

References

Effectiveness of group care:

Numerous reviews of residential treatment centers conclude there is no evidence of lasting benefits for youth who received treatment. A significant portion adolescents who function well at discharge subsequently experience a decline when transferred to a lower level of care. There is no evidence of a relationship between outcomes in residential treatment and functioning in less restrictive environments (Bickman, Lambert, Andrade & Peñaloza, 2000). Youth in residential care did worse on developmental measures one year following placement, had higher re-admission rates after reunification, and two to three times higher costs than foster care (Barth, 2002).

See, for example:

- Barth, R. P., (2002). Institutions vs. foster homes: The empirical base for a century of action. Chapel Hill, NC: UNC, School of Social Work, Jordan Institute for Families.
- Barth, R. P. (2005). Residential care: From here to eternity. *International Journal of Social Welfare*, 14, 158-162.
- Bickman, L., Lambert, E. W., Andrade, A. R., & Peñaloza, R. V. (2000). The Fort Bragg continuum of care for children and adolescents: Mental health outcomes over 5 years. *Journal of Consulting and Clinical Psychology*, 68(4), 710-716.
- Curry, J.F. (1991). Outcome research on residential treatment: Implications and suggested directions. *American Journal of Orthopsychiatry*, 61, 348-357.
- Epstein, R.A., Jr. (2004). Inpatient and residential treatment effects for children and adolescents: A review and critique. *Child and Adolescent Psychiatric Clinics of North America*, 13, 411-428.
- Hair, H.J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993 to 2003. *Journal of Child and Family Studies*, 14, 551-575.

Little, M., Kohm, & Thompson, R. (2005). The impact of residential placement on child development: Research and policy implications. *International Journal of Social Welfare, 14*, 200-209.

Pumariega, A.J. (2006). Residential treatment for youth: Introduction and a cautionary tale. *American Journal of Orthopsychiatry, 76* (3), 281-284.

Some authors have concluded that residential care is a widely used but empirically unjustified service and that any gains made during treatment are seldom maintained once the adolescent returns to the community. Any gains made during a stay in residential treatment may not transfer well back to the youth's natural environment, creating a cycle where children are often repeatedly readmitted. For example, Burns et al. (1999) reported that one large longitudinal six-state study of adolescents discharged from residential treatment found at a seven year follow-up that 75 percent had either been readmitted or incarcerated. Asarnow, Aoki, & Elson (1996), reported that the rate of returning to placement was 32 percent after one year, 53 percent after two, and 59 percent by the end of the third year post discharge, consistent with the view that residential treatment is frequently associated with continuing placement and dependency. Another study found that when children aged ten and older left residential care, for 59 percent of them their next stop was detention, a psychiatric hospital, another residential placement or an unknown destination- because they left residential care by running away from it (cited by Casey Strategic Consulting Group, 2007).

See, for example:

Asarnow, J.R., Aoki., & Elson, S. (1996). Children in residential treatment: A follow-up study. *Journal of Clinical Child Psychology, 25*, 209-214.

Barth, R. P., Greeson, J. K., Guo, S., Green, R. L., Hurley, S., & Sisson, J. (2007). Outcomes for youth receiving intensive in-home therapy or residential care: A comparison using propensity scores. *American Journal of Orthopsychiatry, 77* (4) 497-505.

Burns, B.J., Hoagwood, K., & Mrazek, P.I. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review, 2*, 199-254.

Casey Strategic Consulting Group, Virginia Children's Services Reform Overview, (December 5, 2007). Point presentation to the Joint

Subcommittee on Comprehensive Services for At-Risk Youth and Families.

Dishion, T. J., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. *American Psychologist, 54*, 755-764.

Hoagwood, K., Burns, Kiser, L., Ringeisen, H., & Schoenwald, S. (2001). Evidence-based practice in child adolescent mental health services. *Psychiatric Services, September, 2001, Vol., 52 (9)*, 1179-1189.

Kerman, B., Maluccio, A. N., & Freundlich, M. (2009). *Achieving permanence for older children and youth in foster care*. New York: Columbia University Press.

Lee, B. R., Bright, C. L., Svoboda, D., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*, 177-189.

Mercer Government Human Services Consulting. (2008). *White Paper Community Alternatives to Psychiatric Residential Treatment Facility Services Commonwealth of Pennsylvania, Office of Mental Health and Substance Abuse Services*.

Pecora, P. J., Whittaker, J. K., Maluccio, A. N., Barth, R. P., & DePanfilis, D. (2009). *The Child Welfare Challenge* (3rd ed.). Piscataway, NJ: Aldine-Transaction Books.

U.S. Surgeon General (1999). *Mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Effectiveness of residential care for youth involved in the JJ system:

Youth who engage in seriously violent and aggressive behavior have not shown statistically significant improvement in residential care; similarly, those youth diagnosed with oppositional, defiant, or conduct disorder do poorly in residential settings. No change from residential treatment has been found for aggression, disobedience, impulsivity, and inappropriate sexual behavior; anxiety and hyperactivity often worsen.

See, for example:

Joshi, P. K., & Rosenberg L. A. (1997). Children's behavioral response to residential treatment. *Journal of Clinical Psychology, 53*, 567-573.

Lyons, J. S., Terry, P., Martinovich, Z., Peterson, J., & Bouska, B. (2001). Outcome trajectories for adolescents in residential treatment: a statewide evaluation. *Journal of Child and Family Studies, 10*, 333-345.

Similarly, it has been found that the most restrictive out-of-home placements for mental health treatment, including residential treatment centers, are not effective for most child and adolescent offenders. As cited by Surace and Canfield (2007), an analysis of Maryland youth discharged from residential placements revealed that 66 percent of youth were re-arrested within two years and 76 percent were re-arrested within three years.

See, for example:

Bazelon Center for Mental Health Law (2006). *The Detrimental Effects of Group Placements/Services for Youth with Behavioral Health Problems*. Available through the Bazelon Center for Mental Health Law [Online]. Available at: <http://www.bazelon.org/>

Burns, B.J., Goldman, S.K., Faw, L., & Burchard, J. (1999). The wraparound evidence base. In B.J. Burns & S.K. Goldman (Eds.), *Promising practices in wraparound for children with serious emotional disturbances and their families: Systems of care* (pp.77- 100). Washington, DC: American Institutes for Research, Center for Effective Collaboration and Practice.

Knitzer, J., & Cooper, J. (2006). Beyond Integration: Challenges for children's mental health. *Health Affairs, 25(3)*, 670-679.

Office of the United States Surgeon General. (2001). *Youth Violence: A Report of the Surgeon General*. Rockville MD: Author. Available at: <http://www.ncbi.nlm.nih.gov/books/NBK44294/>

Surace, C. S. & Canfield, E. (2007). *Evidence-based practices for delinquent youth with mental illness in Maryland: Medicaid must cover these cost*

effective services. A Public Report by the Maryland Disability Law Center.

Research on the group care experience:

Evidence has indicated that group homes significantly increased the risk of youth arrest.

See:

Ryan, J. P., et al., (2008). Juvenile delinquency in child welfare: Investigating group home effects, *Children and Youth Services Review*,
[doi:10.1016/j.chilyouth.2008.02.004/](https://doi.org/10.1016/j.chilyouth.2008.02.004/)

Rates of maltreatment of children in residential treatment centers are higher than in foster homes.

See, for example:

Blatt, E. (1992). Factors associated with child abuse and neglect in residential care. *Children & Youth Services Review*, 14, 493-479.

Colton, M., Vanstone, M., & Walby, C. (2002). Victimization, care and justice: Reflections on the experiences of victims/survivors involved in large-scale historical investigations of child sexual abuse in residential institutions of child sexual abuse in residential institutions. *British Journal of Social Work*, 32 (5), 541-551.

Spencer, J.W., & Knudsen, D.D. (1992). Out-of-home maltreatment—An analysis of risk in various settings for children. *Child and Youth Services Review*, 14 (6), 485-492.

Children in group care settings report seeing family members less often as compared with children in family based care, and are less likely to reunify with biological caregivers.

See, for example:

Barth, R. P., (2002). Institutions vs. foster homes: The empirical base for a century of action. Chapel Hill, NC: UNC, School of Social Work, Jordan Institute for Families.

Wulczyn, F., Hislop, K., & George, R., (2000). Foster care dynamics 1983-1998. Chicago: Chapin Hall Center for Children.

Length of stay in group care:

There is growing evidence that most of the gains of residential care (if any) are made within the first six months. For example, a study cited by Hair (2005) reported that the majority of measures that assess behavioral and emotional problems demonstrated progress during the first six months of treatment, whereas no additional gains were noted subsequently. Leichtman, et al., (2001) followed 120 adolescents for four years following a short term residential program (3-4 months). These treatment gains were shown at discharge and at 12 months post discharge.

See:

Hair, H.J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993 to 2003. *Journal of Child and Family Studies, 14*, 551-575.

Leichtman, M., Leichtman, M. L., Barber, C. C., & Neese, D. T. (2001). Effectiveness of Intensive Short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry, 71*(2), 227-235.

Lyons, J. S., Terry, P., Martinovich, Z., Peterson, J., & Bouska, B. (2001). Outcome trajectories for adolescents in residential treatment: a statewide evaluation. *Journal of Child and Family Studies, 10*:333-345.

Results of one literature review concluded that residential treatment (when necessary) should have a duration of no longer than 3-6 months. There has been data demonstrating the pitfalls of congregate care stays in excess of nine months.

See:

Lee, B. R., Bright, C. L., Svoboda, D., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*, 177-189.

Magellan Health Services Children's Health Services Task Force (2008).
Perspectives on residential and community-based treatment for youth
families. Retrieved from: www.magellanhealth.com/

Connections to Neuroscience:

Research has been influential in curbing group care for young children. There are decades of developmental research on the science of attachment in support of a focus on permanent adult connections. Research on the impact of congregate care on older youth is more limited. However, a report on adolescent brain development cites evidence that young people need caring one-on-one adult connections in a real-world setting to learn appropriate risk taking. This report indicates that in the teenage years, the brain undergoes a period of development—a window of learning opportunity—similar to the early years. Because of the brain's ability to be molded during this period, the right interventions can help overcome the effect of early trauma.

See, for example:

Frank, D.A., Klass, P.E., Earls, F., & Eisenberg, L. (1996). Infants and young children in orphanages: One view from pediatrics and child psychiatry. *Pediatrics*, 97(4), 569-578.

Freundlich, M. (2011). The adolescent brain: New research and its implications for young people transitioning from foster care. St. Louis, MO: Jim Casey Youth Opportunities Initiative. Retrieved from <http://jimcaseyyouth.org/adolescent-brain%E2%80%94research-and-its-implications-young-people-transitioning-foster-care/>

Harden, B.J. (2002). Congregate care for infants and toddlers: Shedding new light on an old question. *Infant Mental Health Journal*, 23(5), 476-495.

Smyke, A.T., Koga, S., Johnson, D.E., Fox, N.A., Marshall, P.J., Nelson, C.A., Zeanah, C.H., & the BEIP Core Group. (2007). *The Journal of Child Psychology and Psychiatry*, 48(2), 210-218.

Zeanah, C.H., Shaffer, C., & Dozier, M. (2011). Foster care for young children: Why it must be developmentally informed. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50(12): 1199-201.

Evidence based practice in group care

There is a small amount of support that evidence based practices can be implemented in group care settings (for example, Multimodal Substance Abuse Prevention, Aggression Replacement Training, Ecologically Based Family Therapy, Dialectical Behavior Therapy). However, several significant implementation barriers exist in group care settings that are not present in community based programs. Four themes about implementation barriers emerge: 1) Client receptivity; 2) Staff receptivity; 3) Treatment factors such as instability and uncertainty related to placement impact youth's ability to trust and engage and group contagion; 4) Structural/organizational barriers such as lack of continuity in group leadership due to shift work and overtime needs, uneven implementation, variability in "dosage", scheduling factors.

See, for example:

Coleman, M., Pfeiffer, S., & Oakland, T. (1992). Aggression replacement training with behaviorally disordered adolescents. *Behavioral Disorders, 18*(1), 54-66.

Friedman, A.S., Terras, A., & Glassman, K. (2002). Multimodal substance abuse intervention program for male delinquents. *Journal of Child and Adolescent Substance Abuse, 11* (4), 43-65.

James, S., Alemi, Q., Zepeda, A. (2013). Effectiveness and implementation of evidence-based practices in residential treatment. *Children and Youth Services Review, 35*(642-656).

Morehouse, E., & Tobler, N.S. (2000). Preventing and reducing substance abuse among institutionalized adolescents. *Adolescence, 35* (137), 1-28.

Sunseri, P.A. (2004). Preliminary outcomes on the use of dialectical behavior therapy to reduce hospitalization among adolescents in residential care. *Residential Treatment for Child & Youth, 21* (4) 59-76.