC) • Cognitive Behavioral therapy (CBT) • Cognitive Processing Therapy • Coping Cat • Ecologically-Based Family Therapy	• Eye movement desensitization and reprocessing (EMDR) • Multisystemic Therapy (MST) for Youth with Problem Sexual Behavior • PAX Good Behavior Game (PAX GBG) • Trauma-Focused Cognitive Behavioral Therapy
Supported	
• Adolescent Community Reinforcement Approach • Aggression Replacement Therapy (ART)(OJJDP rated it as effective) • Brief Strategic Family Therapy • Cognitive Behavioral Therapy (CBT) for Adolescent Depression(NREP rating 3.4-3.7) • Dialectical Behavior Therapy (DBT) • Ecologically-Based Family Therapy	• Functional Family Therapy • Moral Reconation Therapy(NREP ratings 1.9-2.0) • Structured Sensory Intervention for Traumatized Children, Adolescents and Parents – At-risk Adjudicated Treatment Program (SITCAP-ART)(NREP 2.5 rating) • Trauma Affect Regulation: Guide for Education and Therapy (TARGET)(NREP ratings 3.0 - 3.2)
Promising	
• Anger Replacement Training® (ART®) • Adolescent Coping with Depression(NREP ratings: 3.6 – 3.8) • Interpersonal Psychotherapy for Depressed Adolescents (IPT-A)	• Residential Student Assist Program (RSAP) (OJJDP rated it as effective) • Solution-Focused Brief Therapy (SFBT)(OJJDP rated it as promising) • Theraplay

Table continues on next page

Not Able to Be Rated Because of Insufficient Research Evidence At This Time	
• Anger Management Group Treatment Model • Applied Behavior Analysis (ABA) approaches with Individualized Intensive Behavioral Interventions (IBI) • Attachment, Regulation and Competency (ARC) • Biofeedback and Neurofeedback • Complex Trauma Treatment • Equine Therapy • Focused ABA interventions	• Music Therapy • Real Life Heroes • Sensorimotor techniques • Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) • *Therapeutic Crisis Intervention (TCI)* • Trauma Systems Therapy (TST) • Trust-Based Relational Intervention (TBRI®) Therapeutic Camp

Things to consider doing to improve TRC

Much of previous work cited in this brief has spanned both congregate care and the more specific TRC programs. As highlighted by Ainsworth, James, Whittaker and others, we are suggesting that refinements be made in the terminology for this area, and will now focus on issues related more to TRC.[25] A number of policy-makers are calling for TRC to be reserved for the short-term treatment of acute emotional and behavioral health problems to enable stability in subsequent community-based settings.[26] Program and legislative reform provisions for therapeutic residential treatment and group care must be comprehensive because reductions in the use of residential treatment and group home care are dependent upon other system reforms and services. These reforms go beyond the walls of TRC agencies, and thus we have identified what some of those other reforms should be (see the Casey Research Brief for references):

1. Understanding your community's data — who is being placed in specific types of TRC and other forms of congregate care, including emergency shelter care? For whom is congregate care being used as a first placement and *why*? Are there differences in utilization patterns by type of child functioning or problem areas? What kinds of transfers are occurring in terms of moves from birth family care to TRC or from foster family care to TRCs? A number of experts caution that strategies to address each of these uses of TRC and other forms of congregate care may be distinctly different.[27] And failure to consider "down-stream" implementation side-effects and barriers may undermine the best-intentioned reform efforts if foster parents or essential after-care services become overwhelmed.
2. Increasing the availability of "up-stream" community-based prevention services, including in-home parent coaching and interventions for families in crisis such as

Functional Family Therapy (FFT), Intensive Home-Based Services, and Multi-Systemic Treatment (MST).

3. Improving multi-dimensional assessment for intervention targeting.
4. Using multi-disciplinary teams and team decision-making to carefully assess child needs and make child placement decisions. (Team meetings that are co-led by families can more accurately specify what needs to be addressed and the clinical interventions that may be needed.)
5. Improving kinship care licensing by offering rent deposits, house modifications, transportation supports, and other strategies to ensure timely availability of relative caregivers. Provide those kinship parents with the clinical supports they need to parent effectively if the child's needs outstrip current kin caregiver skill levels.
6. Expanding the supply of treatment foster homes, including those involving kinship caregivers.
7. Reinforcing the philosophy that children belong with families, and shift workers are never sufficient — even if a child is "safe" and "stable."
8. Setting aggressive targets for reducing the number of children placed in shelter care and TRC by shortening length of stay whenever clinically possible. Related to this is distinguishing dosage and intensity from length of treatment or level of restrictiveness. For example, length of stay is not a substitute for providing the right overall dosage or intensity of an intervention.
9. Providing foster parent supports, as well as interventions designed to prevent a child's behavior problems from escalating, such as FFT, HOMEBUILDERS, MST or Project KEEP, because some youth escalate into TRC after a placement disruption.
10. Refining the array of clinical interventions in TRC to better meet the needs of the children, including careful use of psychotropic medications.
11. Offering financial incentives and support to help TRC agencies make the transition to becoming providers of aggressive family finding, wraparound, family team decision-making, youth emancipation, respite and other key services.
12. Using refined performance metrics and redesigned performance-based contracting fiscal incentives to achieve the reform targets.
13. Making assertive permanency planning efforts if a child is placed in TRC.
14. Training juvenile court judges about key values and the most effective community and TRC strategies, because some judges order TRC or other forms of congregate care placements without full consideration of other options.

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

Summary and conclusions

A review of the literature on congregate care and the subset of TRC programs suggests ongoing calls for reform in both the utilization of and services provided by these agencies. National data indicate the majority of youth served in TRC settings are adolescents (69%), while a concerning 31% are under the age of 13 years. Furthermore, for 1 in 4 youth TRC is a first placement, and 40% have no clinical level indictors that suggest this level of care is needed. However, data also suggest that youth who are referred to TRC are 3 times more likely to have a DSMIV classification and 6 times more likely to have behavior problems than youth referred to lower levels of care in the community.

While these data suggest that TRCs are serving more youth with higher level mental health and behavioral concerns, it is unclear whether with appropriate community-based services that these youth could be served in their communities. Questions about level of care need and type are especially relevant when cohort analyses reveal that 4 out of 6 youth served in these facilities do not have any clinical indicators, and 2 out of 3 youth did not have any indicators for behavior problems that would automatically warrant higher levels of care.

As discussed more extensively in the full research brief, evidence regarding the effectiveness of congregate care and the subset of TRC programs is limited. Research that is available is mixed: some studies show improvements in functioning; however, in some studies these improvements are not necessarily retained upon re-entry into the community and/or sustained long term.[28]

However, more encouraging research suggests that additional service components could improve outcomes, including increased family involvement and after-care supports that include promotion of stable placements when a child/youth returns to the community. Reviews of TRC services have identified treatment goals, principles of practice, and effective clinical approaches that may improve outcomes. These reviews include recommendations regarding an increased focus on trauma-informed care. The research focusing on treating special issues for latency age youth appears to be a promising approach — services that address issues earlier rather than later.

We believe that with appropriate services, more of these youth could be served effectively in their communities, especially with short-term in-patient and follow-up coordinated step-down services in the community. But additional research is needed. In fact, research on effective interventions that could be used more broadly than as just part of TRC appears more promising, especially since these services can be used in residential as well as community-based settings.

It is interesting to note that the interventions that are considered "well-supported" primarily focus on clinical level anxiety and depression (ABC, CBT, Coping Cat and EMDR), while two promising programs focus on PTSD (EMDR and Trauma-Focused Cognitive Behavioral Therapy or TF-CBT). About one-half of the "supported" EBP's focus on mental health issues, and the others focus on risk behaviors. An interesting question is whether there is a match between needs and services for the children and youth assigned to different facilities that offer different service interventions — for example, are youth with behavior problems assigned to programs that have EBP's that address behavior problems?

The full research brief summarizes key elements of effective practice that are based on the needs of children and youth referred to therapeutic residential treatment and group home care. We also describe how certain interventions and broader systems reforms, when implemented together, can help ensure that the right youth are served in TRC, with the most appropriate interventions, and for the shortest amount of time necessary to achieve key safety, therapeutic and permanency planning goals. Key concerns are being raised about the consistency, quality and effectiveness of TRC services, and they should be thoughtfully addressed.

Experts in TRC interventions and models have identified evidence that supports the potential for community-based services, including programs such as the Multi-Dimensional Treatment Foster Care that targets key traumas and risk behaviors identified for youth with higher needs. Based on the characteristics of the population of children served by TRCs, all programs should include therapeutic elements to address social, emotional and behavioral management issues for children/youth served in these programs. Also important in the discussion about TRC components of practice is an understanding of the larger service context within which TRC services exist. Understanding and addressing these larger contextual issues can only improve the likelihood that TRC services, as an integrated part of an overall service system, will improve the outcomes for children/youth served by child welfare systems. Of particular importance is the need for comprehensive assessments to identify individual youth and family needs, as well as providing information on an aggregate level to assist in planning the number of types of services needed. More targeted services, along with a philosophy of permanency for all youth and use of data to inform the development of service approaches, can only increase the likely effectiveness of these programs

Our review found a range of interventions, many of which can be delivered in two to six months. But we also found a lack of rigorous outcomes research for many interventions that would (1) provide key information to help guide the field in which interventions are especially effective for addressing which youth treatment needs, and (2) enable them to be more fully rated by various practice registries.[29] Stated another way, while an array of promising and experience-informed interventions are available, we need more research that better specifies which interventions are most effective for which youth needs, and how to best sequence and combine them.

Endnotes

1. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2015). *The AFCARS report - Preliminary FY1 2014 Estimates as of July 2015.* (No. 22) Retrieved 9-27-2015 from http://www.acf.hhs.gov/programs/cb/resource/afcars-report-22
2. See for example:
   - The Annie E. Casey Foundation. (2010). *Rightsizing congregate care: A powerful first step in transforming child welfare systems*. Retrieved from http://www.aecf.org/~/media/Pubs/Topics/Child%20Welfare%20Permanence/Foster%20Care/RightsizingCongregateCareAPowerfulFirstStepin/AECF_CongregateCare_Final.pdf
   - Jenson, J. M., & Whittaker, J. K. (1987). Parental involvement in children's residential treatment: From pre-placement to aftercare. *Children & Youth Services Review, 9*, 81-100.
   - Kerman, B., Maluccio, A. N., & Freundlich, M. (2009*). Achieving permanence for older children and youth in foster care.* New York: Columbia University Press.
   - Pecora, P. J., Whittaker, J. K., Maluccio, A. N., Barth, R. P., & DePanfilis, D. (2009). *The child welfare challenge.* (3rd ed.) Piscataway, NJ: Aldine-Transaction Books.
3. See for example:
   - Courtney, M. E., & Iwaniec, D. (eds.) (2009). *Residential care of children: Comparative perspectives*. New York: Oxford University Press.
   - Whittaker, J. K. et al. (2006). Integrating evidence-based practice in the child mental health agency: A template clinical and organizational change. *American Journal of Orthopsychiatry*, 76(2), 194-201.
   - Whittaker, J. K., del Valle, J. F. & Holmes, L. (2015). Therapeutic residential care for children and youth: Developing evidence-based international practice. London, UK: Jessica Kingsley.
4. See:
   - The American Association of Children's Residential Care Agencies. (2011). *Redefining residential series: One through eight.* Milwaukee, WI. Retrieved from http://aacrc-dc.org/page/aacrc_position_paper_first_series_redefining_role_residential_treatment
   - The Annie E. Casey Foundation. (2010). *Rightsizing congregate care: A powerful first step in transforming child welfare systems*. Retrieved from http://www.aecf.org/~/media/Pubs/Topics/Child%20Welfare%20Permanence/Foster%20Care/RightsizingCongregateCareAPowerfulFirstStepin/AECF_CongregateCare_Final.pdf.
5. See an infographic produced by the U/.S. Children's Bureau at https://www.childwelfare.gov/fostercaremonth/promote/congregate-care-infographic/
6. Proportionately, children in congregate care composed 18% of the foster care population in 2004 and 14% in 2013 — a notable decrease. Additionally, over the past 10 years, the number of children and youth in the child welfare system on the last day of the FFY declined by 21%, from 507,555 in 2004 to 402,378 in 2013. Comparatively, the number of children in care on the last day who were placed in a group home or institution decreased by 37% (a decline from 88,695 to 55,916). U.S. Children's Bureau.

(2015), (pp. i and ii). Also see Wulczyn, F., Alpert, L., Martinez, Z. & Weiss, A. (2015). *Within and between state variation in the use of congregate care.* Chicago, Chapin Hall Center for Children, The Center for State Child Welfare Data. Wulczyn and his colleagues found counties that used very little congregate care and counties where nearly 9 out of 10 children entering out-of-home care were placed in a non-family setting (p.1).

7. For PRTF service requirements, coverage criteria and limitations, refer to Clinical Coverage Policy #8D-1, *Psychiatric Residential Treatment Facilities*
8. Briggs, E.C., Greeson, J.K.P., Layne, C.M., Fairbank J.A., Knoverek, A.M., & Pynoos, R.S. (2012) Trauma exposure, psychosocial functioning, and treatment needs of youth in residential care: Preliminary findings from the NCTSN Core Data Set. *Journal of Child and Adolescent Trauma*, 5: 1-15. See page 7.
9. For the federal analysis, congregate care was defined as a placement setting of group home (a licensed or approved home providing 24-hour care in a small group setting of 7 to 12 children) or institution (a licensed or approved child care facility operated by a public or private agency and providing 24-hour care and/or treatment typically for 12 or more children who require separation from their own homes or a group living experience). These settings may include child care institutions, residential treatment facilities, or maternity homes. The Children's Bureau found that although all states submit placement data gathered in accordance with Adoption and Foster Care Analysis and Reporting System (AFCARS) definitions, many have developed their own levels of care within those categories. See http://www.acf.hhs.gov/programs/cb/success-story/congregate-care, page 1.
10. U.S. Children's Bureau. (2015). Pages ii and iii.
11. Length of time was calculated by totaling all time in a particular placement type during the course of a child's entire first removal episode. This accounts for placement moves and provides a better picture of the actual overall time spent in a setting type.
12. U.S. Children's Bureau. (2015). *A National Look at the Use of Congregate Care in Child Welfare.* Washington D.C.: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. Page ii. Retrieved August 23, 2015 from: http://www.acf.hhs.gov/programs/cb/resource/congregate-care-brief
13. U.S. Children's Bureau. (2015). Page iii.
14. U.S. Children's Bureau. (2015). Page iii.
15. Finkelhor, D., Ormrod, R.K. & Turner, H.A. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse & Neglect*, (31), 7–26.
16. Center for Early Childhood Mental Health Consultation, adapted from Blumenfeld, et al, 2010; http://www.ecmhc.org/tutorials/trauma/mod1_2.html
17. See http://www.cebc4cw.org/. And for more complete definitions, see http://www.cebc4cw.org/ratings/scientific-rating-scale/
18. http://www.blueprintsprograms.com/ Office of Juvenile Justice and Delinquency Prevention (OJJDP) (n.a). From http://www.ojjdp.gov
19. For examples of meta-analyses reporting intervention effect sizes, see:
    - Lee, B. R., Bright, C. L., Svoboda, D. V., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*(2), 177-189. doi:10.1177/1049731510386243
    - Leenarts, L.E.W., Diehle, J., Doreleijers, T.A.H., Jansma, E.P., & Lindauer, R.J.L., (2012). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: a systematic review. *European Child Adolesc Psychiatry* 22, 269-283.
20. For recent reviews of the utilization and effectiveness of EBPs in TRC, see:
    - James, S. (2011a) What works in group care? A structured review of treatment models for group homes and residential care. *Children and Youth Services Review 33*, 301–321.
    - James, S., Alemi, Q. and Zepeda, V. (2013) Effectiveness and implementation of evidence-based practices in residential care settings. *Children and Youth Services Review 35*, 4, 642–656.
    - James, S., Thompson, R. et al. (2015). Attitudes, perceptions and utilization of evidence-based practices in residential care. *Residential Treatment for Children and Youth*, 32(2), 144-166.
21. There is an MST adaptation for congregate care developed by Eric Trupin at the University of Washington, Department of Psychiatry called MST-FIT. MST-FIT aims to start working with youths and families prior to the youth's release from residential treatment and juvenile correction services.

The model is described in the "MST Adaptations" document on the MST website (mstservices.com) and also in this article: Trupin, E. J., Kerns, S. E. U., Walker, S. C., DeRobertis, M. T., & Stewart, D. G. (2011). Family integrated transitions: A promising program for juvenile offenders with co-occurring disorders. *Journal of Child & Adolescent Substance Abuse, 20,* 421-436. FSRC Publication #399. Also, the MST parent organization has standard MST programs within provider organizations that also provide residential treatment services (Personal communication, Scott W. Henggeler, Nov. 13, 2015).

22. See for example, Leenarts et al. (2012).
23. Chadwick Center and Chapin Hall (2016), p. 6. Also see the CEBC's Disruptive Behavior Treatment topic area (http://www.cebc4cw.org/topic/disruptive-behavior-treatment-child-adolescent)
24. Kagan, R., & Spinazzola, J., (2013). Real life heroes in residential treatment: Implementation of an integrated model of trauma and resiliency focused treatment for children and adolescents with complex PTSD. *Journal of Family Violence* 28: 705-715. Page 707.
25. Ainsworth, F., & Hansen, P. (2005). A dream come true–no more residential care: A corrective note. *International Journal of Social Welfare, 14*(3), 195–199; James (2011, 2013); Whittaker, del Valle & Holmes (2015).
26. Blau, G., Caldwell, B., Fisher, S. K., Kuppinger, A., Levinson-Johnson, J., & Lieberman, B. (2010). The Building Bridges Initiative: Residential and community-based providers, families and youth coming together to improve outcomes. *Child Welfare, 89*(2), 21–38.
27. See Chadwick Center and Chapin Hall (2016), pages 8 and 9.
28. Sunseri, P.A. (2005) Children referred to residential care: Reducing multiple placements, managing costs and improving treatment outcomes. *Residential Treatment for Children & Youth*, (22)3, 55-66.
29. Many of these limitations have been raised in relation to psychotherapy for children and adolescents. For example, see Schmidt, S., & Schimmelmann, B.G. (2013) Evidence-based psychotherapy in children and adolescents: advances, methodological and conceptual limitations, and perspectives. *European Child & Adolescent Psychiatry,* (22), 265-288.

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