Institutions *vs.* Foster Homes

The Empirical Base for a Century of Action

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Executive Summary

The debate about the role of institutional care vs. family-centered care is well into its second century. Institutional (or group) care has many forms and purposes, including serving as a component of the child welfare services system of care and as a treatment component of the children's mental health systems system of care. Within the child welfare role, institutional care may be used as a large or small shelter care facility, as a place for children to go when family care is not immediately available, and as a place where children go who have not been able to be maintained in foster family care. The varied roles of institutional care make an analysis of its efficacy difficult. This is made more difficult because of the lack of third-party studies of institutional care and, more generally, of out-of-home care.

Children in Group Care

One of the justifications for placing children in group care is that their behavior is substantially worse than could be managed in foster care. Recent evidence indicates that the children in group care are older and, in general, have more problems than children in kinship care of foster care. Yet, there are children served in foster care and kinship care who do not have significantly worse developmental and mental health conditions than children in group care.

Perceptions of Group Care

Because of the scarcity of research on the outcomes of different types of out of home care, perceptions of out of home care become a useful source of data. Children and youth have quite negative perceptions of group care (compared to foster care or kinship foster care). Even child welfare workers do not have uniformly positive views of the quality of community based group care, indicating that it is often poorly run. From the perspective of research on parenting and on efficacious mental health counseling, group care appears to have a low likelihood of being able to provide a powerful and positive intervention. The Surgeon General's Report on Children's Mental Health (US DHHS, 2000) confirms this theoretical analysis, finding little to recommend about group care. From the perspective of providers, however, residential treatment centers are quite successful at accepting children who come from, or would go to, higher levels of helping them step down to less restrictive settings.

Outcomes of Out of Home Care

This review considered four components of service outcomes: safety and well-being of children while in care, permanence/re-entry from care, long-term success of children in out of home care, and the costs of out of home care.

Children in institutional care may experience less chance of abuse or neglect while in care, although the rates of abuse of children in all forms of care are low. Children in group care almost certainly also have fewer interpersonal experiences that support their well-being, including the chance to develop close relationship with a significant individual who will make a lasting, legal commitment to them. These disadvantages of group care for developing relationship skills may hold for children of all ages, but are most clearly demonstrated for young children. For more than 50 years, a variety of studies have shown that young children fare better in family like settings than in institutional care.

Although educational problems are endemic to children in out-of-home care, these may be exacerbated for children in group care because such placements limit the options of children to be involved with such positive aspects of the schools as extra-curricular activities. The opportunity that group care programs have to provide educational instruction with greater individualized attention appears not to be consistently realized. This is in part because the high levels of structure make it very difficult to allow children to pursue their individual development in academic and extra-curricular activities.

Placement Stability and Re-Entry

There is little solid evidence about the stability of placements in different types of placements. Kinship care and treatment foster care may have lower placement disruption rates, although the evidence is difficult to interpret with confidence.Youth exiting from group care and from foster care are more likely to be reunified than children in kinship care. Children who leave group care to reunification have higher re-entry rates than children in other types of settings. Family-centered residential care is evolving as a component of the mental health services system of care, and appears to have a positive impact on the likelihood of a successful reunification.

Long-Term Success/Adult Outcomes

An important review of studies on the outcomes of out-of-home care indicates that young adults who have left group care are less successful than those who have left conventional care—a finding which is likely to be partially attributable to the selection of more troubled children into group care. Yet, recent evidence does indicate that the youth in group care and other forms of out of home care, at one year following placement, have poorer scores on developmental measures. Because of its structure and the expectation that group care will take total responsibility for the child (McKenzie, 1999), group care often fails to provide real life opportunities—like doing chores or preparing or purchasing food—that youth need to prepare for independent living.

Cost

The costs of institutional care far exceed those for foster care or treatment foster care. The difference in monthly cost can be 6 to 10 times as high as foster care and 2 to 3 times as high as treatment foster care. Since there is virtually no evidence that these additional expenditures result in better outcomes for children, there is no cost-benefit justification for group care, when other placements are available.

Policy and Program Implications

Alternatives To Group Care Should Be Pursued

Evidence from a few studies indicates that foster care and treatment foster care are more desirable and efficient than institutional care and their development should be treated as the priority of policy makers and program developers. The budgetary commitments to group care are substantially greater than they are to any other form of out of home care—a situation that should be examined and corrected in a variety of ways.

Centralized emergency shelters are not a necessary or efficient way to bring children into out-of-home care. Many municipalities have stopped using centralized emergency shelters and successfully provide entry into care on an emergency basis, provide comprehensive assessments of the children, and take care to make appropriate and safe placements into foster family homes. Receiving centers are a relatively new component of the child welfare services system of care that can supplement the traditional placement process in order to provide some of the functions of emergency shelters without the costs or risks. Other alternatives to shelters can be pursued.

Special Problems Group Care Can Help Address

Group care can provide services that may be more difficult to successfully provide for some special groups of youth. Youth who have previously run away from foster care may be more able to be served in a more remote or highly supervised setting. Youth who are destructive or self-destructive may also need a more restrictive setting, although some treatment foster homes can also serve this population of youth. Youth who are in process of stepping down to their home from more restrictive mental health or probation settings may benefit from a family-centered group setting until parental and community supports are in place.

Summary

Placement in group care settings is not an essential component of child welfare services systems of care for the vast majority of children. There is no substantial evidence to support the necessity or value of large centralized emergency shelters or residential treatment centers for most children involved with child welfare services. The costs of these placements are so much higher than other placements, yet their efficacy appears to be no greater. Therefore, their use cannot be justified on a cost-benefit basis if any other levels of care can provide a safe place for children.

Institutions vs. Foster Homes
The Empirical Base for a Century of Action

Section 1. Background

Concerns about the role of institutional care for children are as old as the institutions. More than a third of a century ago, Wolins and Piliavin (1964) summed up a century of debate on institutional care and foster care, indicating that there is a role for excellent institutional and foster care tailored to the needs of the children they serve. Since their important treatise, new evidence has emerged to reflect on this continued debate. The review is particularly important because of the continued, and possibly accelerating, challenges of finding enough qualified foster parents—since labor force participation and adoption by foster parents are pressuring the supply of foster parents.

The direct information on this question is very limited. There are almost no studies that rigorously compare outcomes for residential care and foster care among youth (cf. Chamberlain, 1998) and there are none that make that comparison for children in child welfare services (a very few studies look at this issue for children receiving mental health or juvenile justice services). There are studies that loosely compare outcomes for children who emancipated from care after spending substantial time in group care vs. foster home care (reviewed by McDonald, et al., 1996) but those studies fail to adequately address the selection bias—the evidence that youth who reside in group care have more problems than youth in foster care. Almost nothing has been done to address the results of placing younger children in group care, although several states have now constrain this practice (e.g., California and Wisconsin), based on the developmental theory that young children should have the chance to develop relationships with a primary caregiver rather than with shifts of child care workers (Berrick, et. al., 1997).

Still, questions continue to arise about the benefits of group home care vs. foster care. For example, in 2001, Colorado and Florida entertained legislative initiatives to give placement in group care far greater likelihood for children who were experiencing some foster care placement instability. The apparent rationale for these proposals is that group care is more stable, at least for children who are experiencing some placement instability, than foster care and that group care is safer than foster care (because there are typically more licensing regulations that govern group care).

In this discussion all of institutional care will be treated as conceptually related because it is primarily provided by shifts of unrelated caregivers. Yet this analysis will be more useful by optimizing the level of detail that is available, because group care provided at the entry into foster care is likely to have a different form and significance from group care provided much later in a child's placement career. The paper will endeavor to make distinctions between "shelter care" (which is planned to be short-term and transitional with primary goals of protection and assessment, see the glossary) and "residential care/group care" (which is intended to provide shelter and change behavior). Although there are likely to be important differences in service delivery between larger campus-based institutions and smaller (6–8 bed) community-based group homes and institutions with and without their own nonpublic schools, there is virtually no research that makes these distinctions.

This analysis necessarily considers placements or services that are alternatives or supplements to foster care and to group care. These include kinship foster care, treatment/specialized foster care and receiving centers, which inform this debate because they represent important alternatives to the standard approaches to placement. (These are also briefly described in the Glossary.) For the most part, the research on institutional care does not dis-

tinguish between small and large institutional care arrangements. One exception involves several program specific studies conducted at larger residential treatment centers (RTCs). In a very few studies, when there is information that the data were collected with regard to smaller community-based group homes, this distinction is preserved in this report. Otherwise, the terms "Institutional Care" and "Group Care" are used to discuss the general phenomena of placements that have shift care provided by adults who are unrelated to each other or the children in their residence.

1.1 Types and Uses of Institutional Care

The many forms and uses of institutional care present substantial challenges to contrasting the role and functioning of institutional care with other forms of out of home care. In many cases, children will pass through a "children's shelter" in route to another kind of more family like care. These stays may only be a few hours or days, but may also last as much as a month or year. A primary reason for originating this review is concern about the use of large group care facilities for emergency shelter—a practice abandoned in many jurisdictions, in favor of using smaller units of care like foster homes or community-based group homes. Because shelter care has received the least of the little research done on group care, many of the conclusions from this report will have to rely on inferences from other tangential sources of evidence to the shelter care debate.

In many municipalities, group care is principally intended to provide intensive mental health services, replete with consistent and high quality psychopharmacological therapeutic interventions and is used as a placement of last resort. In other communities, group care is more often than not the first placement after entering care (Webster, 1999). Much of the critique of group care—most notably, in the Surgeon General's report on children's mental health (U.S. DHHS, 2000) is a critique of group care's role in mental health services.

Group care may be used in some other way—neither very therapeutic nor short-term. In such instances, group care use may be for children without mental health problems who are assigned to group care because no foster care placement was immediately available or developed (Fisher, 2001). We do not know how often this occurs, but the evidence from recent studies indicates that many children are in group care with levels of problems that are not very different from children, of the same age, who are in foster care or kinship foster care. This suggests that the decision to place a child in group care was not entirely or largely based on the youth's need for treatment or a more restrictive setting. Some of these findings are reviewed, next.

1.2 Background on Group Care and Placement Processes

This section provides background information about the children in group care and family foster care. The perspectives of four key stakeholders—children, child welfare workers, researchers, and residential treatment providers—are also described. Each of these analyses stands on a very small research platform.

1.2.1 How Different Are Children in Institutional Care?

Some of the rationale for use of group care as part of the child welfare services continuum of care is based on the assumption that children who are in group care are different than children in other settings. Although they are clearly older than other children, the evidence that they have worse behavior is less clear (NSCAW, 2002). In the NSCAW sample of children in out of home care for one year, children in group care at the time of the assessment had significantly more behavioral and cognitive scores in the borderline or clinical range (see Exhibit 1). This appears, however, to be so because the group care setting provides care for older children. After controlling for age, children in group care do not appear to have higher clinical scores than children of the same

age who experienced the same abuse types and who now reside in kinship or non-kinship care.

The NSCAW (2002) report also compares the scores of all the children in the sample (n=727) to each other by converting their measures to z-scores. Z-scores have a mean of zero and a standard deviation of 1. Z-scores were worse for youth in group care (Mean = -.42) than for those in foster homes (-.09) or kinship care (.19). This analysis complements the one depicted in Exhibit 1, which is based on scores that compare the children to test norms. Using z-scores shows that children in group care are scoring substantially worse on standardized measures from other children in the study. Another difference between children in group home care is that these children are 3.5 Xs more likely to have experienced sexual abuse (27%) than children who reside in foster care or kinship care.

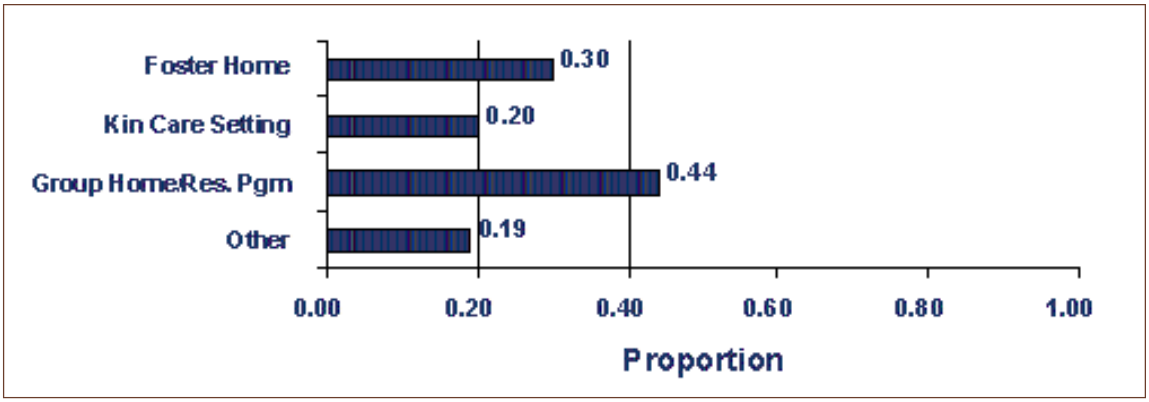

Exhibit 1
Proportion of Clinical/Borderline Scores by Type of Out-of-Home Placement

A regression analysis that controls for age, ethnicity, and the proportion of clinical scores shows that children with higher proportions of clinical scores are more likely to be in group care ($p<.01$). That this is true even after just one-year in care supports Webster's (1999) findings that many children do not work their way into group care after long spells in foster care. Children in group care are somewhat more troubled than other children in out-of-home care, although the overall level of problems shown by children in other out of home care settings is also substantial. Many children who have a range of social, cognitive, and behavioral problems are also in kinship care and foster care. These findings do not buffer the interpretations made by others (see for example, McDonald, Allen, Westerfelt, & Piliavin, 1996) that the poorer outcomes of children who age out of group care are attributable to the kind of care that they are in rather than worse conduct prior to or while in group care. These findings are consistent with other studies indicating higher levels of problems experienced by children who leave group home care (Pecora, Whittaker, Maluccio, & Barth, 2000).

The NSCAW (2002) data also showed that children in group home care were significantly more likely to receive mental health services than children in kinship care or foster care (when age, level of problems, and other factors were controlled). Among the children in group home care, 61% were receiving some form of specialty mental health services (other than the group care itself) whereas the proportions for children in foster care and kinship care were 28% and 13 %, respectively. [Of particular note, children in group care are significantly more likely ($p<.01$) to have been served in a psychiatric hospital or unit.] A multivariate analysis that controls for age, gender, race, clinical scores, and type of abuse determines that children in group home care are more than 3Xs more likely to receive specialty mental health than children in foster care and 7Xs more likely than children in kinship care.

1.2.2 Children's Perception of Types of Out of Home Care

Little effort has been made to compare the perspectives of children about their living arrangements. In the National Survey of Child and Adolescent Well-Being, children 6 and older and in care for about one year were asked for their view about out of home care. Children living for one year in out-of-home care are generally satisfied with their living arrangements and schools,

although children residing in group care appear to have different perceptions in several ways. First, they are almost 4 times as likely as those in non-kin foster homes and 10 times as likely as those in kinship care to report that they do not like the people with whom they are living ($p<.05$ and $p<.01$, respectively). They are more likely to report never seeing their biological father or mother (OR = 5.13, $p<.05$; OR = 4.19, $p<.01$). From these analyses it can be inferred that children in group care differ significantly from children both in kinship care arrangements and those in foster care with non-kin. Those in group care are less positive about their experience than children in the other two arrangements.

Children in group care and foster care reported seeing their family members less than children in kinship care. Children in foster care were three times as likely to report seeing their biological mother less

Exhibit 2: Perceptions of Children in Out of Home Care (N=320)

	Foster Care (%)	*Kinship Care (%)*	*Group Care (%)*	*Total (%)*
Family Visits				
Contact with Mom < twice per month e,f	69	39	73	60
Desires more contact with Mom	71	56	65	65
Contact with Dad < twice per month c	74	26	92	73
Desires more contact with Dad	68	46	73	60
Desires more contact with siblings	77	84	71	77
Family visits are frequently cancelled. c,d	28	29	60	34
Child frequently misses family b	84	66	78	78
View of current placement (% yes)				
Child likes who they are living with a,f	91	97	73	90
Feels like part of the family	90	95	96	92
Wants this home as a permanent home a,f	50	65	22	50
Child has tried to runaway from the home b,f*	11	10	15	11
Child wants caregiver to adopt them	39	33	30	36
Child moved to a different neighborhood	89	83	91	87
Neighborhood is better/worse than previous	55	56	47	54
Child goes to a different school	87	76	88	84
New school is better/worse than previous	61	51	62	59
Hopes for the future				
Believes they will live with their parents again	57	61	61	58
Believes living with parents will be different this time	72	77	76	74

*N = actual n in each cell; percentages are weighted percentages

a Comparison between foster care and group care significant at .05.

b Comparison between foster and kinship care significant at .05.

c Comparison between kinship care and group care significant at .05.

d Comparison between foster care and group care significant at .01.

e Comparison between foster and kinship care significant at .01. (not used)

f Comparison between kinship care and group care significant at .01.

than once each month as children in foster care ($p<.01$). Children in group care were four times as likely to report seeing their biological mother less than once each month as children in kinship care ($p<.01$). Children in group care were five times as likely as children in kinship care to report seeing their biological fathers less than once each month ($p<.05$). Finally, children in group care are more likely to report visits being cancelled frequently than are children in non-kin or kinship foster homes (OR = 3.83, $p<.01$).

1.2.3 Community-Based Group Homes from the Child Welfare Worker's Perspective

Child welfare workers have not been given many chances to describe their experiences with group care. Informally, this author has heard that children may get placed into group care because there is less uncertainty about the level of supervision and caregiving. Yet, some recent information indicates that child welfare workers have concerns about community level group care, although these have rarely been probed. Choice et al. (2000) conducted focus groups with child welfare placement specialists at the Alameda County Social Services Department in California. When asked about local group homes (generally six-bed homes), participants responded that the quality of care for these homes was low. Participants pointed to the lack of trained staff, as evidenced by this statement: "You can't tell who are the kids and who are the staff" (p. 23).

Participants mentioned some of the homes' neglect of children's needs, for example a situation was given in which homes said they had no money to buy clothes for the children. Participants said they thought this resulted from misunderstanding of the use of clothing allowance funds, in which homes thought the county should pay for clothes and the county maintained that they included the allowance in the board rate. Participants complained about the physical conditions of the homes, for example one person described some group homes as "uninviting, horrible, like a crack house" (Choice et al., 2000, p. 23).

Despite group homes supposing to offer a higher level of care in comparison to other placements, participants saw them as warehouses or shelters for children. One participant did claim that there are some very good group homes, but this point was not expounded. These findings have to be carefully interpreted because of the small number of respondents and because only one county is represented. Still, they indicate that there is reason for concern about the assumption that group care provides a consistent and high quality environment (and that there is substantial need to collect information from child welfare workers about group care).

1.2.4 Social and Developmental Science Perspectives on Group Care

The work of understanding the effectiveness of group care in children's services has recently been complemented by analyses of related information from the literature on effective therapy, effective parenting, and effective children's mental health services.

1.2.4.1 Critique of RTC Using Research on Therapist Efficacy and Parenting.

Given the absence of research on the characteristics and outcomes of institutional care, we are left to deduce the likelihood that institutional care will be effective from understanding the components of care and their association to other research. Shealy (1995) applied the findings of psychotherapy literature and the parenting literature to the characteristics or residential care to generate hunches about the likely efficacy of residential care. According to Shealy, these workers are neither "parents nor therapists, but appear to appear to perform both of these roles as 'therapeutic parents'" (p. 565). He proposed a model based upon therapist efficacy and research on effective parenting. Shealy explained that the rationale behind therapeutic parenting is that children in youth facilities are often the product of disturbed parenting behavior.

Thus, youth care workers should not exhibit similar harmful conduct and should exhibit healing aspects of successful therapies. According to this analysis, factors commonly associated with therapist efficacy, including unconditional positive regard, empathy, interest in helping, firm, and nurturing, should also be evident in the behavior of residential caregivers if their work is to be effective. According to the therapy literature, these are the behaviors that residential care providers should exhibit. Parent behaviors associated with psychopathology in offspring included hostility, criticism, mixed messages, blurred boundaries, and rigidity, among others. According to the therapeutic parenting model, these are the behaviors child workers should not exhibit.

Can residential child care workers live up to these therapeutic and parenting standards? According to Shealy's data collection (from observations, interviews, personal testimonials, and research on child care), there is no reason to assume that they will necessarily provide any better parenting than the children's original parents or will be able to consistently provide therapeutic interventions. Whereas the capacity exists for better care by youth workers than by parents, this is made unlikely by their selection, inadequate compensation, and inadequate training.

1.2.4.2 The Surgeon General's Report on Children's Mental Health.

An extensive review of the literature on group care as an element of mental health services by some of the nation's leading children's mental health researchers has been described in the recent Surgeon General's report (U.S. DHHS, 2000). (See, also, Hoagwood, Burns, Burns, Kiser, Ringeisen , & Schoenwald, 2001, for an extensive and confirming review of this literature.) The report indicates that residential treatment has not shown substantial benefit to children and youth with mental health problems and hints at the possibility that residential treatment may have adverse effects because of the contagion of problem behavior from one child to another. The report concludes that for youth who manifest severe emotional or behavioral disorders, the positive evidence for home- and community-based treatments (e.g., multisystemic therapy, intensive case management, treatment foster care) contrasts sharply with the traditional forms of institutional care, which can have deleterious consequences. Even for youth in danger of hurting themselves (suicidal, runaways, and so forth), brief hospitalization or intensive community-based services may be a more apt intervention than RTC. For example, Henggeler et al. (1999) have shown that children randomly assigned to community treatment or inpatient hospitalization have better outcomes if served in the community.

Yet, some favorable findings have emerged from residential care programs that meet the best standards of care. These attributes of more successful residential care inlcude: "family involvement, supervision and support by caring adults, a skill-focused curriculum, service coordination, development of individual treatment plans, positive peer influence, enforcement strict code of discipline, building self-esteem, family-like atmosphere, and planning and support for post-program life (GAO, 1994; Whittaker, 2000).

The Surgeon General's report cited three controlled studies that buttress the argument that residential treatment is no better than community-treatment. Weinstein (1984) conducted an evaluation of adolescent males in Project Re-Education (Re-Ed), a residential program with teacher-counselors (with the aid of mental health specialist) who provide therapeutic services to the children and their families. Adolescents showed improvement in self-esteem, impulsivity, and internal control versus a non-treated, comparison group. The 1988 follow-up study revealed that the adolescents maintained the improvements at 6 months post discharge, however community factors at admission (family and school situation, community support) were more predictive of outcomes than client factors (age, IQ, school achieve-

ment, diagnosis); therefore, community interventions may have been just as effective as the residential program. Another controlled study, Rubenstein et al. (1978), compared RTC with a therapeutic foster care program. The therapeutic program proved just as effective, but the residential program cost twice as much.

Findings for uncontrolled studies showed that most children (60 to 80%) show improvement in clinical status, academics, and peer relations, among others. Several recent studies have confirmed these findings, indicating that the maintenance of improvement is linked to family involvement during treatment and environmental support after discharge (Hooper, Murphy, Devaney, & Hultman, 2000; Leichtmann, Leichtmann, Barber, & Neese, 2001; Lewis, 1988; Wells, 1991).

In summary, youth who are placed in RTCs clearly constitute a difficult population to treat effectively. The outcomes of not providing residential care are generally unknown, although when community base services are available, they provide outcomes that are equivalent, at least . Transferring gains from a residential setting back into the community is unlikely to occur without clear coordination between RTC staff and community services, particularly schools, medical care, or community clinics. Typically, this type of coordination or aftercare service is not available upon discharge. Given the limitations of current research, it is premature to endorse the effectiveness of residential treatment—even for the most troubled adolescents. Moreover, research is needed to identify those groups of children and adolescents for whom the benefits of residential care outweigh the potential risks and to better understand whether placing younger children into residential treatment programs can result in untoward outcomes due to their greater exposure to older peers.

1.2.5 Perception of RTCs From the Provider Perspective

Since so little is known about the outcomes of residential care, and there is a general perception among social scientists that residential care is not effective, residential care providers have endeavored to remedy this by conducting their own research. The Child Welfare League of America has launched the "Legacy Project" and a national survey was recently completed by the American Association of Children's Residential Centers (AACRC, 2000) to track children's services outcomes in residential treatment centers (RTCs). Ninety-six RTCs across 33 states and Canada completed the survey; these facilities had an average bed capacity exceeding 75 beds.

Results from the survey indicated that RTCs served more boys (68%) than girls (32%). Minorities made up a disproportionate share of the client caseload with 30% African-American and 10% Hispanic (whites made up 52% of the caseload, with the remaining children having other racial and ethnic designations). Common reasons for being placed in the facility included (in order of frequency): severe emotional disturbance (clinical depression, PTSD, anxiety disorders, and so forth); aggressive/violent behaviors; family/school/community problems; and physical, sexual, or emotional maltreatment. Prior to placement in this residential facility, 6 out of 10 children were in a congregate care setting (e.g., a group home, another RTC, or juvenile detention). Over half of referrals to RTCs come from state departments of social services and 70% of funding for RTCs comes from social services.

About two out of three RTCs said they provided after care services (case management, family support, and outpatient services), but funding was problematic for these services. Most of the RTCs in the study offered a variety of medical/psychiatric, psychological, academic and health education service. Services not often provided were detoxification (0% provided), respite care (24% provided), job placement (26%), intensive in-home support (27%), and transitional aftercare group (36%), among others.

The AACRC study found evidence of achievement of a key indicator of suc-

cess—that eight out of ten children were discharged to a lower level of care from the RTC. Many were discharged to biological parents (34%). The next largest categories included: 12% to groups homes, 11% to therapeutic foster care, 7% to another RTC, 7% to a foster home, and 6% to a relative home. No evidence is provided about the duration of these post-RTC placements, which is a major shortcoming of the study given the legacy of previous studies of high recidivism from RTCs (Whittaker, 2000). Nor do their findings disaggregate the outcomes for children of different ages or referral reasons. Still, they indicate that children coming to larger Residential Treatment Centers are subsequently moving to less restrictive and more family-centered settings.

Section 2. Outcomes of Out-of-Home Care

Decisions about the optimal kind of care must draw on a variety of data. In the remainder of this review, the focus is on outcomes of care. There is no more important consideration in determining which kinds of care to provide than evidence about the likely impact of the care on the child's development and well-being. Because this is difficult to measure, understanding the child's permanency outcomes—including evidence of impermanence like running away and re-entry to care—is, at times, the most adequate indicator. Third, the child's satisfaction with care—if all else is equal—is an important consideration. Fourth, promotion of success in the transition to adulthood. Fifth, and not insignificant, is the cost of the different kinds of care. Given the scarcity of child welfare resources—services that provide equivalent benefit but cost less are more valuable to the public.

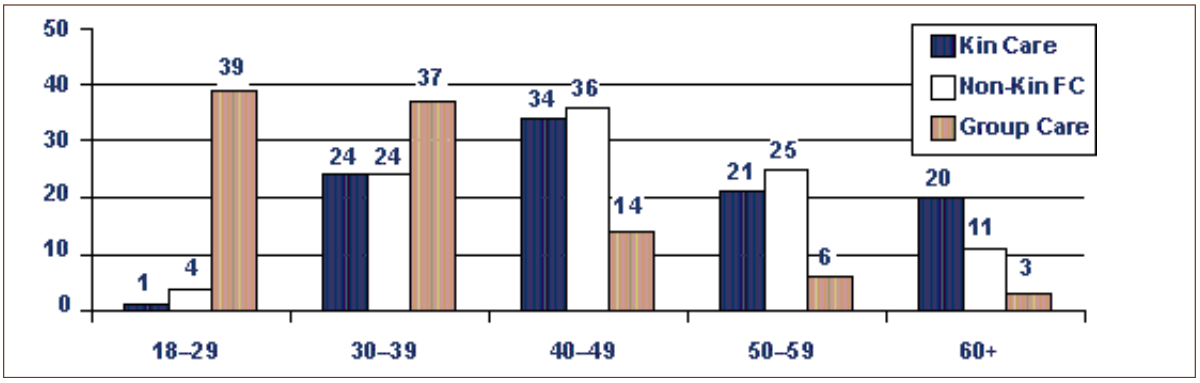

Exhibit 3
Caregivers by Age and Placement Type

2.1 Safety and Well Being

Children enter out of home care with the intent of guaranteeing their safety and promoting their well-being. One of the most powerful indicators of safety and well-being for children is the rate of abuse and neglect in the place they reside. Incidence data like these are very difficult to gather, and tend to be skewed toward higher rates of reports for older youth who are more able to communicate them to their child welfare worker or other mandated reporter. Thus, there is a general bias in the results toward having higher reports of abuse and neglect in group care settings because they generally care for older children (Blatt, 1992).

2.1.1 Abuse of Children in Institutional Care

Despite these challenges, several informative efforts have been made to understand the abuse rates in different settings. Spencer and Knudsen (1992) examined reports of maltreatment by children in out of home care and found that abuse rates in residential treatment centers were 6 times what they were in foster homes—unfortunately, they do not provide confidence intervals to indicate the meaningfulness of those differences in rate nor do they control for the fact that the children in residential care are older.

Blatt (1992) argued that younger (less than age 35) staff and male staff were most likely to be reported as perpetrators. He reasons that these findings are consistent with the higher reporting rates of younger parents in the general population, and that parents with a bit more experience are more likely to find constructive, alterna-

tives approaches to parenting. Group caregivers are much younger than caregivers in foster or kinship foster homes, according to the National Survey of Child and Adolescent Well-being (NSCAW Research Team, 2002). More than three-quarters of the group caregivers were under 40 years of age—39% were 18 to 29 years of age and 37% were 30 to 39 years. There were also 11% who were ages 40 to 49 years, 7% were between the ages of 50 and 59 years, and 3% were 60 or older (see Exhibit 3). The ages of caregivers in group care do, however, more closely approximate those of the general population, than do the ages of foster care givers. Although the findings about the younger age of group care providers offers no direct evidence of higher risk of maltreatment of children in group care, it does indicate that the children in group care very often have caregivers without their own parenting experiences.

Most recently, Garnier and Poertner (2000) used administrative data to examine the rate of reports of abuse and neglect for children in various types of out of home care in Illinois. In 1988 and 1999, about 2.0 reports were made for every 100 child years of exposure to care. The lowest rates were for adoptive families (0.0), then for institutional care (1.6), group care (1.6), kinship care (1.7), specialized [treatment] foster care (1.9), and family foster care (2.7). The higher rate for family foster care is partially explained because abuse by parents (during home visits and trial visits) and retrospective reports (for example after finding out that a child had been molested) are also included in the rate calculations. These events might be more likely to be made by foster families than other providers.

There have been numerous studies of the abuse of children in residential care in other countries. Hobbs, Hobbs, & Wynne (1999) examined the incidence of abuse of children in foster and residential care in the United Kingdom. In a retrospective study of 158 children, Hobbs et al. found that there 191 incidents of alleged physical and/or sexual abuse as assessed and reported by pediatricians over a 6 year period from 1990 to 1995 in Leeds, England. Hobbs et al. differentiated between types of care: foster versus residential (or children's homes) care. They also examined the following characteristics of the children: reason for placement in care, physical and mental functioning, and other abuse characteristics, such as type of perpetrator. The population of foster care children included 59 boys and 74 girls who ranged in age from 1 to 18 years old. Eight girls (mean age 12.75 years) and 17 boys (12.36 years) in residential care were included in the study.

In this study on abuse incidents in foster care, 42 children suffered physical abuse, and almost twice as many children (76) experienced sexual abuse; 15 children suffered both types of abuse. Of those abuse incidents in residential care, 12 children suffered physical abuse, 6 sexual abuse, and 6 both types of abuse. Thus, abuse in group care was more likely to be physical abuse than sexual abuse, when compared to foster care. As to type of perpetrator for children in foster care, 28 children were physically abused and 22 sexually abused by foster parents. (Three families were identified in multiple allegations of abuse.) Twenty-two children were sexually abused by biological parents, during visits. In 24 cases, children were the perpetrators of sexual abuse. As to type of perpetrator for children in residential care, 8 children were abused by a staff member (all physical abuse). In 17 cases, children were abused by another child, 4 by a child within the residential care home (2 sexual and 2 physical abuse) and 13 by a child outside the home (9 sexual and 4 physical).

When compared to the general population in Leeds, foster children were 7 to 8 times more likely to be assessed by a pediatrician for abuse. Children in residential care were 6 times more likely (the differences between foster children and group care children are not significant). Hobbs et al. (1999) noted that children in foster and residential care are obviously easier to monitor by professionals than children in the general population, so this accounts for

some of these differences. Hobbs et al. (1999) argue that a comparison between children in care and the general population can be assumed to be valid given that all pediatric assessments have the same doctors, referral pathways, and diagnostic criteria. Yet, they fail to account for the fact that the children in group care do not come from the general population, they come from a small subset that may be quite different.

Hobbs et al. (1999) argue that although children in care are more likely to be assessed for abuse, they are also at a higher risk of abuse, given their prior histories of abuse. Prior abuse history increases the likelihood of re-victimization and of becoming a perpetrator. Findings of Hobbs et al. (1999) suggested that a factor in re-victimization might be the behavioral problems of the children themselves, especially in cases of physical abuse by caregivers. Thus excellent preparation is needed for caregivers in dealing with behavioral issues of abused children.

2.2 Exposure to Violence in Out-of-Home Care

Although children may receive many services while in out-of-home care, the contact they have with their caregivers is likely to be the most extensive and influential. Few studies have endeavored to directly assess the differences between foster home and group care environments. New information is emerging from the National Survey on Child and Adolescent Well-Being (NSCAW) from children and youth about their safety-related experiences with their caregivers (see Exhibit 4).

To gain additional clarification about the experiences that children had in their current setting, the Conflict Tactic Scale Parent Child version (CTS-PC) was used to assess the frequency and extent of nonviolent discipline and child maltreatment incidents as reported by children ages 11 and older (Strauss et al., 1998). If the children indicated an incident had occurred on the CTS-PC, they were then asked to indicate on six of the severe items if it had occurred in the past 3 months. The question—"Did this happen in the last 3 months?—was not completely clear as to whether this was by the parent or other adult caregiver, or if it had happen in the community. The percentages of children who reported such exposure were low in all settings and no significant differences using chi square analysis were found between the three types of out of home care. Thus the earlier cited evidence of the disaffection of children for group care occurs even though the proportions of children who report that they are experiencing or witnessing being yelled at or spanked in group care are no higher than in other settings.

2.2.1 Education and Residential Treatment

Lewis (1988) investigated personal and ecological outcomes for children in a residential treatment program 6 months after discharge. The treatment program, Cumberland House, employs cognitive-behavioral, educational and ecological interventions with the children and their families. Students of the program tend to have serious behavioral problems, are behind in school, and usually have been referred by mental health or by order of the juvenile court. Given the centrality of education to the Cumberland program, educators are primary treatment providers versus mental health or child-care staff.

The ecological intervention is a unique part of the program and thus deserving of further explanation. Treatment involves defining a child's ecosystem (home, school, community, etc.) and behavioral expectations for those settings. If a child is not meeting those expectations, then an intervention is performed by either increasing the child's competence with the desired behavior (for example less temper tantrums) or expectations (of parents, teachers) for the child's behavior may be changed to create a better match with the child's actual behavior.

Lewis's (1988) study sample included 106 consecutive voluntary admissions, 82 which complete data was obtained. Personal characteristics of the sample

Exhibit 4
Incidents Experienced by Children by Type of Out-of-Home Care (in %)

Incident within Last Month	Foster Care	Kinship Foster Care	Group Care
Saw yelling at someone else			
Current (n=198)	14	11	4
Month (n=199)	15	11	4
Yelled at by current resident			
Current (n=193)	15	10	4
Month (n=193)	10	12	4
Saw something thrown at someone else			
Current (n=97)	3	2	<0.50
Month (n=96)	4	2	<0.50
Adult threw something at child			
Current (n=67)	4	<0.50	<0.50
Month (n=67)	4	<0.50	<0.50
Saw Adult shove someone else			
Current (n=92)	1	1	1
Month (n=96)	6	1	1
Adult shoved child			
Current (n=80)	1	3	3
Month (n=80)	4	2	2
Saw adult slap someone else			
Current (n=82)	1	<0.50	1
Month (n=82)	4	<0.50	1
Adult slap[slapped ok? CO] child			
Current (n=64)	2	<0.50	1
Month (n=66)	2	3	1
Saw adult beat up someone else			
Current (n=81)	5	<0.50	1
Month (n=78)	2	1	1
Adult beat up child			
Current (n=47)	2	2	1
Month (n=47)	6	3	3
Saw person steal from another in the home			
Current (n=108)	4	1	3
Month (n=109)	4	2	3

	Foster Care	Kinship Foster Care	Group Care
Saw adult point knife or gun at someone else			
Current (n=52)	2	0	<0.50
Month (n=53)	3	1	<0.50
Adult pointed knife or gun at child			
Current (n=27)	<0.50	0	<0.50
Month (n=27)	2	<0.50	<0.50
Saw Adult stab someone else			
Current (n=24)	<0.50	<0.50	0
Month (n=23)	0	1	0
Saw adult shoot someone else			
Current (n=19)	2	1	<0.50
Month (n=19)	2	<0.50	1
Saw person arrested			
Current (n=123)	3	2	2
Month (n=121)	2	2	1
Saw person deal drugs			
Current (n=63)	<0.50	1	<0.50
Month (n=63)	<0.50	<0.50	1
Saw other kid getting spanked			
Current (n=184)	11	6	1
Month (n=182)	12	5	<0.50
Child was spanked			
Current (n=145)	8	6	1
Month (n=144)	4	3	<0.50

included: 42% repeated at least one grade; 27% had been in residential treatment before; and 26% were involved with the juvenile court. The average length of stay was 7 months. After discharge, children returned to the following settings: 71% to their own homes, 15% to relatives, 8% foster families, 3% group homes, and 2% to some other residential treatment program. A teacher-counselor who worked with the students and their families obtained data at admission, discharge and 6 months after discharge. Ecological measures included assessment of family problems, school climate, community resources, parenting measures and student adjustment post discharge. Inter-rater reliability was determined for each measure except for the school climate rating scale.

Other interesting findings included that students with higher SES backgrounds tended to have better post discharge functioning. Lewis also found a relationship between higher scores on father's behavior management practices and improved home adjustment, while higher scores on mother's behavior management was related to better adjustment in school. In addition, raters expectations at discharge for home and school adjustment, progress in presenting problem, and the development of new problems was found to be predictive of actual outcomes in these measures. Lewis concluded that the results from this study suggest increasing both the ecological support and the student's ability to meet the demands of his or her ecology result in better adjustment to home and community.

2.2.2 Education of Children in Group Care

Residential settings have long been the locus of educational opportunity and achievement in America, as witness the high status of our private boarding schools, the military academies, and public and private universities (Wolins, 1974). Yet, the assumption that group home care also represents a powerful educational environment has not been well tested. The American Institutes for Research (AIR, 2001) investigated the educational outcomes for children in California group homes or Licensed Children's Institutions (LCIs). AIR obtained data via state data analysis, agency surveys (social services, educational, group homes, and so forth), site visits and interviews with key stakeholders (students, policymakers, among others). The AIR study found that 18,416 children were in LCIs and that 47% of those children were in special education. Forty-six percent of the students in special education were being educated in nonpublic schools (which are often affiliated with LCIs) as opposed to 1% of non-foster care, non-group home children and 4% of foster care, non-group home children in special education. In addition, residing in an LCI increased the probability that children in a disability group (e.g., emotionally disturbed) would attend a nonpublic school versus those emotionally-disturbed children who did not reside in LCIs.

Interview data revealed that a shortage of group homes forced placements of children into LCIs that were not appropriate to their educational needs. For example, children in LCIs might end up unnecessarily receiving schooling by a nonpublic school and thus might violate the federal special educational requirement of least restrictive environment. Agency survey information showed that one-half to three-quarters of respondents said that funding considerations often affected educational placement decisions. Non-group home respondents also said that they often relied on funding from affiliated nonpublic school programs to help cover the costs of residential or other non-educational services.

Site visits to group homes revealed that staff reported getting little or no educational information from caseworkers and having great difficulty in getting transcripts from schools. Many group homes said they had to hire staff to track down educational information. Students had several complaints: being placed far away from neighborhood schools; subpar teaching; discomfort with teacher in discussing educational needs or goals; and missing and/or lost transcripts' effect on the quality of educa-

tion and likelihood of timing and graduation from high school. The study's review of educational records at the group homes revealed that only 27% had transcripts and only 25% had educational assessments.

The AIR (2001) study concluded, that changes to the educational system must be made in order to assure that group home children receive appropriate educational services. For example, the study noted that education by nonpublic schools might provide the services needed by some students to achieve school success, such as those with emotional disturbances. The authors also suggest, however, that even for children who momentarily need them, nonpublic schools should be seen as transitional services that prepare children for public school settings. In addition, interagency coordination between educational, social services, and mental health agencies should be established to ensure the timely provision of appropriate education services to group home children.

Foster and kinship homes also have had limited success in helping children to make normative academic progress (Ferguson, 2001). There is no scientific basis on which to conclude that children in foster care make greater academic gains than children in group home care.

2.2.3 Group Care and Developmental Concerns for Young Children

Young children reared in families appear to have better developmental outcomes. This finding has been shown by researchers to be consistent and longstanding (see review by Berrick, Barth, & Jonson-Reid, 1997). Following on a long series of studies that have shown that children in institutions have poor developmental outcomes (e.g. Hunt, Mohandessi, Ghodessi, & Akiyama, 1976), Nelson & Budd (2001) recently found corroborating evidence in follow-up assessments of children adopted from China. Children reared in "foster/private homes" had significantly better developmental (motor and mental) outcomes at one year than children raised in orphanages.

Although generalizing from Chinese babies to American children requires a significant leap, some of the mechanisms for the lower developmental performance of institutionalized children posited by Nelson & Budd (2001) are consistent with group care practices—for example, in shelter care—in the U.S. They proposed that the lack of: physical contact, one-on-one relationships, and extended interactions are iatrogenic contributors. Group care and shelter care policies and practices often prohibit or preclude physical contact with children, being along with a child for extended times, and significant prolonged interactions with staff that promote the development of relationships.

2.3 Permanence/Re-entry

2.3.1 Placement Instability

Placement instability is widely viewed as harmful to children, yet research about it is very limited. Webster et al. (2000) studied the number of placement moves of a cohort of 5,557 children over an eight-year period of time using data from the California Children's Services Archive at the University of California at Berkeley. The cohort consisted of children age 0 to 6 first entering out-of-home care between January 1988 and December 1989 and who remained in care for the entire eight year period studied. Thus, it is important to note that the children studied comprised 28% of the total number of children who entered care during the same time span and represent all children who remain in long-term foster care.

The study did not include placement moves required to achieve reunification, guardianship, or adoption. The predominant placement setting was coded as either kinship or non-kinship care. Non-kinship care included foster homes, specialized foster care homes, and group care. Webster et al. (2000) employed a multivariate analysis to determine the likelihood of placement instability. The study defined "placement stability" as the children having "three or more moves in care following placements experienced during their first year in care"

(p. 10). The multivariate analysis tested for the effects of age, placement setting, and number of placements during the first year in care on placement stability.

Children in kinship care experienced fewer moves than children in non-kinship care—a disparity which held across time. A year into care, 64% of children in kinship care versus 49% of those in non-kinship care were still in their first placement. After two years in care, the percentage still in their first placement was 55% (kinship) to 38% (non-kinship). After eight years in care, those still in their first placement were 37% (kinship) and 22% (non-kinship). As far as placement instability, gender, age, and being African-American were strongly related to instability. Males were 35% more likely to experience instability than females and children entering care as toddlers were one and three quarters more likely to have instability versus infants. African-American children were 25% less likely to experience placement instability as Caucasian children.

2.3.2 Family-Centered Residential Care

Family focused, community-oriented residential programs have shown considerable success. Hooper, Murphy, Devaney, & Hultman (2000) conducted a single sample design study of ecological outcomes for 111 adolescents who completed a re-education residential program, the Whitaker School, in North Carolina. The Whitaker School is a publicly funded program that operates under the Re-Education model (Hobbs, 1982). This model is based on systems theory in that emotional conflict is derived from interpersonal and system level problems, such as service provision problems in the mental health system. The Whitaker School is particularly intended for students who have not been treated successfully in more traditional programs. Unique to the program is its emphasis on community involvement for the students before, during and after the program. Thus, it offers community/family-oriented wrap-around services.

The sample consisted of adolescents aged 13 to 16 at the time of admission who were mostly male, 67%, and white, 60%. The average length of stay was 9 to 10 months. Most of the adolescents had major psychiatric diagnoses: most frequently, conduct disorder, attention deficit/hyperactivity disorder, major depression, and post-traumatic stress disorder (85% of the sample were being pharmacologically managed). The majority had some type of documented abuse (80%) and 85% had been in an out-of-home placement prior to admission.Hooper et al. (2000) collected outcome data at 6, 12, 18 and 24 months after discharge in a cross-sectional manner (one follow-up interview per adolescent). The data was collected via telephone interviews with the individual's case managers. The information collected was across the domains of legal, school, and level of care. The case managers rated students' functioning as unsatisfactory or satisfactory from the time of discharge. A satisfactory rating was defined as the individual "continuing to function on a modestly adaptive level" (p. 494). For the legal domain, a satisfactory rating was given to a student if s/he had no new illegal activity since discharge. For the school domain, satisfactory meant ongoing educational participation and for the level of care domain—satisfactory meant that the student had not been hospitalized unexpectedly or moved to a more restrictive treatment level.

Hooper et al. (2000) found that about 58% of the students were rated as satisfactory in all three domains. When only the legal plus one other domain was included, the satisfactory rating increased to around 78% and then to 90% when any two of the three domains was rated. They also found that the students' overall success rate did decrease over time, but Hooper et al. also noted that these results are better than the outcomes of more punitive types of residential programs (Peters, Thomas, & Zamberlan, 1998).

More successful students tended to have the following qualities, they were: female, slightly younger, have higher IQs, better reading and writing skills, less psychiatric diagnoses, and have internalizing types of

behavior as rated by caregivers on the Child Behavior Check List (CBCL). Little variance was due to ecological variables, such as history of abuse and living with biological parents. Hooper et al. suggest that this effect was due to the fact that these variables are more static and other variables (literacy skills, affective symptoms, and SES) are more malleable and thus provide the opportunity for treatment to produce positive changes.

Hooper et al. (2000) acknowledge that their methodology does not allow for a true comparison between the re-education model of residential treatment and other types of more punitive models. However, their findings do suggest that the psychoeducational approach does appear to offer long-term benefits to youth and the community.

In a more rigorous third-party evaluation effort, Landsman, Groza, Tyler, & Malone (2001) conducted a quasi experimental study which examined the effectiveness of a family-centered residential treatment model (the Reasonable Efforts to Permanency through Adoption and Reunification [REPARE] program) in Iowa in a comparison to a traditional program. The REPARE program integrated successful aspects of family preservation into more traditional residential treatment. The program sought to reduce children's length of stay and severity of emotional/behavioral systems, improve family functioning as well as achieve permanency for children. The program was family-centered and engaged families as partners in decision-making and in teaching skills to parents and integrating staff into the home and parents into residential placement.

Landsman et al. (2001) included 82 children in the experimental REPARE group and 57 in the comparison traditional program group. County of residence determined assignment of children to the facilities. The study sample of 139 children (both groups) was mostly male, white and ranged in age from 4.7 to 14 years with an average age of 10. Most children had experienced at least one out-of-home placement prior to their current placement. Many families (40%) in both groups had already received family-centered services and about one-third had intensive family preservation services. Family reunification was the most frequent goal for families in both groups, however the REPARE group had a higher percentage of reunification goals (86% to 59% for the comparison group).

REPARE children had shorter lengths of stay (242 average number of days versus 444 for the comparison group, for children admitted after January 1993, n = 59 to n = 33). REPARE children were more likely to go home after treatment (49% to 19%) and comparison children were more likely to go to group care or long-term family foster care.

In terms of stability, defined as "continuous (uninterrupted) placement with a parent, relative, or legal guardian, or in a planned long-term family foster home" (p. 367), REPARE children also fared better. Six months after discharge, 59% of REPARE children were in stable situations as compared to 38% of comparison children. Eighteen months after admission to residential care, 75% of REPARE children had stability versus 38% of comparison children. In the multivariate analysis of stability, increased length of stay had a negative effect on stability at both time intervals of 6 months after discharge and 18 months after admission. Also at 18 months after admission, assignment to the REPARE group had a positive effect on ability. No other variables studied (number of placements, goal of reunification, number of family visits) were found to affect stability.

2.3.3 Likelihood of Long-Term Care

Understanding the impact of group care on the likelihood of achieving permanency goals is difficult, because the ages of children who enter group care are so much different than those of the typical child entering foster or kinship care. Some efforts have been made to look at older children and to understand their paths through child welfare services. Wulczyn & Hislop (2001) used data from the Multistate Foster Care

Data Arrive to determine the characteristics of 119,000 youth in out-of-home care at age 16 and likely to be there at age 21. Specifically, they looked at the youth's type of placement, whether placements varied by state, whether 16 year-olds were less likely to be in family placements and whether they were more likely to be in residential placements. The sample consisted of youth placed in foster care for the first time between 1990 and 1998.

About 50% of the youth were in foster or kinship care while 42% were in congregate care. The remaining 8% experienced a mixed type of care. This result varied some by state. Alabama, New Jersey and New York were more likely to have youth in congregate care than other states (about 60% of youth were in congregate care). Youth in California (14%) were less likely to be in congregate care. Youth who were already 16 years old at the time they entered care were more likely to be in congregate care versus those who came into care at an earlier age and turned 16 while in care.

The majority of the sample, 41%, exited to reunification with their families. The next most common type of exit, about 1 in 5, was to some other destination, such as being transferred to a program outside of the foster care system (mental health, detention). 19% of the sample ran away while 12% reached the age of majority (21 years old) and a very small percentage (1%) were adopted. In regard to type of placement and type of exit, youth exiting from foster care and youth exiting from congregate care were equally likely to be reunified. Youth exiting from kinship care were more likely to run away than those exiting from other types. Finally, youth exiting from a mixed placement type were most likely to reach the age of majority, while still in child welfare supervised out of home care.

2.3.4 Residential Mental Health Group Care for Child Welfare Supervised Children in California

Decision making mechanisms that promote the use of group care for the most disturbed children can be effective. In California, group homes that have higher payment rates (provided to them because children are receiving special education, child welfare and mental health services), have a higher proportion of teenagers than other group home or out of home care placement types (Webster, 1999). As is also found in the NSCAW (2002) data, there is a higher proportion of Caucasians than African-Americans in group homes in California—especially in mental health group homes. A little less than half of children first placed in mental health group homes are in their 3rd or higher foster care placement.

Children who enter group home care for the first time, have a median stay of about one year. Children who entered care at 6 or older with a first or second placement in a standard or mental health group home were more likely to runaway 2 than children in foster homes.

2.3.5 Re-entry Rates

Children and youth who leave group care have the highest likelihood of returning. In a comparison of re-entry rates by age group and placement type, children aged 6 to 12 in congregate care tended to have the highest rate of re-entry at 34% (Wulczyn, Hilsop, & Goerge, 2001; see Exhibit 5). The next highest rate of re-entry was children in congregate care aged 13 to 18 at 25%. The re-entry rate for children in congregate care aged 3 to 5 was 23% and 0 to 2 was 22%. All age groups in mixed type of care experienced similar re-entry rates from 20 to 22%. Children in foster care aged 6 to 12 (23%) and 13 to 18 (22%) experienced similar re-entry rates as compared to mixed care type. Children in foster care aged 3 to 5 had a 20% re-entry rate and aged 0 to 2 had a 14% re-entry rate. Overall, kinship care had the lowest rates of re-entry for all age groups: 0 to 2, 10%, 3 to 5, 12% , 6 to 12, 13%, and 13 to 18, 12%.

In a comparison of race by placement type per age group, black children who exited from congregate care had the highest re-entry rate at 25% of all races by type of placement (Wulczyn, Hilsop, & Goerge,

2001), although black children also had generally higher rates of re-entry when they left foster care and kinship foster care, regardless of age. when they left. Hispanic children in congregate care had a rate of 21%. Children in foster care of all races experienced similar re-entry rates ranging from 13 to 15%, depending on race, respectively. Children in kinship care of all races had the lowest re-entry rates, ranging from 9 to 12%, respectively.

2.3.6 Placement Disruption Rates

Relatively little is know about how placement instability might differ between types of out of home care. Smith, Stormshak, Chamberlain, & Whaley (2001) explored placement disruption rates for emotionally and behaviorally disordered youth in the Oregon Social Learning Center's treatment foster care (OSLC TFC) program. The OSLC TFC program consists of placement of usually one child per home with treatment foster parents who are trained and supervised by program staff. The sample was comprised of 90 youth (51 male, 39 female) divided into two different age groups: 12 and under (n=61) and 13 and up (n=29). The average number of Axis 1 diagnoses for the sample was 3.33 and the average number of placements was 4.75. Smith et al. (2001) found that the disruption rate for the first six months of treatment was 18% or 16 of the 90 youth experiencing a disruption. The disruption rate for the second 6 months of treatment was 9% with 7 of 76 (the number still in TFC) experiencing disruption. The overall disruption rate was 26% or 23 of 90 youth disrupting. Of those experiencing disruption, 70% experienced a disruption during the first 6 months of treatment. Age was found to be a significant predictor of disruption with older children more likely to disrupt than younger children. In terms of gender and age, older girls were the most likely to have placement disruptions in that they had a .55 predicted probability of disruption whereas the average child had a .17 probability of disruption. Although there was no direct comparison to group care, the authors suggest that the placement disruption rate for their Therapeutic Foster Care Program was, at 18% in the first 6 months and 9% in the second six months, lower than rates identified by other investigators. These figures do seem to be at least as low, and probably lower, than those (cited above) of the general adolescent group care population,

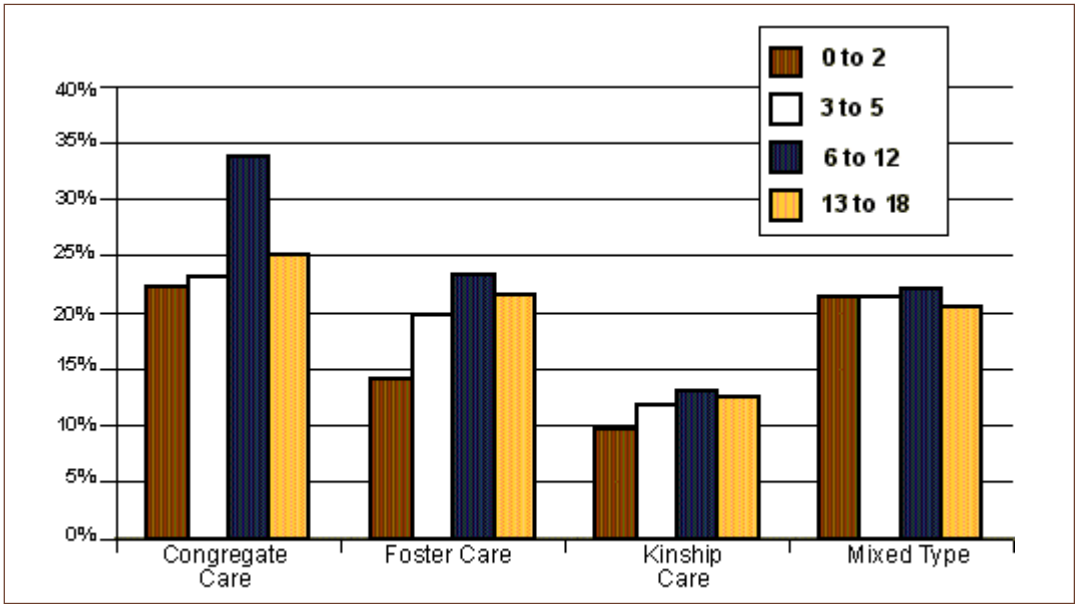

Exhibit 5
Rate of Re-entry by Age and Placement Type

2.4 Long-term Success/Adult Outcomes

Assessing the long-term benefits of services is critical to evaluating their value (Barth & Jonson-Reid, 2000). The challenges and rewards of this form of research are great, explaining why only a handful of such studies are available.

2.4.1 Long-Term Effects of Foster Care and Group Care

One of the most comprehensive reviews of literature on outcomes of foster care and group care is very often cited, unfairly, as showing that children do worse in group care. McDonald, Allen, Westerfelt & Piliavin (1996) synthesized research that assessed the long-term effects of foster care. In terms of placement type and out-

comes for foster children, McDonald et al.'s review led them to conclude that, generally, children who stayed in family foster care tend to have better functioning when adults than those who spent at least some of their time in residential care. McDonald et al. also noted that this outcome may be due to the problems that some children have that make it more likely that they will enter into group care—severe emotional, physical and mental difficulties.

Because McDonald et al. (1996) based many of their findings on the work of Festinger (1983) and Jones & Moses (1984), these studies are worthy of a brief review. Festinger studied 277 young adults, aged 18 to 21, who had been discharged from foster care in New York City in 1975 and had spent five continuous years in care. Festinger used a combination of in-person interviews, telephone interviews and questionnaires to assess current functioning and obtain their views on the foster care experience. Jones and Moses (1984) assessed the current functioning of 328 adults, aged 19 to 28, who spent at least one year in foster care in West Virginia between 1977 and 1984. Jones and Moses also primarily employed personal interviews with youth.

These studies concluded that subjects who were in family foster care functioned better than children in group care in the following areas: they attained higher levels of education (Festinger, 1983); had a lesser likelihood of arrest or conviction (Festinger, 1983); reported fewer substance use problems (Jones & Moses, 1984); had a lesser likelihood of dissatisfaction with the amount of contact they had with biological siblings (Festinger, 1983); and were less likely to move, to be living alone, to be single, head of the household parents and to be divorced (Festinger, 1983). Adults formerly in family foster homes were also more likely to have close friends (Festinger, 1983) and stronger informal support (Jones & Moses, 1984). They also had more satisfaction with their income levels and more optimism about their economic future; and had more positive assessments of their lives (Festinger, 1983).

More positive outcomes for adults who had been in group care versus family foster homes included: having closer and less negative contact with biological family; more likelihood of marriage, and, for men, a greater probability of having custody of their own children (Jones & Moses, 1984). Thus, the sum of these conclusions led McDonald et al. (1996) to the belief that outcomes for children from family foster homes are better than those from group care. They do caution, however, that given the nature of these studies it is difficult to make interpretations of causality. Finally, they point out that it does appear that children who go into group care are usually those with the most significant problems and that group care does not seem to ameliorate those problems. They suggest that family foster homes be developed to meet the special needs of these children.

2.4.2 Treatment Foster Care versus Group Care

The historic debate about foster care vs. group care is increasingly likely to be honed down to a debate about treatment foster care vs. group care. Few studies that compare the two methods of serving children, have been completed. Chamberlain (1998) described a particular model of Treatment Foster Care (TFC) developed by the Oregon Social Learning Center (OSLC) as an alternative to residential and group care for juvenile offenders. In this model, families are recruited and given special training and ongoing consultation to provide treatment to the youth. TFC characteristics include close supervision of youth at home, school and community; minimization of association with delinquent peers; consistent discipline and rule monitoring; and one-on-one mentoring by TFC parents. TFC has expanded to include populations beyond juvenile delinquents, including youth involved in the mental health and child welfare systems.

Chamberlain (1998) concluded that evaluations of TFC have found the model to be more cost effective and producing bet-

ter outcomes for children and families in comparison to alternative residential treatment models. A large comparative study of 79 male juvenile offenders, aged 12 to 17, assessed post-discharge outcomes between adolescents randomly assigned to group care or TFC (Chamberlain & Reid, 1998). One year after completing the programs, TFC youths has significantly fewer arrests and a greater probability of no arrests after treatment than did youths in group care. In addition, TFC youths had fewer incarcerations and spent more time living at home or with relatives as compared to the group care participants. Also, three times as many group care youths were expelled or ran away than the TFC group.

Chamberlain & Reid (1998) also found four program factors that were predictive of arrests post-discharge: supervision, discipline, positive relationship with care-taking adult, and non-association with deviant peers. Chamberlain (1998) concluded from evaluation data on TFC that association with delinquent peers was the most powerful predictor of further offending by the youths. This association with delinquent peers appeared to be a dependent factor related to the amount and quality of supervision and discipline from care-taking adults. Adult caretakers may provide protection from deviant peers and, thus, further arrests.

Although there is evidence that treatment foster care can achieve outcomes that are similar to group care, for children referred for mental health or juvenile justice reasons (Chamberlain, 199x), little is know about how treatment foster care and group care compare in their use in the child welfare services system. This was examined in California, for children in their first spell of out-of-home care in California. Treatment foster care is associated with much longer lengths of stay than either foster are or group care. Median lengths of stay were for treatment foster homes (called FFAs [foster family agencies]) were 25 months, longer than any other form of care. For kinship homes, median stay was 20 months; foster homes, 13 months, group homes, 12 months, and other type, 9 months. FFA also had the longest median lengths of stay for all age groups, the proportion. Yet, these placements are also quite stable—over a 6 year period, children in FFAs had the highest percentage of children still in their first placement (63% at age 2) in comparison to foster (28%) and group homes (27%) (see Exhibit 6).

A permanence index can also be computed for these children. The index is calculated by dividing the number of children achieving permanence (reunified, adopted, with guardian) by the sum of children achieving permanence and the number of children still in care and or re-entered care. For care entries between 1988 and 1991, children in FFAs had a lower permanence index in comparison to foster and group homes (see Exhibit 7). Rates for children in group care were most similar to those of children in foster care, but still lower.

2.4.3 After Group Care

Perhaps the greatest weakness of out-of-home care is that re-entry rates are high and there are almost no after care services available to ease the transition to the home. Hagen (1982) compared the outcomes of a group of 20 boys and their parents who received aftercare services after residential care at St. Vincent's School in California with a matched group of 20 boys from the same program who graduated before aftercare services were implemented—thus, they did not receive such services. Aftercare services consisted of twice monthly home visits with the boys with the

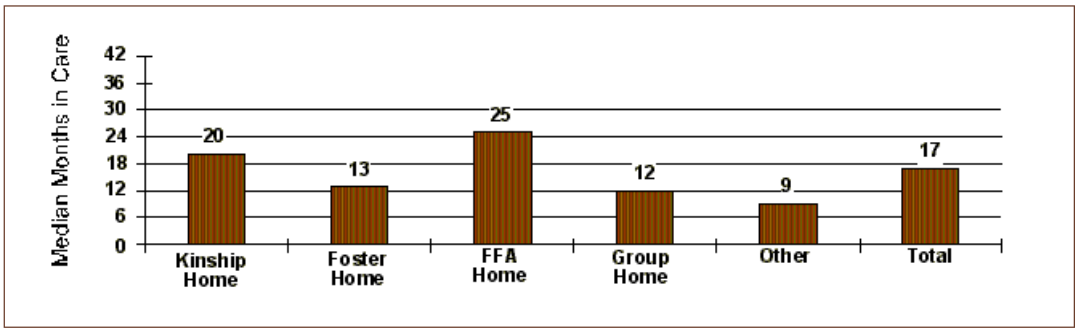

Exhibit 6
1989–1995 Entries: First Spell Median Length of Stay by Placement Type

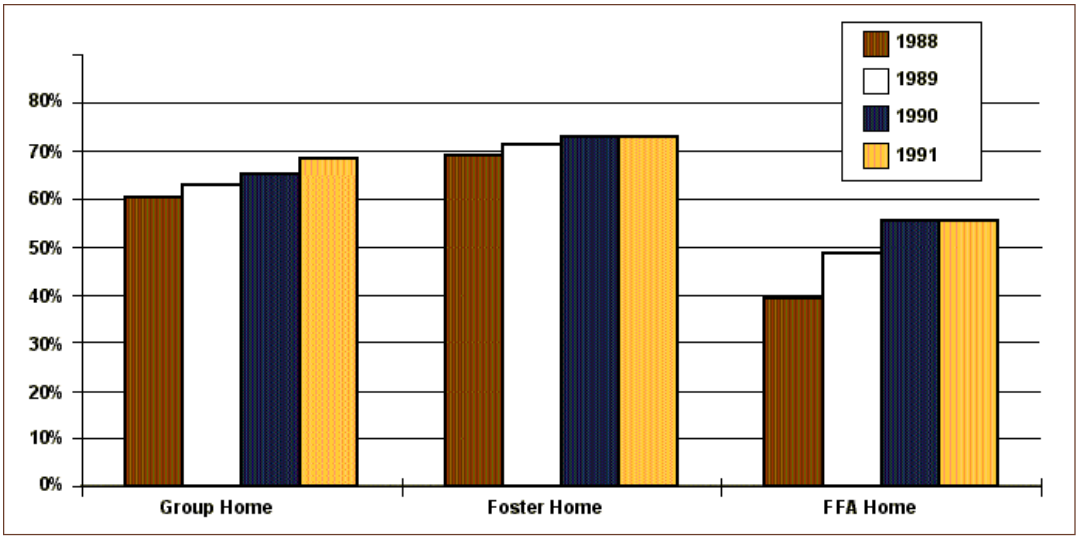

Exhibit 7
1988–1991 Entries: Permanence Index at 4 Years by Placement Type

goal of aiding the boys and their families with the children's adjustment to the community (thereby, offering support, advocacy, and resource information to families).

The boys were aged 10 to 15 and the author specified that no child was psychotic or mentally retarded. Hagen (1982) found that the parenting skills of the parents of the aftercare group continued to improve after discharge while parents of the non-aftercare group showed regression (as rated by a parenting scale developed by the author). They also found that, after six months post-discharge, parents of the aftercare group were more likely to seek community-based support than the parents of the non-aftercare group. In addition, after six months, aftercare children seemed to sustain gains in behavior better than the non-aftercare group. Hagen (1982) also found that more improvement in parenting skills was related to improvement in children's behavior. Hagen (1982) argued that these results, although ambiguous by the weak research design, support the benefit and need for family focused aftercare services as a distinct phase of intervention after children leave residential care.

Kapp et al. (1994) described adult imprisonment outcomes for a longitudinal study of youth who completed a residential treatment program, Boysville of Michigan. The sample consisted of 563 male delinquents and those involved in the child welfare system who were released from the Boysville in 1985 and in 1987. The 1985 group was followed for five years post-release and the 1987 group for three years.

Kapp et al. (1994) found that 20% of the entire sample were sentenced to prison as adults. Most of the youths were imprisoned within three years of release from the program. Juvenile recidivists were more likely to commit offenses in adulthood than non-recidivists. In addition, non-white juvenile recidivists were more likely than other groups to be imprisoned as adults.

Child welfare supervised children were just as likely to be imprisoned as former delinquents. However, given the predictive variables, the most vulnerable group was non-white, juvenile recidivists who were released to non-home settings. Thus, the least vulnerable group was white/juvenile non-recidivists released to their own homes (they had 4.5 times lower likelihood of adult imprisonment compared to the most vulnerable group).

2.5 Cost

The cost of a placement must be understood in relation to its long and short-term meanings. There is no doubt that group care is more expensive on a daily basis. Yet, if group care is a high short-term cost that reduces long term costs then the cost advantage might fall to group care. Webster (1999) indicates that about 8.4% of children in California were in group care on any given day and that they cost 36.9% of all dollars spent—roughly 4.4 times the average unit cost. Treatment/specialized foster care agencies, by comparison, accounted for 12.6% of placements and 25.4% of the dollars—roughly twice the overall unit cost.

Not surprisingly, then, children in kinship care are 47% of the caseload but require 17% of the budget and foster care had 30% of the children but only used 19.9% of the budget. In other words, the board and care provided to children in

group care cost 6.6 times what a child in foster care cost and more than twice what a child in treatment foster care costs. More dollars were spent in 1996 on the 8.4% of children in group care than were spent on the 76.7% of children in foster care and kinship foster care.

Some of these group care costs may offset expenses that would have been incurred by local communities. Group care and treatment foster care costs often include mental health services. Group care costs may also include educational services, although this is not always the case. Indeed, one of the substantial difficulties in determining the relative value of group care is the heterogeneity of residential programs. Group care is provided for children in the child welfare system whether or not they have mental health problems, which makes it difficult to determine the impact of the care on their mental health outcomes. Mental health group home care with educational services was determined to cost in excess of $6,000 per month per child, nearly a decade ago (Hoagwood & Cunningham, 1992). Even without a guarantee of treatment and education, the costs of group care must be assumed to be many times higher than foster care and substantially higher than treatment foster care.

Section 3. Policy and Program Implications

The evidence about foster and group care fails to generate laser bright conclusions but casts major shadows over the use of group care. The findings illuminate several policy and program implications which are, herein, organized according to the evidence they offer for situations in which group care is generally not appropriate and those in which it might be.

Alternatives to Group Care Should be Pursued

3.1.1 Foster Care and Treatment Foster Care are More Desirable and Efficient than Institutional Care

According to widely held principles of human services care (which are embodied in many federal and state laws), clients should be served in the least restrictive, safe setting (Kavale & Forness, 2000; Marty & Chapin, 2000). According to this basic principal, children who can be cared for in treatment foster care or foster care should be cared for in those least restrictive levels of care. There is no evidence that the overall quality of care is better in group homes yet they cost many times more, leaving a balance sheet that clearly favors the less expensive alternative. Although children in group care may have a somewhat lower likelihood of reporting that they were abused or neglected, these rates are not sufficiently low enough to countervail the many developmental advantages of spending time with families that can share the expectations, responsibilities, and endearments of family life.

Most important, children who cannot return home and need a family to adopt them and help them grow into mature adults, have their greatest chance of finding such a family in the foster family that cares for them. They have virtually no chance of gaining support for independent living from group home providers. Although Maluccio, Ainsworth, and Thoburn (2000) indicate that some providers in the U.K. see group care as a desirable setting for youth who are about to emancipate, this seems far less than ideal. For example some children leave group care without ever having gone food shopping—which is done during the day when they are in school (personal communication, June, 6, 2001). More generally, many group care settings provide so much structure that youth are not able to exercise much discretion or learn to take responsibility for themselves (McKenzie, 1999). This structure comes with a deep financial cost and at a cost to the development of youth.

Centralized Emergency Shelters are Not Necessary and are Likely to Be Inefficient

Many municipalities have no centralized emergency children's shelter or "receiving home." Instead, they operate with a series

of emergency foster homes and, for older youth, emergency group homes (of the 6 to 8 bed variety). In some settings, these emergency group care settings are limited to 30 days or less, although many children remain in these placements for longer. In some counties, the group care is limited to older children In other locales, older children who are being placed for the first time are separated from children who have experienced repeated placements in order to try to reduce the contagion that can arise when children of different ages and experiences co-habitate in the same setting.

Shelters have been asked to do a lot for child welfare agencies: to provide a setting for a child to remain while the child welfare worker determines the next placement, to provide a site for multi-disciplinary team review, and to house children for month after month as a substitute for a family like setting (and when no other more therapeutic placement can be found.) They often fail to achieve their goals of providing a family liking setting and sometimes even fail to provide a safe environment (Lucas, 2001). Alternatives to shelters must, then, provide at least these functions which call for the development of specialized services.

Exhibit 8 offers a framework for thinking about alternative forms of care for children first entering out-of-home care. Down the left hand side are functions of care and across the top are the primary sources of out of home care, following a child's removal. None of these approaches, alone, are optimal for all children. Although children's shelters provide the benefit of allowing a child welfare worker to freely go about the business of screening possible foster care and kinship care placements and can have a centralized assessment center, the downside is that they are institutional, house children of many ages (which can result in contagious exposure to problem behavior of older children), have high run away rates, and, in some cases, have lower licensing standards than day care centers, foster homes, or small community-based group homes.

Centralized assessment centers that are parts of shelter care facilities are not the only way to achieve efficient assessment and triage. According to Neil Halfon, a leading figure in the provision of health and mental health care to foster children and author of a soon-to be-released report on the subject, several cities are effectively working with decentralized approaches to assessment. Once children have received an initial, comprehensive medical assessment, they are referred on to regionalized developmental and mental health assessment centers for these children, and approach that is "potentially more viable and feasible given current delivery systems" (Halfon, personal communication, August 31, 2001).

3.1.3 An Alternative: Receiving Centers Plus Emergency Foster Care or Small Group Care

The needed functions of emergency shelters can be achieved by combining receiving centers and emergency foster care or small group care (for older children). This would require considerable expansion of one little used component of a system of care that is an alternative to shelter care—the receiving center (Contra Costa County, August 24, 2001). Several advantages of receiving centers were identified in a site visit and conversation with Linda Canan, the conceiver and manager of the Receiving Centers (personal communication, June 26, 2001). The idea was born when her agency was beginning to implement new policies requiring that child welfare workers assess kin, including criminal record checks, before placing children. This approach also took pressure off child welfare workers to place children who were sitting in their car or office.

Because children can remain at the receiving center for up to 24 hours (and receive considerable car while there), the emergency foster parents who take children have been please with the greater ease of their work. They can now accept children in a more convenient way—allowing them to better meet the needs of children already in their care—and to receive children who are already bathed, fed, clothed, de-loused and comforted. According to Ms. Canan,

Exhibit 8

Functions	Children's Shelter	Receiving Center	Emergency Foster Home	Emergency Shelter (Small Group Home)	Foster Care	Kinship Care
Safe setting for child	Good	Good	Good	Good	Good	Depends upon ability to conduct safety background check prior to placement
Facilitative setting for child assessment	Good	Good	Uncertain or poor due to decentralization	→		
Provides opportunity to assess placement options	Uncertain or poor because setting is not family like	Good, because stay is brief	Good	Uncertain or poor because setting is not family like		Uncertain or poor
Houses children until appropriate placement can be found	Yes	No longer than 23 hours	Yes	Yes	Yes	Yes
Comforts children	Uncertain or poor because of long stays and institutional conditions	Good	Good rules	Uncertain or poor because of group care	Good	Good if relative is known to child
Help child get prepared for placement	Good	Good	Good	Good	Good	Good
Facilitate visiting by biological parents	No	No	Good	Uncertain or poor	Good	Good
Facilitates search of child welfare worker (CWW) for optimum placement	Good	Good	Good	Good	Uncertain or poor because this home may not be optimum	Poor, if this is first placement and kin have not had home or background check

the institution of the Receiving Centers has helped to reverse the resignations of emergency foster home parents and made this a much more attractive role.

Child welfare workers value receiving centers because they can talk confidentially and candidly with foster parents, while receiving center staff care for the children. Further, in some cases, they save on the time required to transport the children to foster care because the foster parents can come and pick up the children at the receiving center. Child welfare workers are also able to provide the foster parents with better information about the child's likes and dislikes—summarized by the receiving center staff. When children are returned home, they often have a new change of clothes, their original clothes are washed, and they are rested and content. Receiving center and health staff also begin to enter information into the health and educational passport. Receiving centers also have a cost, although they can be combined with existing community based organizations (e.g., family resource centers) to reduce unit costs.

Receiving centers may be least effective in assisting "high end" children who have had repeated placement breakdowns because of diminished odds of finding another appropriate setting in less than a day. Some of these youth do send time in emergency group home placements, if foster care homes are not available.

3.2 Special Problems that Group Care Can Help Solve

3.2.1 Youth who have previously run away from foster care

Group care has a role in the solution of several problems that routinely arise in the delivery of child welfare services. Children in out of home care have high rates of running away (Courtney & Barth, 1996; Wulczyn, Hilsop, & Goerge, 2001). Children who run away are largely adolescents. When children run away, they often put themselves at high risk of victimization, and limit their chances to receive rehabilitative services. Small group care can be effective in helping to reduce run away behavior because of the 24-hour supervision, although group care does not eliminate running away (NSCAW Research Team, 2002). Youth who have run away from kinship or foster home care despite the institution of appropriate procedures (Barth, 1986) may be more adequately served in group care. Prior assumptions should not be made, however, that group care is always needed for youth—youth generally prefer foster and kinship care to group care and there is reason to try these settings first.

3.2.2 Youth who are destructive or self-destructive

Group care can provide additional supervision and observation for youth who are destructive of self- and others. There is evidence that youth who would otherwise be hospitalized can be equally well-served with community based services (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) there may still be some advantages of short-term spells in group care for youth who need substantial amounts of supervision to break patterns of destructive behavior. Although we lack controlled studies of group care vs. treatment foster care for this group, anecdotal evidence indicates that foster parents often ask to have destructive youth replaced into group care. Concerned parents are also turning to direct placement of their children in group care when they see no community alternatives that can assist them (Rimer, 2001). Efforts to test the efficacy of treatment foster care for youth who are dually involved in the juvenile justice and mental health systems are now underway (Farmer, 2000).

One way to boost the efficacy of institutional care for dealing with destructive youth is to increase family involvement. In the last half-century, institutional care has evolved substantially from large dormitory style buildings to smaller cottages and community-based settings and continues to evolve—in the next century that evolution should result in increased involvement of

family members with children in care (Whittaker, 2000). Several recent studies indicate that family-involvement appears strongly associated with obtaining better outcomes for youth with serious mental health problems. Leichtmann et al. (2001) investigated outcomes of 123 adolescents placed in an intensive short-term residential treatment program at the Menninger Clinic. The program offers psychiatric services comparable to hospital programs, including pharmacotherapy, psychotherapy, group and family therapy. The program is "short-term" because its lengths of stay are considerably less than traditional residential programs and it employs principles of short-term therapy. These principles include treating a finite number of the most severe symptoms aggressively in conjunction with their families, so that the adolescents may move down to other less intensive and less expensive settings. The program also has a significant orientation towards helping the adolescent transition back into the community and thus, works with outside resources including extended family, schools, and recreation programs.

At 3 months post-discharge, 49% of adolescents showed reliable improvement (improvement of greater than 13 points) and 70% showed clinically significant improvement in YSR scores (mean score closer to the normal average). On the CBCL scores, as rated by parents, 71% showed reliable improvement (by five points) and 53% clinical improvement 3 months after discharge. In terms of the CAFAS, 79% showed reliable improvement in functioning 3 months post-discharge (at least a 40 point improvement) and 65% showed clinically significant improvement. Furthermore, at 12 months post-discharge, adolescents retained improvements on all of these measures.

Although this study population is limited to children with severe psychiatric symptoms and lacks a control group, the findings are still germane to this question of foster care and institutional care. The strong results of the study indicate that redesigned residential treatment programs could provide benefits to our most seriously troubled children. Residential treatment programs could, then, make an important contribution to the continuum of child welfare and mental health care.

3.2.3 Youth who are moving back to the community from more restrictive care

Many of the youth who enter group care come there from other more restrictive levels of care—e.g., psychiatric hospitals and juvenile detention facilities. This can be an appropriate role for group care in the overall system of care because it is short-term and planned with a clear goal of reunification. If combined with a family-focused reunification program, this use of group care could provide more time to implement the plan than is typically available when children are returned directly home from psychiatric facilities.

3.3 Summary

Group care is expensive and restrictive and should be used only when there is clear and convincing evidence that the outcomes will be superior to those of foster care and other community-based services. Some communities and states have legislation that all but precludes the use of group care with younger children. Consistent with that policy direction, the International Development Corporation has recently called for the dismantling of all group care for the routine placement of children (IDC, 2001).

At the same time, ironically, some state legislatures are considering the expanded use of group home care because of a belief that it better provides for the needs of children. Yet, this review indicates that there is virtually no evidence to indicate that group care enhances the accomplishment of any of the goals of child welfare services: it is not more safe or better at promoting development, it is not more stable, it does not achieve better long-term outcomes, and it is not more efficient as the cost is far in excess of other forms of care.

New models of care need to continue to be developed. There is no empirical reason

to return to large residential facilities to care for children entering placements at the point of a family emergency or for those remaining in child welfare services for a longer time. There is no new or old evidence to indicate that shelter care, or group care in general, is a sound approach to caring for most children entering child welfare services. Group care should only be considered for those children who have the most serious forms of mental illness and self-destructive behavior.

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Glossary of Types of Out of Home Care

Children's Shelter/Receiving Home: This is a term used to describe centralized emergency shelters that children were taken to by police or child welfare workers while decisions were made about their future placements. Typically these planned stays may be for as short as one night and as long as 30 days—sometimes they last much longer than this, however. "Children's shelter" is a more apt description than "receiving home" because these facilities do not fit the characteristics of a "home." Some of them are quite large—housing hundreds of children. Unlike a home, they are not permanent, personal, unique, and filled with family members. Instead, they are filled with staff, relatively sterile, often overcrowded, and governed by rules that may be necessary for operating an institution (for example, no hugging of children by staff).

Receiving Center/Transfer Center): A child-friendly, temporary environment in which children who have been removed from their homes can wait, be fed, sleep, be comforted, and (as appropriate) be bathed and deloused prior to going to their next setting. A receiving center allows child welfare workers to gain the privacy they need to contact possible placements and the time to go out and visit possible kinship placements and do background checks to see if they are safe. Foster parents may pick children up at the Receiving Center. After hours child welfare staff have access to the Receiving Centers and staff to help with children are on call at all hours. Because they are not licensed, children cannot stay at Receiving Centers for more than 23 hours.

Emergency Foster Home: A foster home that is especially designed and funded to care for a few children for a few days, weeks, or months. Emergency Foster Homes routinely care for smaller children, but may also care for adolescents. Providers are typically given a per diem rate per bed, whether or not the bed has a child in it—this assures that a space will be available when needed. Children may enter Emergency Foster Home directly following pick up by the child welfare worker, following a stay ad a Receiving Center, or following a stay at the Children's Shelter. Children do not stay in Emergency Foster Homes after the point at which it is clear that they are not going home and after the point at which another foster home can be identified that will be part of the reunification or permanency planning efforts.

Foster Home: In some child welfare systems of care, children go first into foster homes. These homes may be treatment foster care homes (see below) or traditional foster homes. Child welfare workers must first identify that they have available space and, ideally, assess whether or not the foster care provider would be likely to be able to provide a longer term (even permanent) placement for a child. Because of the demands of making expeditious placements, it is difficult to use foster homes in such an ideal way.

Kinship Foster Home: In kinship foster home care, foster care is provided by the child's relative (other than mother or father). These placements may eventually need to be licensed, but generally do immediately need to meet basic requirements like criminal record check clearance. Because kinship foster care providers may not

meet the criminal record check requirements or be appropriate for providing care (because of their own health or familial constraints), some states are curtailing the practice of having child welfare workers bring children directly into kinship foster care and are first conducting preliminary assessments of kinship options.

Group/Congregate Care/Children's Residential Center: A general term for facilities that provide 24-hour care to children that is supervised by unrelated adults in shifts.

Group Home: Generally a 6 to 8 bed facility that provides group care. Some group homes serve as "emergency shelters" for adolescents, and have a payment arrangement similar to emergency foster homes.

Residential Treatment Center: An organization whose primary purpose is the provision of individually planned programs of mental health treatment, other than acute inpatient care, in conjunction with residential care for seriously emotionally disturbed children and youth, typically ages 17 and younger. CTCs have a clinical program within the organization that is directed by a psychiatrist, psychologist, social worker or psychiatric nurse who has a master's degree or doctorate. The primary reason for the admission of more than half the clients is serious emotional disturbance/behavior disorder that can be classified by the DSM-IV, other than moderate to severe mental retardation or developmental delay (2).

Treatment/Specialized Foster Care/Home: An adult-mediated treatment model in which community families are recruited and trained to provide placement and treatment to youth who might otherwise have difficulty in maintaining placement in regular foster care. Treatment foster care homes usually have no more than two children.

Juvenile Detention Center: Detention is a secure, temporary facility where a child in foster care may stay, if charged with a crime, while waiting to go to court or until a placement can be arranged.

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