Why Quality Residential Care Is Good for America's At-Risk Kids:

A BOYS TOWN INITIATIVE

BOYS TOWN
Saving Children   Healing Families

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Residential Care Is Under Attack

POLICY ADVOCATES AND SYSTEM REFORMERS ARE CRITICAL OF RESIDENTIAL CARE,

and argue that it should be reduced or eliminated as an out-of-home placement for at-risk youth. These critics contend that residential care:

» Traumatizes children and families by separating children from their families

» Produces poor outcomes

» Invites abuse and negative peer contagion

» Is expensive

Boys Town disputes these arguments because they are not supported by research and practice, and do not pertain to all residential care.

The critics do not differentiate between poor-quality and high-quality residential care. High-quality residential programs have high levels of youth and family engagement, consistently demonstrate positive outcomes, and have not been shown to produce negative peer contagion. Additionally, quality residential care is cost effective.

The critics also ignore research that shows that quality residential care is the best option for a subset of at-risk, high-needs children whose treatment needs cannot be met through less-restrictive approaches like foster care and family-based programs.

Boys Town advocates for quality residential care for these youth because it is in their best interest and gives them the best opportunity to achieve positive outcomes.
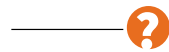
The Necessity for Quality Residential Care

RESEARCH AND PRACTICE DEMONSTRATE THAT QUALITY RESIDENTIAL CARE

is an essential component of any continuum of care for at-risk youth.[1]

Some critics of residential care say that foster care and family-based programs can adequately meet the needs of children. Many organizations like Boys Town acknowledge and agree that at-risk youth should be served in their own homes or in foster care whenever possible, and have already made a shift to that approach. For example, where Boys Town used to provide care for 85% of youth through its residential program, it now serves more than 90% of the nearly 30,000 youth who receive services, in their own families or in family-like settings.

But even with that shift, we still know that these less-restrictive approaches cannot meet the needs of all youth, particularly those with serious behavioral or emotional problems.

High-quality residential care has been demonstrated to be effective for youth with high needs, especially those who have repeatedly been failed by attempts to help them in less-restrictive interventions.

And although quality residential care may be costly in the short term, it results in long-term personal and economic benefits for youth, their families and society.

the INSIDE story

These stories about youth who found help in the Boys Town Family Home Program^{SM} are real. The youths' names have been changed to protect their privacy and therapeutic interests.

JAMISON

Jamison was headed toward real trouble. Skipping school, fighting, and not listening to his parents were common behaviors. When he was 15, he was arrested for stealing a bike. When he violated his probation for that offense, he landed in jail.

The judge who handled the case decided to give Jamison a second chance, and soon, the teen was living in a Boys Town Family Home.

Working with his Family-Teachers®, and with the support of his parents, Jamison focused on developing his academic and social skills. He got better at reading and spelling, his schoolwork improved, and he began to earn praise from his teachers. His attitude changed too, as hostility and aggression gave way to the warmth and caring around him. The kid who had been headed for trouble now seemed headed for success.

As Jamison got better, a Boys Town's In-Home Family Services® Consultant began working with the teen's parents to improve their parenting skills. The Consultant also showed them how to solve family problems and use helpful community resources.

The powerful combination paid off. After living with his Boys Town family for a little more than a year, Jamison was able to reunite with his parents and get a fresh start.

PREVALENCE LEVELS *for At-Risk Youth*

The proportion of at-risk youth served is directly related to the restrictiveness of service settings: *Very few youth are served in residential care*.
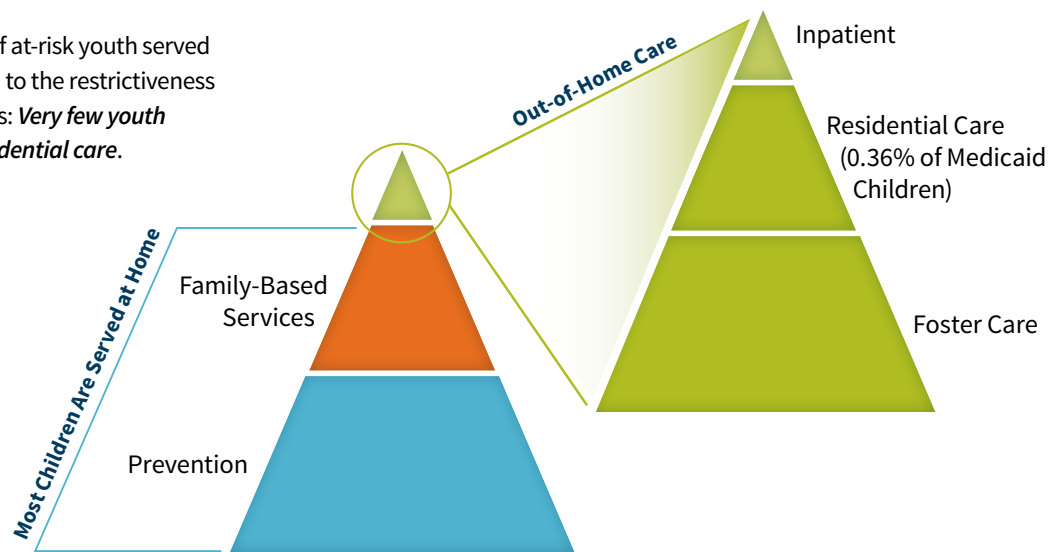
Most Children Are Served at Home

Out-of-Home Care

Prevention

Family-Based Services

Inpatient

Residential Care (0.36% of Medicaid Children)

Foster Care

Figure based upon National Medicaid Data.

Outcome Data Indicate Poor Outcomes for Children in the Child Welfare System

DATA FOR ALL YOUTH IN THE CHILD WELFARE SYSTEM SHOW

that current services are not meeting youth needs. For example:

Education

» Dropout rates are as high as 75%[3]

» Special education status is 29% higher than that of the general population[4]

Drug abuse

» Use of marijuana is 29% higher than in the general population[5]

» Use of inhalants is twice as high as in the general population[5]

» Use of hard drugs is 50% higher than in the general population[5]

Delinquency

» Arrest rates are 55% higher than in the general population[6]

» Arrest rates for violent crimes are 96% higher than in the general population[6]

» Juvenile detention rates are 6.9 times higher than in the general population[7]

Mental Health

» Up to 80% of youth have mental or behavioral health problems[8]

CONCLUSION: *Child welfare youth are already significantly at-risk.*

Foster Care and Family-Based Programs Are Not Enough

RELIANCE ON FOSTER CARE AND FAMILY-BASED TREATMENT OPTIONS ALONE IS NOT WISE.

For example, many youth in foster care in the United States have had multiple placement disruptions, especially youth who enter care with significant behavior problems (see Figure 1[9] and Figure 2[10]).

Foster care disruption rates during the first 12 to 18 months of a child's placement range from 28% to 57%.[11] These placement failures require children to adjust to new families and schools, and they often experience increasing emotional and behavioral problems.[12] Such repeated placement experiences result in more trauma.

FIGURE 2:
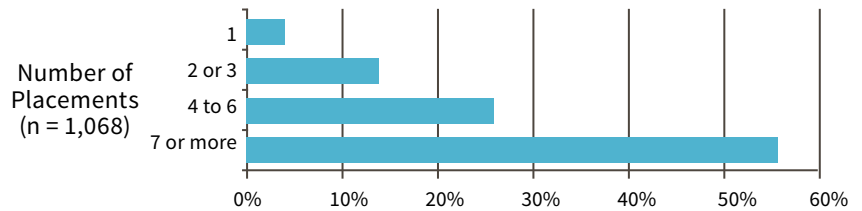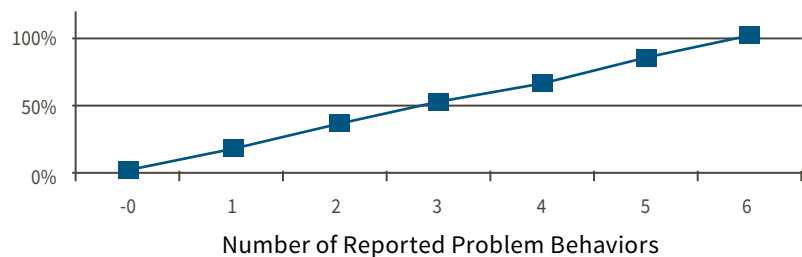
TOTAL PLACEMENTS DURING FOSTER CARE HISTORY[9]

Number of Placements (n = 1,068)

- 1
- 2 or 3
- 4 to 6
- 7 or more

0% 10% 20% 30% 40% 50% 60%

FIGURE 2:

RATE OF FOSTER CARE DISRUPTION[10]

Risk of disruption increases by 17% for every problem behavior reported.

100%
50%
0%

-0   1   2   3   4   5   6

Number of Reported Problem Behaviors

CONCLUSION: *Something else is clearly needed.*
Quality residential care is one effective option.

One example of the negative impact of the absence of residential care comes from Warwickshire County, England, where eliminating residential care as a service option for youth failed to accomplish the intended reform goals.[13]

After 10 years of planning, Warwickshire County closed its last children's home in 1986, implementing a new policy that favored foster care. New services were funded from the closing of residential facilities.

The results were not good for children or the county's child care system:

» There were more placement disruptions.

» Youth had less-frequent contact with their families and friends.

» Educational outcomes worsened.

» There were high levels of emergency admissions.

» New services did not reduce youth admissions to care.

» Following several placement disruptions, youth were placed in out-of-area residential programs.

Overall, the policy disadvantaged children.

A second example comes from Australia, where a similar approach to eliminate residential care also produced negative results and failed to accomplish the intended service reform goals.[14]

During the 1990s, Australian State and Territory governments indiscriminately closed residential programs. The reason behind the closing was that foster care (especially kinship care) was preferable and cheaper.

Again, children were disadvantaged and the child care system was damaged:

» A crisis occurred in foster care as foster parents became exhausted and burned out, and left the system.

» Many youth ended up having their basic needs met through homeless programs or ended up in juvenile justice settings because they turned to crime.

» Child welfare expenditures decreased, but overall taxpayer costs increased.

» Youth were largely unsupervised and their needs went untreated.

LESSONS LEARNED:

» *It is unrealistic to expect foster parents to manage extreme youth behaviors.*

» *Foster care cannot be the only out-of-home option for youth with emotional and behavioral challenges.*

» *When foster care fails, many youth eventually end up in some form of negative residential placement (homeless/juvenile justice programs).*

» *This approach only transfers responsibility for the most vulnerable children to less-capable services.*

WISE *words*

"Those who fail to learn from history are condemned to repeat it."

— GEORGE SANTAYANA

What Is High-Quality Residential Care?

QUALITY IS VARIABLE AT ALL LEVELS OF CARE FOR YOUTH. THERE IS NO ONE DIMENSION

that defines quality residential care.

Quality in residential care is a combination of acknowledged performance standards.[15] Some of these standards include:

Safety

» Youth are safe from:
  - Abuse
  - Crime
  - Drugs
  - Physical discipline

» Mechanisms are in place to prevent self-harm and harm to others

» Premises are suitable and safe

» Only clinically appropriate psychotropic medications are prescribed

» Program is licensed and has external monitoring on validated standards

» Mechanisms are in place for youth and staff to report problems

» Independent auditing of potential safety issues is a standardized, routine part of the program

Effectiveness/Positive Outcomes

» Evidence-based programs/practices

» Comprehensive assessments

» Data-/Assessment-driven treatment

» Full access to required therapeutic supports

» Transition planning

» Demonstrated positive outcomes

» Preparation of youth for transition to adulthood

» Aftercare and community service coordination

Program Elements

» Clearly defined model of care

» Focus on permanency, safety, and well-being of youth

» Trauma-informed

» Strengths-based

» Child-focused

» Individualized

» High level of family involvement and engagement

» Youth learn prosocial behaviors and practice them

» Youth rights are respected and communicated

» Youth time is highly structured

» Youth activities are closely supervised

» Skilled, trained, well-supervised staff

» Culturally sensitive staff

» CQI evaluation framework

Normative (Normality)

» Family-style living environment

» Family engagement

» Child is involved in the community

» Normal schooling

» Exercise and sports opportunities for youth

» Youth physical health, dental, and optical needs are assessed and met

Evidence-Based Status of Quality Residential Care Models

RESULTS OF A RECENT SCIENTIFIC REVIEW OF THE EVIDENCE FOR MODELS OF RESIDENTIAL CARE

based on the California Evidence-Based Clearinghouse for Child Welfare indicated that there are four evidence-based models[16]:

» Teaching Family Model and Boys Town Family Home Program[SM]

» Sanctuary Model

» Positive Peer Culture

» Stop Gap Model

Teaching Family Model programs and the Boys Town Family Home Program[SM] (which was derived from the Teaching Family Model) are prime examples of quality residential care and are the most researched models of residential care in the United States.[14]

The Teaching Family Model includes the following elements:

» Multiple layers of safety systems for youth and staff

» Positive short-term and long-term outcomes

» Manualized training, supervision, and staff certification systems

» Evidence-based practices that are embedded in the program

» Youth experience the program in a normalized family environment; they attend school and participate in family, school, and community activities

» There is a focus on supporting youth transition from the program to a permanent family

the INSIDE *story*

SAMANTHA

Samantha carried the scars of abuse and neglect with her for years. As she bounced from one foster home to another, she could never overcome the pain and loneliness of being hurt by people who were supposed to love and protect her.

When she arrived at a Boys Town Family Home, Samantha was an angry, resentful teenager who was hesitant to trust any adult.

Samantha's Family-Teachers knew they had a difficult task ahead of them. But they consistently worked with her to teach essential skills and how to build healthy relationships. Most importantly, they gave her a family, and showed compassion and understanding that slowly gained the teen's trust. It took more than a year, but the hard shell Samantha had created to protect herself began to break away and a loving, smiling girl began to emerge.

Samantha's schoolwork improved and she was able to put the pain of her past behind her. When she graduated high school and entered college, she was ready to take on life as a mature, responsible young adult.
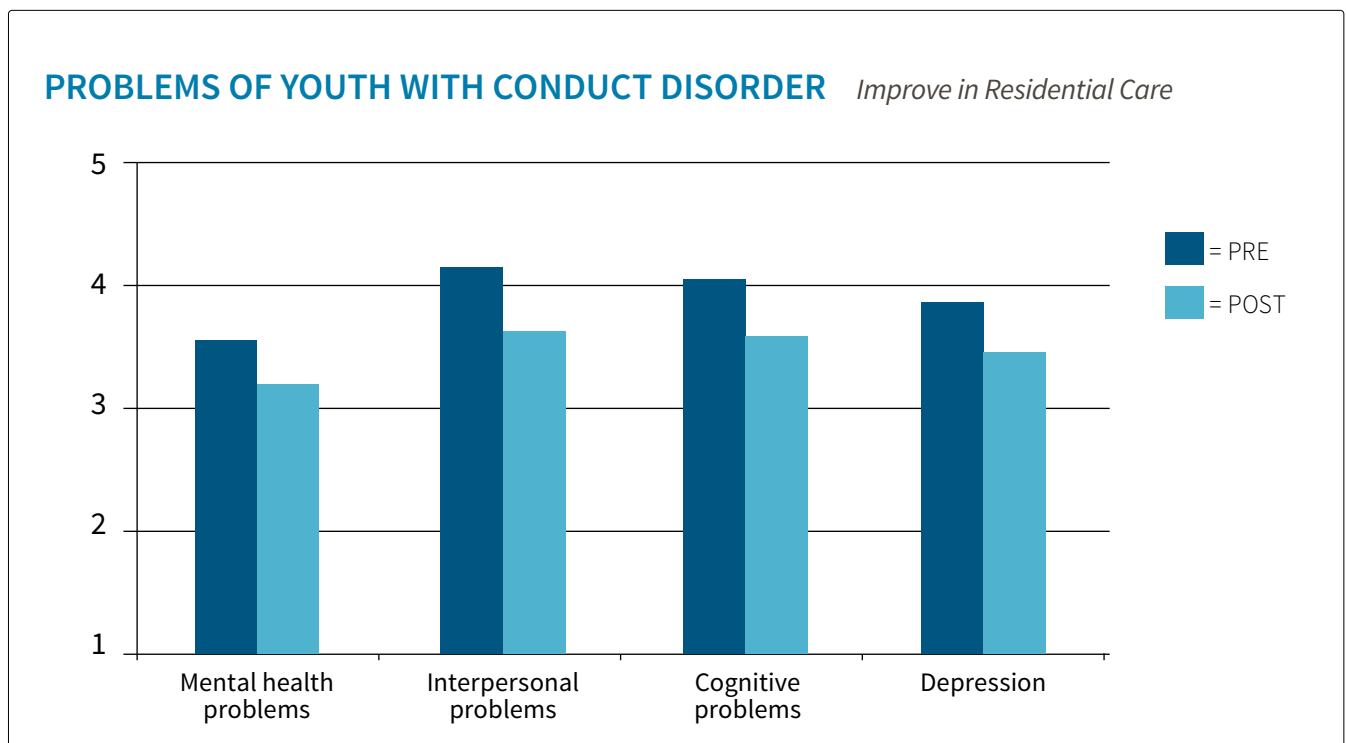
Effectiveness of Residential Care

RESIDENTIAL CARE HAS BEEN SHOWN TO BE EFFECTIVE

for youth whose problems are difficult and costly to treat, and who have experienced failure in other services. An example is youth who have Conduct Disorder, which is characterized by persistent antisocial and aggressive behavior. In a large study of youth in residential care in Illinois, youth who were diagnosed with Conduct Disorder made statistically significant improvement in problem behaviors during an episode of residential care.[17]

CONCLUSION: *Children whose needs are not met and who are traumatized because they experience failure in less-restrictive interventions can be successful in quality residential programs.*

PROBLEMS OF YOUTH WITH CONDUCT DISORDER *Improve in Residential Care*

= PRE
= POST

	Mental health problems	Interpersonal problems	Cognitive problems	Depression

Family-style residential care has demon-strated positive outcomes, which youth maintain into adulthood.

Examples of High-Quality Residential Care

THE TEACHING FAMILY MODEL AND BOYS TOWN'S ADAPTATION OF IT — THE FAMILY HOME PROGRAM —
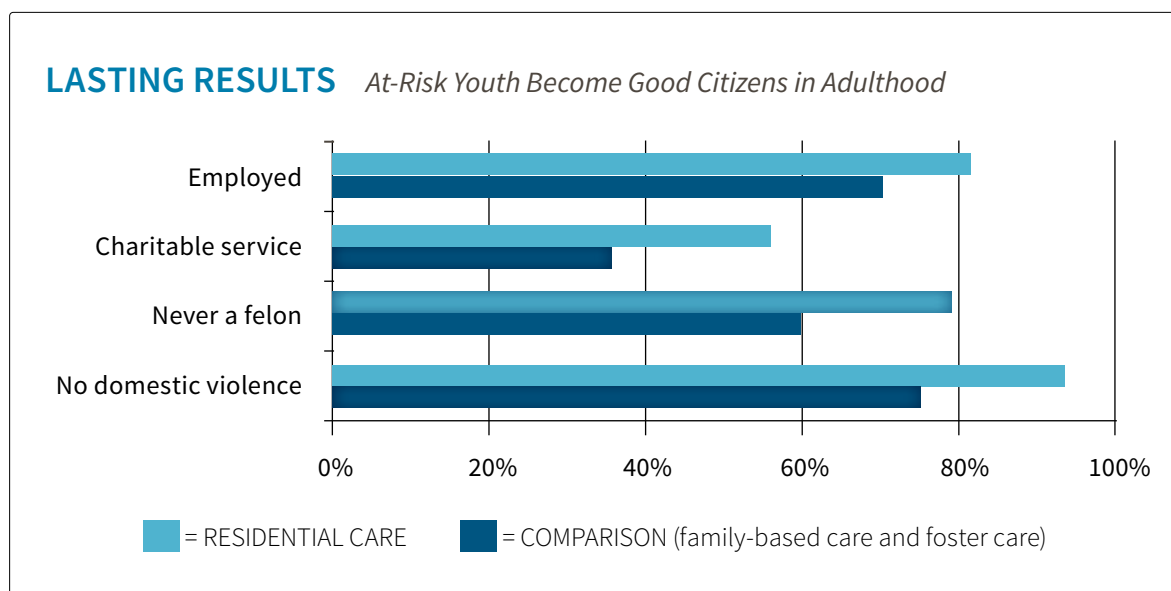
are examples of high-quality residential care.[18]

The Teaching Family Model was developed in an applied research setting and is based on four decades of applied research. During the first two decades, the majority of this research was done at the University of Kansas and other Teaching Family Model sites. Since that time, the majority of Teaching Family Model research has been conducted at Boys Town on the Model's major

adaptation, the Boys Town Family Home Program[SM].

The Teaching Family Model and the Boys Town Family Home Program provide a comprehensive, multidimensional, manualized approach to residential care that has been replicated nationwide. They include systems for replication with fidelity, and have produced positive outcomes for youth in adulthood up to 16 years post-discharge.[19]

An added major benefit of the Teaching Family Model and the Boys Town Family Home Program is that children in care experience these programs as part of a family, much like they would in a foster family. Yet these programs can effectively help youth who have failed in numerous less-restrictive placements such as foster care or other group home settings.

LASTING RESULTS *At-Risk Youth Become Good Citizens in Adulthood*

■ = RESIDENTIAL CARE   ■ = COMPARISON (family-based care and foster care)

Data from Boys Town's 16-year follow-up study.

Family Home Program:
No Evidence of Negative Peer Contagion

IN SOME CARE ENVIRONMENTS, INTERACTIONS WITH PEERS CAN LEAD CHILDREN TO INCREASE

their aggressive, delinquent, and drug use behaviors. The threat of this negative peer contagion has been a special concern in some residential care settings and critics have focused on it as a detrimental element of residential care.

However, research that specifically examined this in the Family Home Program indicates that youth do not experience negative peer contagion because they are part of a positive, effective teaching model where youth learn positive skills and behaviors, including from each other, and use these skills and behaviors with each other.

The research showed that in Family Home residential care:

» There is no relationship between exposure to deviant peers and an individual youth's externalizing behavior patterns over time.[20]

» Youth had significantly fewer problems/negative behaviors over time, and youth with more serious problems/negative behaviors showed greater improvement.[21]

» Having a higher percentage of troubled youth in a residential home is not related to the total number of problem behaviors within the home.[22]

Quality Residential Care Pays Off in Long-Term Financial and Societal Benefits

RESIDENTIAL CARE IS COSTLY IN THE NEAR TERM. BUT QUALITY CARE CAN PRODUCE

positive long-term outcomes, and youth, families, and society can benefit personally and economically.

Current Medicaid Cost of Residential Services[23]:

» $1.5 billion for 71,003 children

Youth Benefits from the Boys Town Family Home Program[SM] (after departure from program)[24]:

» 77% of youth are arrest-free

» 86% of youth are not heavy drug users

» 90% of youth graduate from high school (compared to the typical graduation rate of 50% in foster care[25])

SOCIETAL COST OF A LOST CHILD *(low-high)*[2]

HS Dropout
$.7 — $1.0 million

Heavy Drug Use
$1.1 — $1.3 million

Career Criminal
$3.2 — $5.7 million
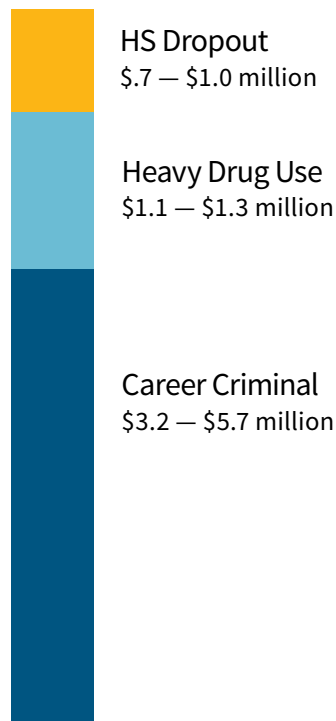
→ Conclusion

ELIMINATING QUALITY RESIDENTIAL CARE IS NOT THE ANSWER TO CUTTING COSTS, REFORMING THE CHILD WELFARE SYSTEM, OR PROVIDING NECESSARY CARE FOR YOUTH WITH HIGH NEEDS.

At-risk youth should be served in their own homes or in foster care if those services meet their needs.

To improve outcomes for at-risk youth in care programs, the focus must be on providing the right services, at the right time, in the right way. For some youth whose needs cannot or have not been met in less-restrictive settings (family-based programs, foster care), quality residential care must be a placement option.

Residential care is an essential element of any continuum of care and, when needed, can be the treatment approach of choice to stabilize a child, teach the skills he or she needs for success, and help prepare the child for placement in a permanent, forever family.

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