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 of 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:


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:


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.


**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:


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:


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


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

*See, for example:*


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:*


**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:


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:

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:


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:


