LOOKING BEYOND OUR BORDERS: WHAT THERAPEUTIC RESIDENTIAL CARE IN OTHER COUNTRIES CAN TEACH US

ACRC International Therapeutic Residential Care Summit

KEYNOTE

5 November 2020

INTRODUCING OURSELVES

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WHAT WE WILL COVER

- Introduction – TRC terminology and landscape
- Mapping cross-country differences of TRC – an ERASMUS project
  - The macro context
  - Characteristics of children and youth
  - Residential care personnel and training
- Key takeaways

TRC DEFINITION: ORIGINAL

"Therapeutic residential care' involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection to children and youth with identified mental health or behavioral needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources" (Whittaker, del Valle, & Holmes, 2014, p. 24).

TRC DEFINITION

Most (T)RC programs do these things

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TRC DEFINITION

Most treatment -focused programs do these things

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TRC DEFINITION

Many programs set these as ideals but not always attain

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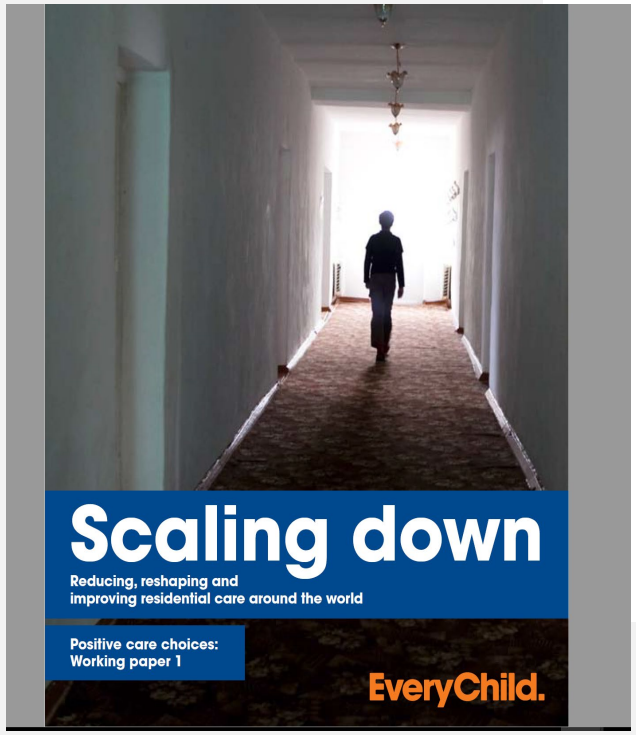

Consensus Statement on Group Care for Children and Adolescents: A Statement of Policy of the American Orthopsychiatric Association

Mary Dozier
University of Delaware

Joan Kaufman
Yale University

Roger Kobak
University of Delaware

Thomas G. O'Connor
University of Rochester

Abraham Sagi-Schwartz
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Stephen Scott
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Judith Smetana
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Leiden University

Charles H. Zeanah
Tulane University

Group care for children and adolescents is widely used as a rearing environment and sometimes used as a setting in which intensive services can be provided. This consensus statement on group care affirms that children and adolescents have the need and right to grow up in a family with at least 1 committed, stable, and loving adult caregiver. In principle, group care should never be favored over family care. Group care should be used only when it is the least detrimental alternative, when necessary therapeutic mental health services cannot be delivered in a less restrictive setting.

CSAC Issue Brief

Continuum of Care Group Home Reform

Background

Governor Brown signed AB 403 (Stone) in October 2015, eliminating most group homes starting in January 2017 and ushering in a foundational shift for the state's foster youth.

The goal of the bill, called "Continuum of Care Reform" (CCR), is to provide better, more appropriate care and services for foster children in home-based settings and to reduce the time spent in congregate care, or group homes. This will require investing in

AB 403 will require, at a minimum, funding for capacity building and new practice requirements in county child welfare services, probation, and mental health agencies.

The Governor has proposed $96 million for foster family recruitment and probation services in his 2016-17 January budget. While the funding is welcome, it falls far short of what is needed for implementation and ongoing activities associated with AB 403—

Stockholm Declaration on Children and Residential Care

The second international conference on Children and Residential Care held in Stockholm 12 – 15 May, 2003, sponsored by the Swedish Foreign Ministry and the Swedish International Development and Co-operation Agency (Sida), has discussed the situation of children in long-term residential care. There is indisputable evidence that institutional care has negative consequences for both individual children and for society at large. These negative consequences could be prevented through the adoption of national strategies to support families and children, by exploring the benefits of various types of community-based care, by reducing the use of institutions, by setting standards for public care and for the monitoring of the remaining institutions.

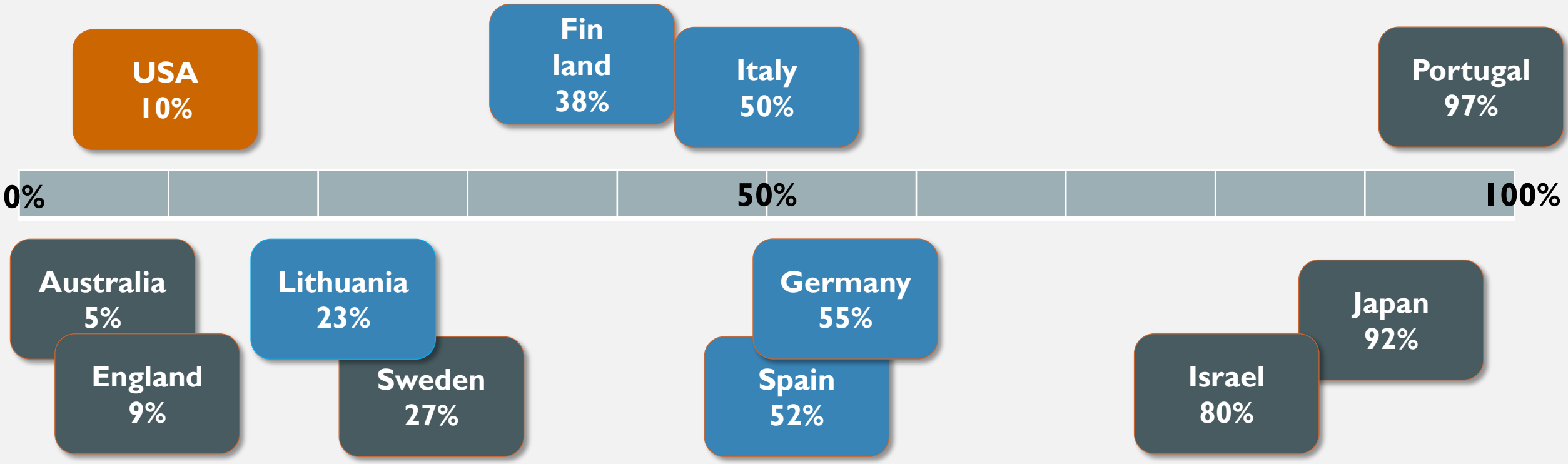
The participants at the conference – more than 600 individuals from governments, civil society and the research community from 71 countries – have agreed on the following:

(T)RC – A FADING INTERVENTION?

CONSEQUENCES

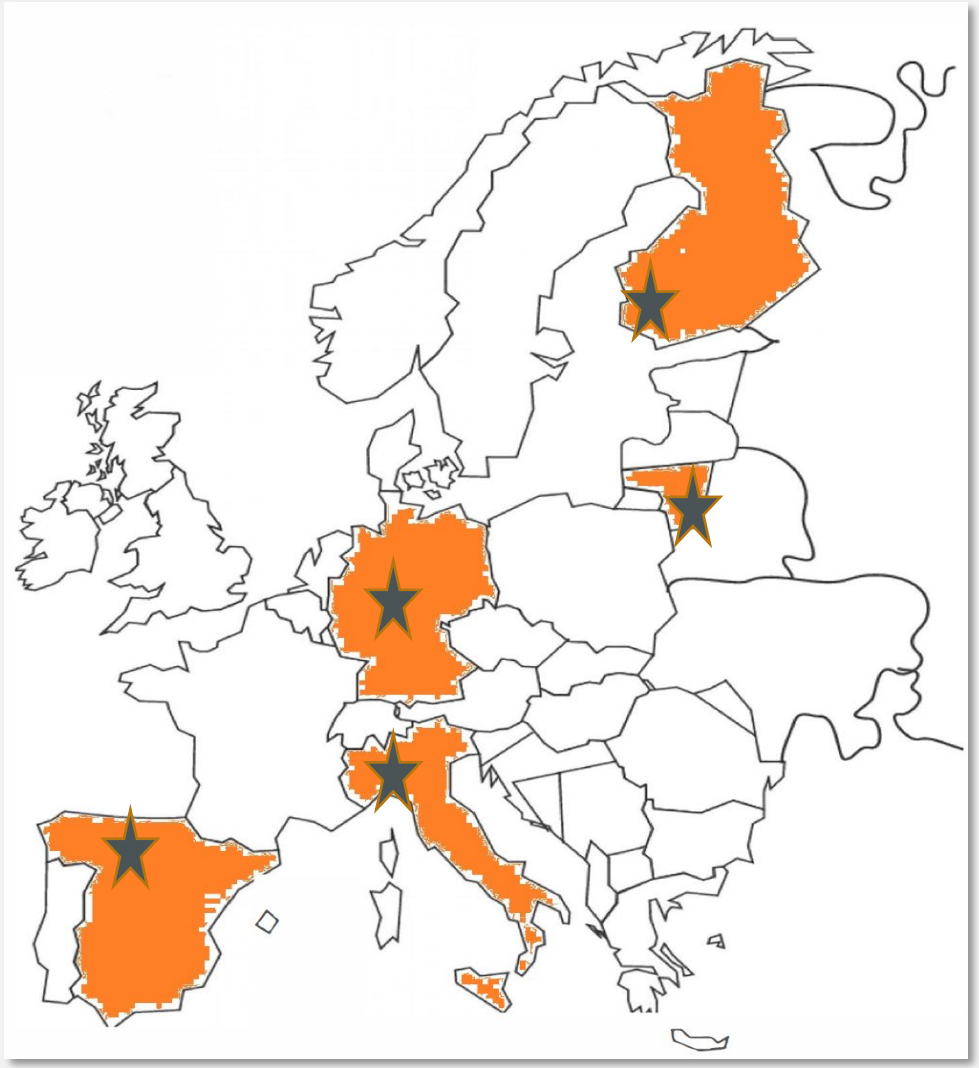
- Various policy initiatives to reduce RC
- Documented reductions in RC use
- Growth of community- and family-based alternatives
- Closure and/or diversification of RC programs
- RC as short-term or stop-gap option
- Increased clinical severity of youth in RC

YET…
CONSIDERABLE CROSS-COUNTRY DIFFERENCES IN THE UTILIZATION OF RESIDENTIAL / GROUP CARE



Ainsworth, F. & Thoburn, J. (2014). An exploration of the differential usage of residential childcare across national boundaries. *Int J Soc Welfare 23*, 16-24.

ERASMUS PROJECT
"EMPOWERING RESIDENTIAL CHILD CARE THROUGH INTERPROFESSIONAL TRAINING" (2018-2021)

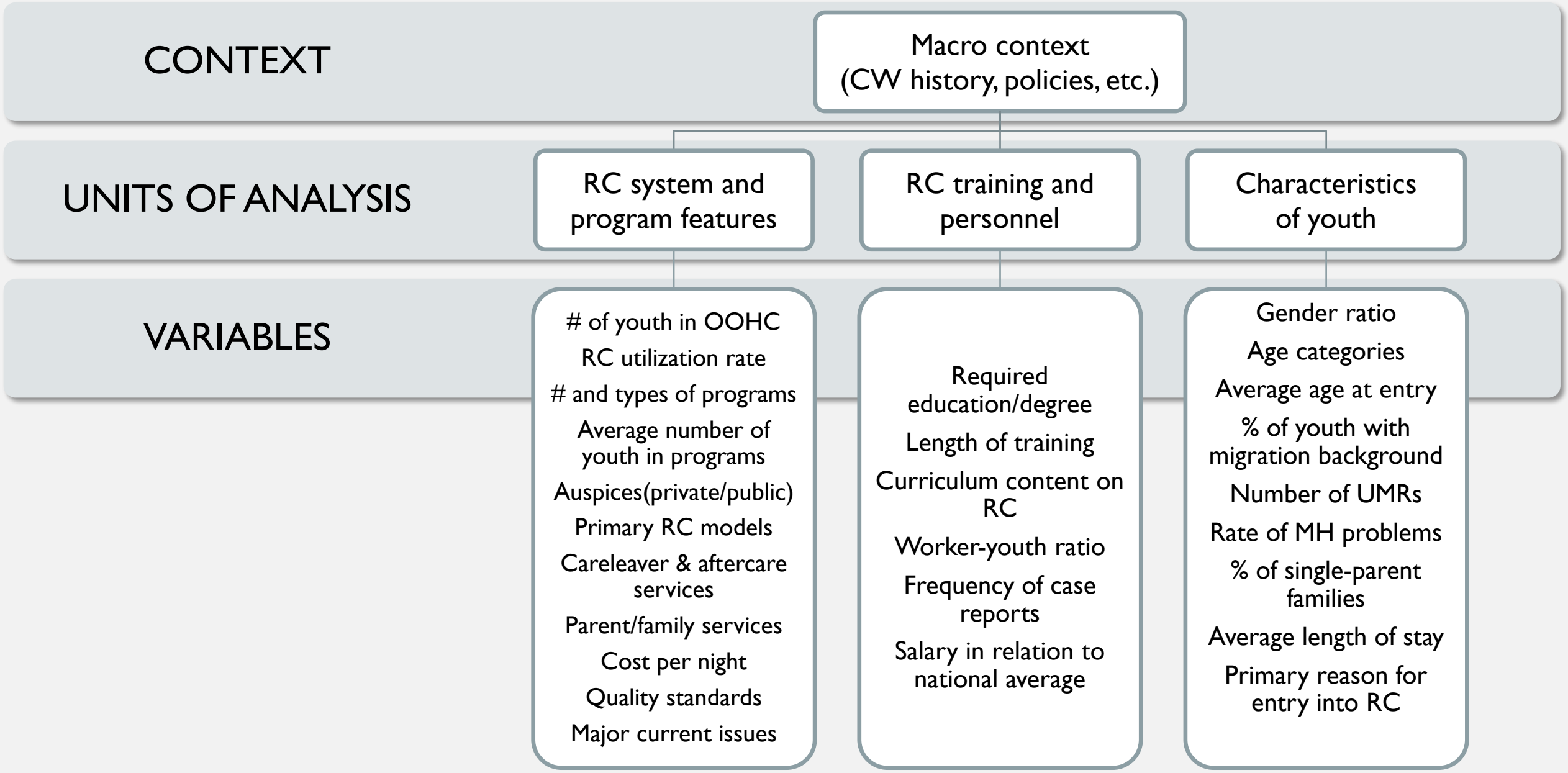


Project partners: Finland, Italy, Lithuania, Spain, Germany

AIMS

1. To understand differences in the use and function of RC in the partner countries
2. To understand needed competencies, qualifications and training for RC personnel across countries
3. To create an evidence-based teaching module to foster needed competencies
4. To disseminate and evaluate the use of teaching module

TOWARD MEANINGFUL COMPARISONS



DATA COLLECTION PROCESS

Development of a matrix capturing analytic categories (deductive and inductive process)

"Data collection" by each team between April and July 2019: government reports, administrative data, research studies, relevant websites, etc.

Analysis of data – cross-case synthesis and pattern-matching (intra and inter comparisons)

MACRO CONTEXT

social democratic welfare state; shift toward a child- and family-centered (preventive) approach, ratified in Child Welfare Act of 2007; foster care preferred over residential care; OOHC as a last resort; yet, comparatively high OOHC rates per 1000 children

Finland

first social welfare system; long and noted history of RC and pedagogical traditions; favors RC over family-based options; major RC reforms following scandals and anti-authoritarian movement in the 1960s and 70s

Germany

long history of institutionalization based on religious and cultural traditions; reluctance to remove children; cultural preference for residential over foster care yet policy promotes foster care; since 2001 closure of large residential facilities

Italy

strong institutional care traditions inherited from the Soviet system; since gaining independence in 1990, major child welfare reforms; 2014 strategic plan to speed up institutionalization; since then establishment of smaller group homes

Lithuania

long history of institutionalization based on religious and historical traditions; reforms in 1990s toward more family-based options and smaller RC programs; greater decentralization

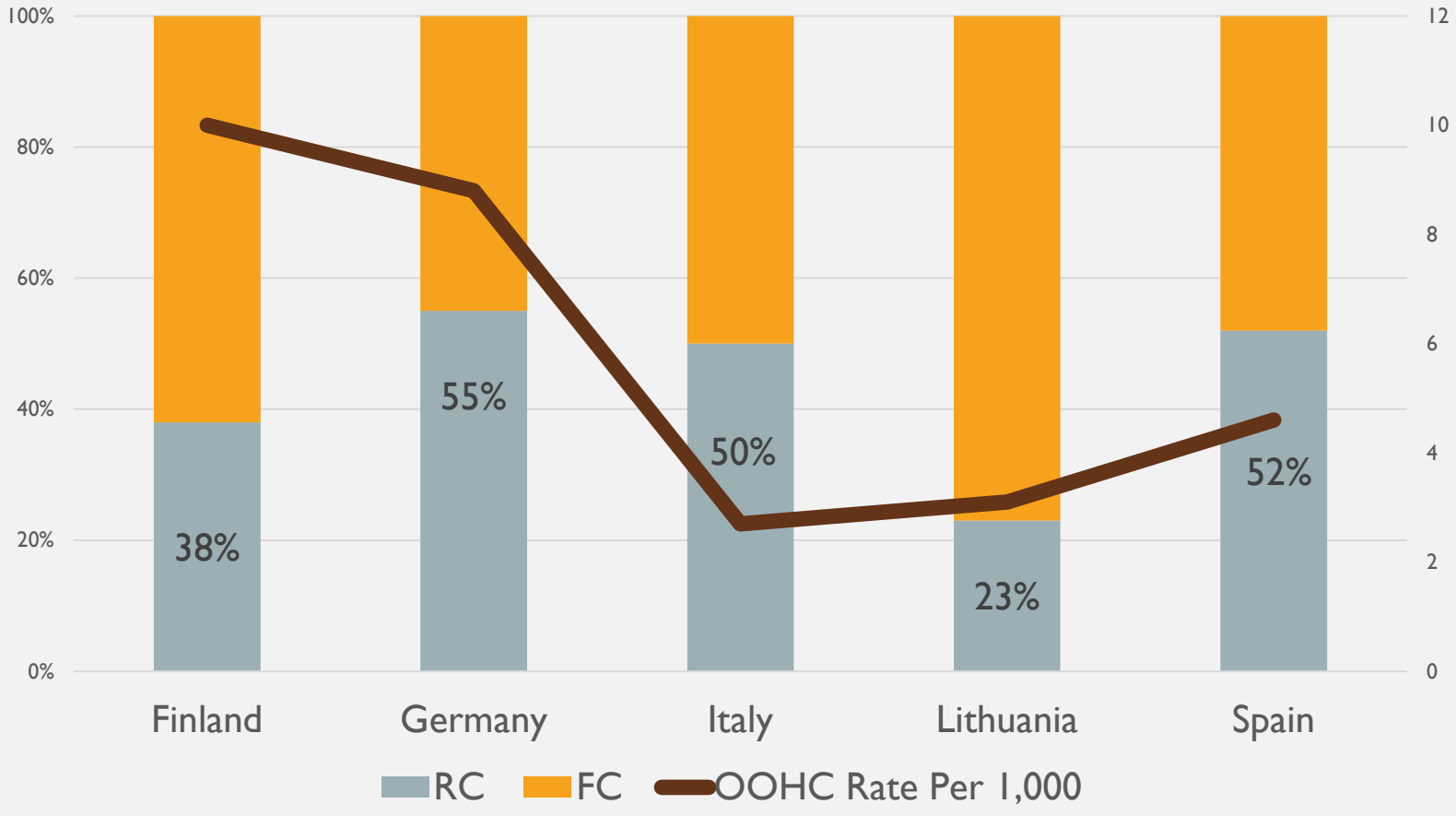
Spain

RESIDENTIAL CARE SYSTEM AND FEATURES

	FINLAND	GERMANY	ITALY	LITHUANIA	SPAIN
OOHC rate per 1000					
% of children in RC vs. FC					
Utilization trends					
Number and types of RC					
Service system (CW, MH, JJ, etc.)					
Auspices (private/public)					
# of children per program					
Parent/family involvement					
Careleaver program					
Primary conceptual model					
Stated aims of RC					
Cost per night / funding					
Quality standards					
Perceived strengths & deficits					
Major current issues					

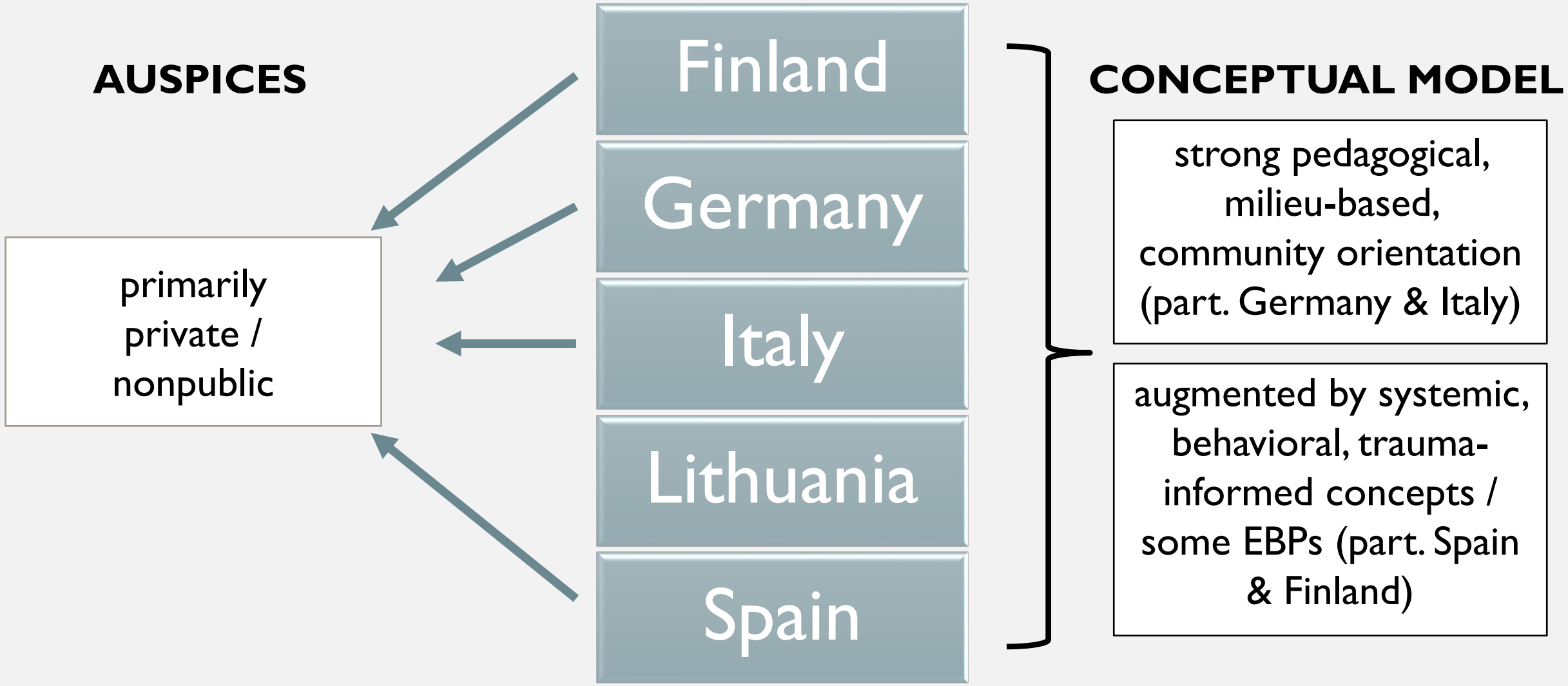
PLACEMENT AND RC PROPORTION

What % of OOHC are RC?



Line shows rate of OOHC per 1000 youth

AUSPICES & PRIMARY CONCEPTUAL MODEL



FAMILY INVOLVEMENT & CARELEAVER PROGRAMS

Agreement that both elements are important; increasingly, captured in policy and defined as a standard; however, significant variability in implementation

GERMANY – possible until age 24 or 27 if indicated (but rare)

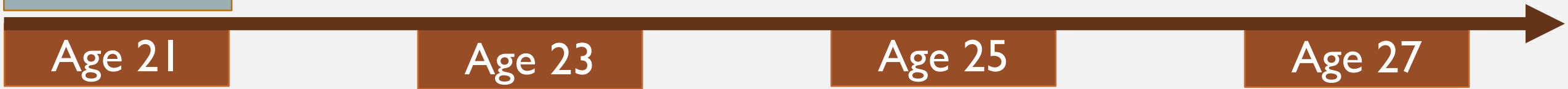
FINLAND – guarantees transition support until age 25

LITHUANIA – possible until age 24 if receiving formal education

SPAIN – possible until age 23

ITALY

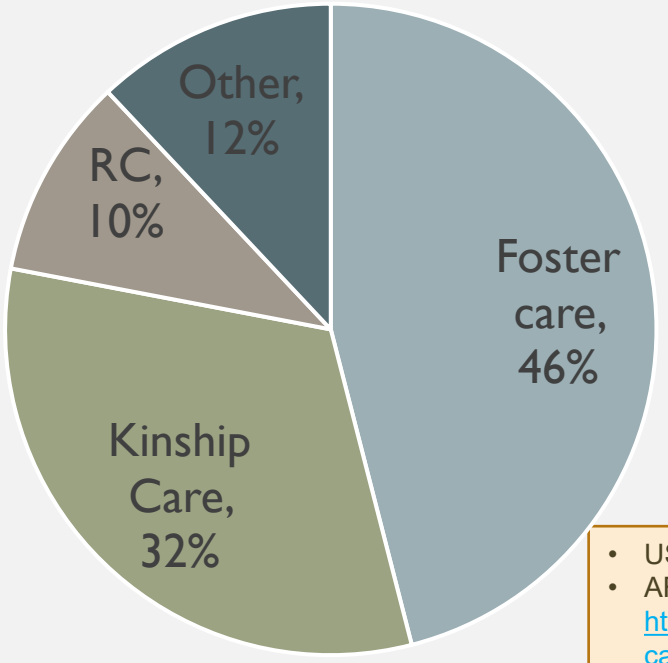
CARELEAVER SERVICES

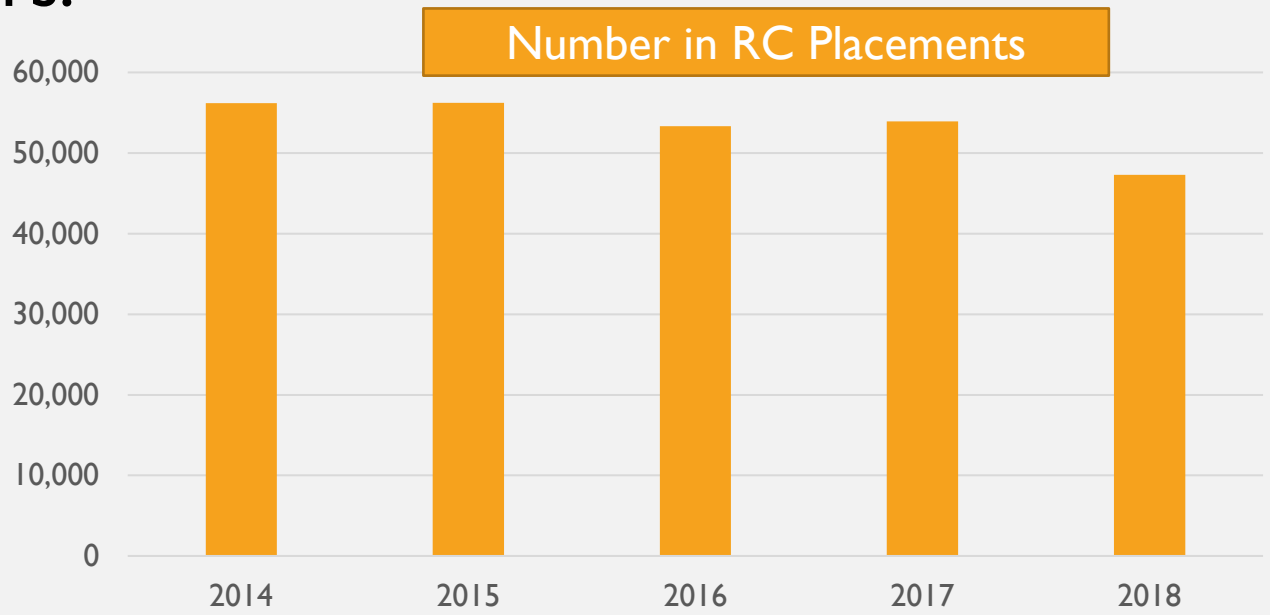


US COMPARISON: MACRO SYSTEM

Focusing on Child Welfare:

- As of 2018, we have 437, 283 youth in out-of-home care.
- 6 youth in OOHC per 1,000 minors.





- US DHHS (2019). The AFCARS Report. Preliminary Estimates for FY 2018 as of August 22, 2019 (26). https://www.acf.hhs.gov/cb
- AFCARS data and US Census Bureau data compiled by KidsCount (Annie E. Casey Foundation). https://datacenter.kidscount.org/data/tables/6242-children-0-to-17-in-foster-care#detailed/1/any/false/37,871,870,573,869,36,868,867,133,38/any/12985,20455
- AFCARS Reports #22-26.

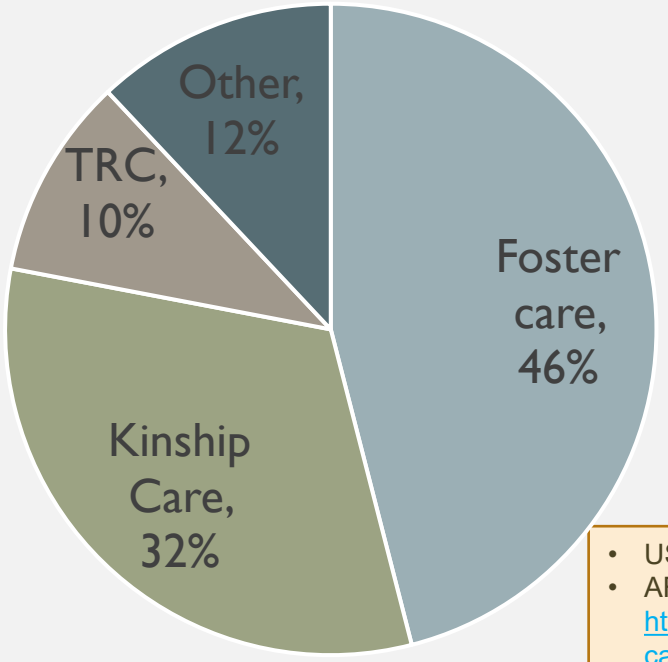
US COMPARISON: MACRO SYSTEM

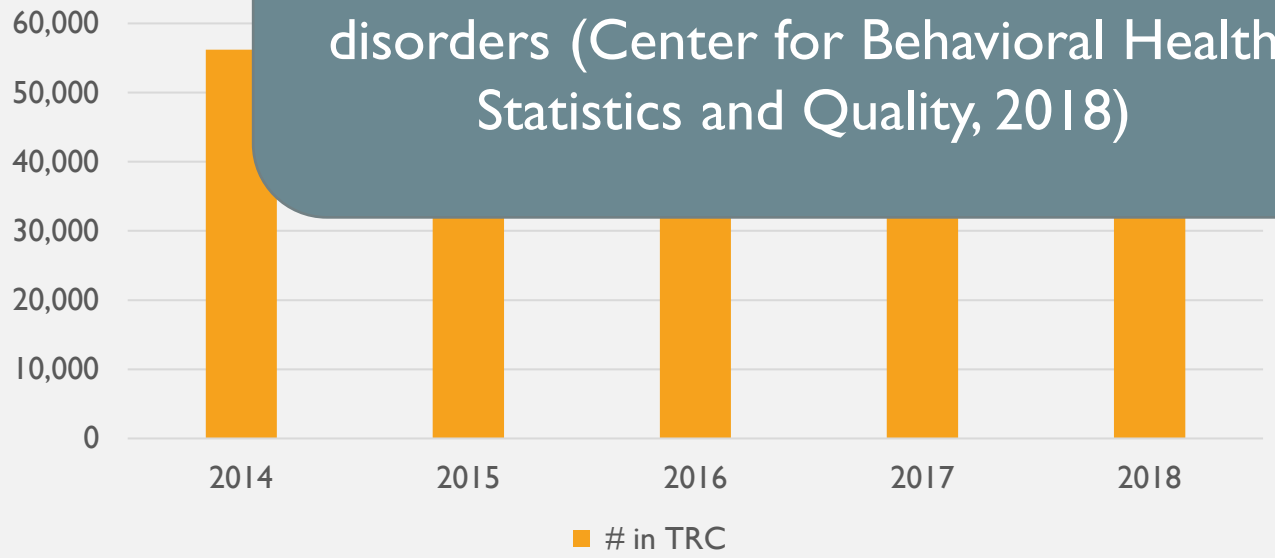
But this is only Child Welfare!

Focusing on Child Welfare:

- As of 2018, we have 437, 283 youth in out-
- 6 youth in OOHC per 1,000 minors.

311,000 children and adolescents lived in residential treatment (RT) facilities to treat severe mental health and behavioral health disorders (Center for Behavioral Health Statistics and Quality, 2018)





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US MACRO SYSTEM LIMITATIONS

- Child Welfare
- Juvenile Justice
- Behavioral Health
- Education
- Private Insurance

- Separate systems challenge knowledge of:
  - Average cost per day/stay;
  - Number/type of programs;
  - Number of kids/program;
  - Agency type: public, private, non-profit, for-profit;
  - Aims of (T)RC;
  - Average length of stay;
  - Primary concepts/theories;

- Also, states vary in policy/regulation and little national guidance

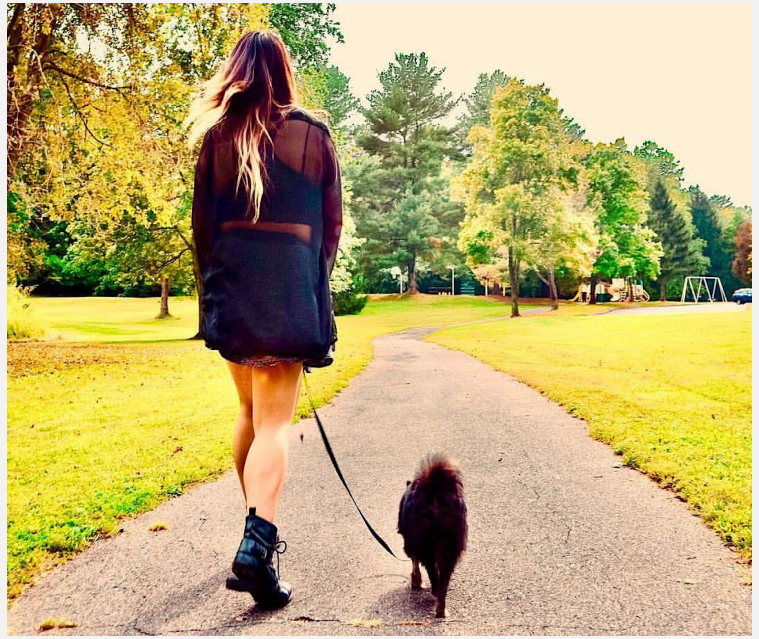
US (T)RC PROGRAM FEATURES

- Conceptual Model: Evidence-Based Practice?
  - 88% of ACRC programs reported using at least one EBP*
    - 56% reported using 3 or more practices

- No national quality standards, some state policies.
  - Structured program model may be indicator of program quality (Farmer et al., 2017)
  - Accreditation is becoming more commonly required (for QRTP but also in some states), but no empirical evidence to support accreditation as a necessary/sufficient quality standard;

*James, S., Thompson, R., Sternberg, N., Schnur, E., Ross, J., Butler, L., & Muirhead, J. (2015). Attitudes, perceptions, and utilization of evidence-based practices in residential care. *Residential Treatment for Children & Youth, 32*, 144-166.

US (T)RC PROGRAM FEATURES



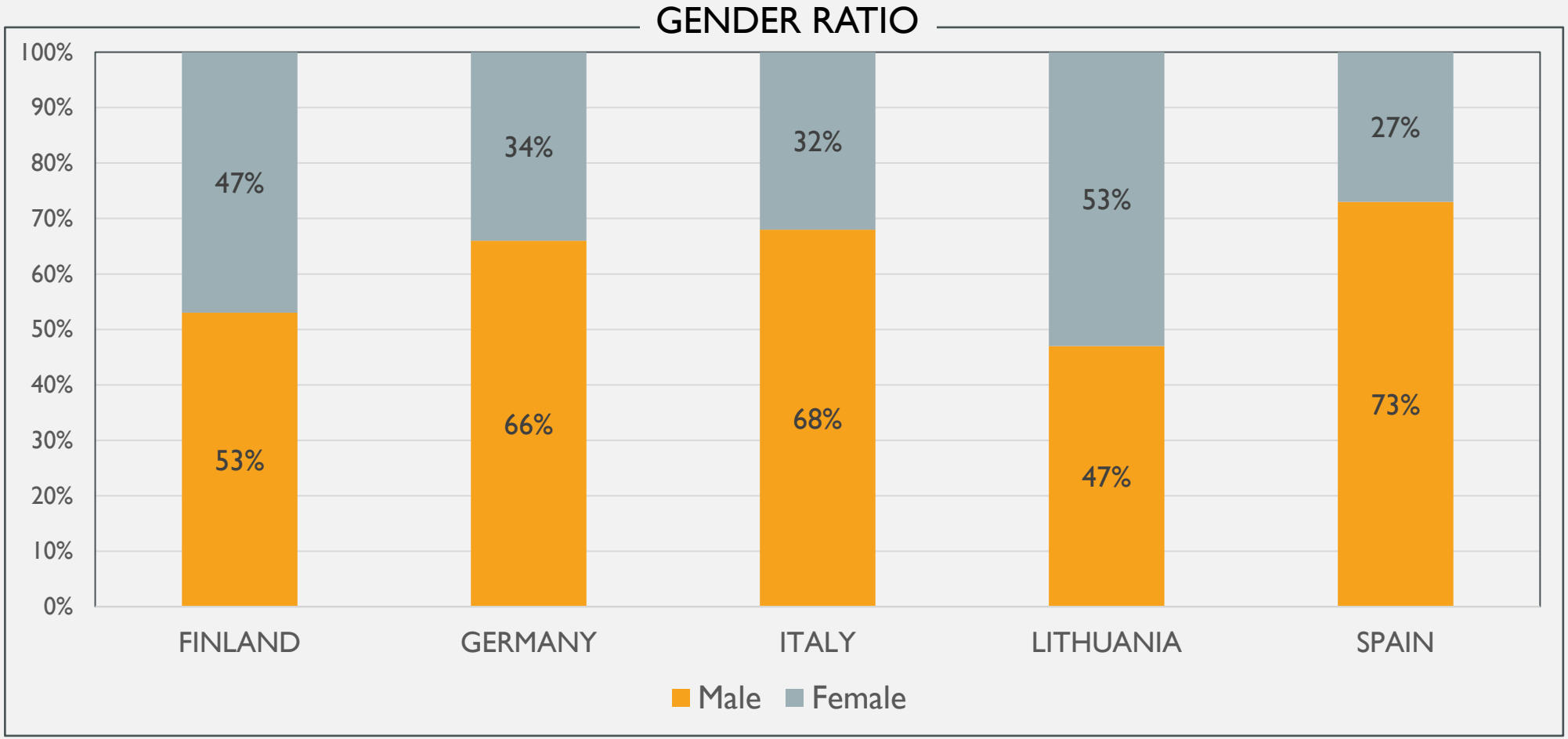
- Extended Foster Care (providing supports to older youth/ careleavers) beyond 18 is active in 46 states*;
- Aftercare is increasingly understood as important, but inconsistently funded/required (other than QRTPs);

*Child Welfare Information Gateway (2017). Extension of Foster Care Beyond Age 18. Available: https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/extensionfc/

CHARACTERISTICS OF YOUTH

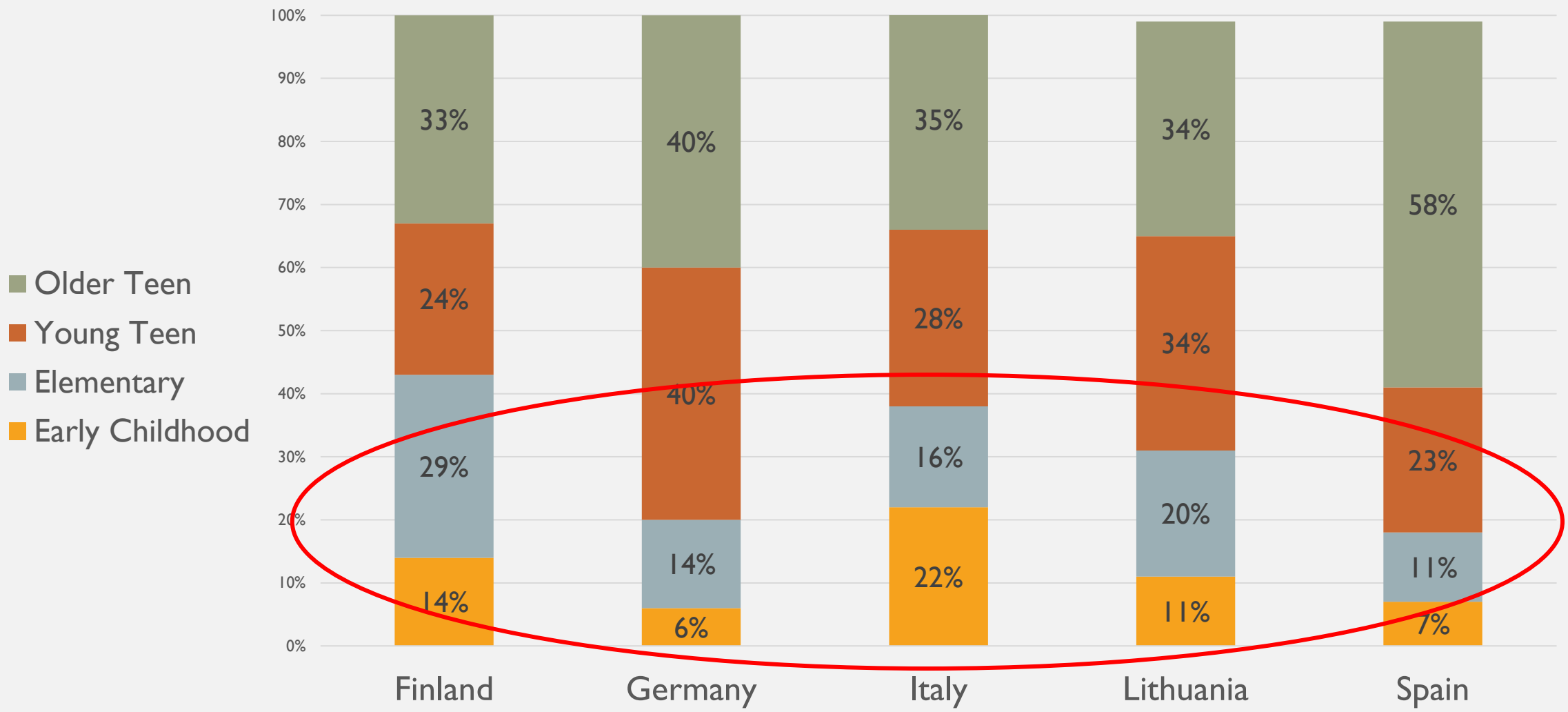
	FINLAND	GERMANY	ITALY	LITHUANIA	SPAIN
Gender ratio (m/f)					
Average age/age categories					
Average age at entry into RC					
% of youth in RC w/ a migration background					
Number of UMRs					
Rate of mental health problems					
% of single parent families					
Primary reason for entry into RC					
Average length of stay					

GENDER RATIO & % OF YOUTH WITH MIGRATION BACKGROUND



MIGRATION BACKGROUND IN RC	no data available	53.3%	24.7%	no data available	55.0%
			not officially counted		

AGE DISTRIBUTION IN RC / % OF YOUNG CHILDREN



A FEW MORE DATAPOINTS …

	FINLAND	GERMANY	ITALY	LITHUANIA	SPAIN
Rate of MH problems	30-80%	57.1% met criteria for 1 or more ICD10-F dx	no data	150 children in RC with a psychiatric dx	61% meeting clinical criteria / CBCL
Length of stay	48 months	17 months	<3mos: 14.5% 3-12mos: 31% 12-24mos: 22.7% 24-48mos: 17.2% >48mos: 14.5%	no data	42.6 months
Primary reason for entry	Parental exhaustion: 58% Parenting problems: 50% Family conflict: 49% Parental coping with daily life: 32% Domestic violence: 23% Youth MH problems: 37% Living arrangements w/ neg effect: 10%	**Limited parenting competence** Child engangerment: Insufficient support of child Youth behavior problems Family conflict Developmental problems Educational problems	Problems in parenting Family relational problems Family violence	Child abuse and neglect: 75%	Child abuse and neglect: 61.8% Unaccompanied migrant status has become a primary reason for entry

US YOUTH IN (T)RC

What we believe to be true of youth in (T)RC in US:

- More males than females
- Older youth (most over 12 years old)
- Some TRC placement for Unaccompanied Minors, but not systematically measured;
- Efforts to reduce length of stay (under 1 year);
- (Very/increasingly) High rates of mental health need:
  - Most TRCs are treatment-oriented for mental health needs, trauma, etc.
  - TRC placement sometimes requires meeting "medical necessity" criteria;
  - High rates of psychotropic medication usage

RC TRAINING & PERSONNEL

	FINLAND	GERMANY	ITALY	LITHUANIA	SPAIN
Educational requirements					
RC Team composition					
Length of training					
Worker:Youth ratio					
Turnover rate					
Frequency of case reports					
Salary (compared to national average)					

EDUCATIONAL REQUIREMENTS FOR RC WORKERS

Finland

- 2-3yr vocational training in social or health care (Care worker)
- 3.5yrs BA in social services or nursing (counselor)
- main SW in CW (MA degree)

Germany

- 5yr vocational training as Educator
- 3-3.5yrs BA in Social Work or Social Pedagogy
- Social Assistants with 2yr vocational training may also be part of a RC team

Italy

- 3yr BA in Educational Sciences

Lithuania

- 4yr BA in Social Work
- SW assistants with special training courses

Spain

- 4yr BA Social Education
- 2yr vocational training as a Technical Educational Asst.

US (T)RC TRAINING AND PERSONNEL

- No national standards for staff training, staff-youth ratios, or salary;
- Some individual states and accrediting bodies provide guidance;
  - MD: Child and Youth Care Practitioner 21-credit certificate program;
  - CA: Child and Youth Care Certification Exam at 3 levels: Entry, Associate, Professional;
- No national record-keeping on (T)RC Staffing

POLICY PRIORITIES & MAJOR CURRENT CHALLENGES

FINLAND

- Privatization
- Quality monitoring
- Preventive services insufficient to reduce RC placement
- High turnover of RC personnel
- Lack of integration with MH system

GERMANY

- UMRs
- 'system breakers' and 'closed RCs'
- Predominant use of RC
- Many untested concepts and methods

ITALY

- Deinstitution-alization
- Uneven data collection
- Ambiguous classification of RC
- High turnover
- Insufficient attention paid to bio family
- Lack of integration with other systems

LITHUANIA

- Deinstitution-alization
- Lack of skilled RC workers resulting in premature transfers to specialists
- Quality monitoring

SPAIN

- UMR/Ms
- Challenging profiles of youth
- Insufficient family involvement

(SOME) INSIGHTS FROM THE ERASMUS PROJECT

- Confounding terminology; RC ≠ RC;
- RC fulfills still care and accommodation functions
- While deinstitutionalization efforts and emphasis of family-based options is apparent everywhere, different countries are in different stages
- Family-based alternatives confront significant cultural conceptual & structural barriers in some countries
- Surprisingly high rates of young children in RCs and comparatively long stays in RC
- Agreement (in theory) on some program elements, e.g. parent involvement, transition support/careleaver programs, but difficulties implementing these elements; also considerable regional variability
- No dominant conceptual models but strong pedagogical traditions in some countries
- Different degree requirements for RC workers but signs of professionalization

LEARNING FROM EACH OTHER

(SOME) COMMONALITIES

- High-risk status of RC youth (high rate of MH problems confirmed across countries)
- Consensus on importance of core program elements (e.g., family involvement, aftercare/ careleavers) - but how to best implement?
- General emphasis on family-based care but struggle to find the right balance between RC and FC
- Staff turnover and low salary for RC workers are challenges across countries

WHAT EU CAN TEACH US

- RC can be more than a stop-gap option & has more than a treatment function
- RC can take many different forms (small family-like group homes, supported living)
- EBP yes, but the importance of a pedagogical/ therapeutic milieu
- The need for a professionalized RC workforce
- National quality standards

WHAT US CAN TEACH EU

- How to create more family-based alternatives
- More awareness of clinical issues and need for approaches
- Family voice and family-driven organizations
- Good concepts/ theory aren't enough; need to be tested with data; greater integration of EBPs
- Need for more data and outcomes research

WE WELCOME YOUR COMMENTS & QUESTIONS!

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