A National Look at the Use of Congregate Care in Child Welfare

U.S. Department of Health and Human Services,
Administration for Children and Families, Children's Bureau

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EXECUTIVE SUMMARY

Federal, state, and local agencies have focused on the placement settings and services experienced by children and youth who experience foster care. Current federal policy about the appropriate use of placement settings is limited. Federal law mandates that each child's case plan must include a discussion of how the child's case plan is designed to achieve a safe placement for the child in the least restrictive (most family-like) setting available and in close proximity to the home of the parent(s) when the case plan goal is reunification. Case plans must also address how the placement is consistent with the best interests and special needs of the child (section 475(5)(A) of the Social Security Act, CFR 1356.21(g)(3)). However, states have flexibility and discretion to make decisions for a child on a case-by-case basis to ensure that the best placement is made and the individual needs of the child are met.

Although there is an appropriate role for congregate care placements in the continuum of foster care settings, there is consensus across multiple stakeholders that most children and youth, but especially young children, are best served in a family setting. Stays in congregate care should be based on the specialized behavioral and mental health needs or clinical disabilities of children. It should be used only for as long as is needed to stabilize the child or youth so they can return to a family-like setting.

There has been a significant decrease in the percentage of children placed in congregate care settings in the past decade, and this reduction is at a greater rate than the overall foster care population. ***According to the most recent data available, children spend an average of 8 months in congregate care.*** While these trends suggest that child welfare practice is moving toward more limited use of congregate care, the depth of improvement is not consistent across states, and some cohorts of children and youth have fared better than others. This data brief is designed to help policymakers and advocates at the state and federal level better understand the population of children and youth who are likely to experience congregate care and what, if any, additional supports may be needed to further reduce reliance on it as a placement setting for certain cohorts of children and youth.

In order to provide a basic understanding of the use of congregate care and to paint a picture of the children who are placed in these settings, we analyzed a number of data elements from the Adoption and Foster Care Analysis and Reporting System (AFCARS). In addition to a review of quantitative data, we highlight strategies that a number of state and local jurisdictions have used to increase the effectiveness of congregate care, shorten lengths of stay, and develop alternative placements.

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Using descriptive statistics and limited logistic regression analyses to better understand the children who experience time in congregate care, we found that children with a DSM[1] diagnosis, behavioral health issues, or clinical disabilities other than a DSM diagnosis made up a significant proportion of those children who, at some point during their time in foster care, experienced time in a congregate care setting. Using this "Clinical Disabilities"[2] information and the "Child Behavior Problem (CBP)" as a circumstance associated with the child's removal and placement into foster care, we developed four mutually exclusive subgroups for analyses: Subgroup 1 (No Clinical Indicators), Subgroup 2 (DSM Indicator), Subgroup 3 (CBP Indicator), and Subgroup 4 (Disability Indicator).

QUANTITATIVE RESULTS

This brief examines the use of congregate care from both point-in-time (PIT) and first-time-entry cohort perspectives. PIT analyses provide a snapshot of child welfare caseloads on any given day. A first-time-entry cohort perspective provides a longitudinal look at the experiences of children entering care at a particular time to better understand their total time in care.

The PIT analyses allow us to see how congregate care is being used for all children in care on September 30, 2013 (i.e., the last day of the federal fiscal year (FFY) 2013). We use these analyses to answer the question "What is the difference between children who do and do not experience congregate care?" We find that:

- Children in congregate care settings are almost three times as likely to have a DSM diagnosis compared to children in other settings.
- Children in congregate care settings are more than six times more likely than children in other settings to have "child behavior problem" as a reason for removal from home.
- On average, children spent a total cumulative amount of 8 months in a congregate care setting compared to an average time in a particular placement type of 11 months for children in other settings.[3]
- The overall time in foster care was longer for children who spent some time in congregate care, with an average of 28 months compared to 21 months total time in foster care.

Trends in the Congregate Care Population

Proportionately, children in congregate care comprised 18 percent of the foster care population in 2004 and 14 percent in 2013—a notable decrease. Additionally, over the past 10 years, the number of children and youth in the child welfare system on the last day of the FFY declined by 21 percent, from 507,555 in 2004 to 402,378 in 2013. Comparatively, the number of children in care on the last day who were placed in a group home or institution decreased by 37 percent (a decline from 88,695 to 55,916). ***Congregate care use is decreasing at a greater rate than the overall foster care population, which indicates states are making greater strides in reducing the number of children who spend time in a congregate care setting***.

Cohort Trends in Congregate Care Use

PIT numbers can over represent youth who have been in care for longer time periods and youth who enter care toward the end of the FFY. Therefore, we followed three cohorts of youth for 5 years from the time they entered foster care for the first time in FFY 2006, 2007, and 2008. This allows for a better understanding of how many "new" entries into congregate care occur in a given year.

As with the PIT analyses, all three cohorts were examined using our four-subgroup divisions. Of those who experienced some time in congregate care, on average about 41 percent were in Subgroup 1 (No Clinical Indicators), 20 percent in Subgroup 2 (DSM Indicator), 32 percent in Subgroup 3 (CBP Indicator), and 7 percent in Subgroup 4 (Disability Indicator). Given these similarities among cohorts, additional congregate care analyses only are reported for the most recent cohort (children and youth followed from 2008 to 2013).

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[1] The "Diagnostic and Statistical Manual of Mental Disorders (DSM)" is the standard classification of mental disorders used by mental health professionals in the United States.

[2] The AFCARS definition of clinical disabilities includes mental retardation, visually or hearing impaired, physically disabled, emotionally disturbed (DSM diagnosis), and other medical condition requiring special care (e.g., in most cases, these chronic illnesses requiring ongoing medical care). The operationalized AFCARS definition requires that these disabilities be professionally diagnosed.

[3] Length of time was calculated by totaling all time in a particular placement type during the course of a child's entire first removal episode. This accounts for placement moves and provides a better picture of the actual overall time spent in a setting type.

Similar to the PIT results, the majority of the children in the 2008 cohort did not spend long periods of time in a congregate care setting. Thirty-six percent spent 60 days or less in congregate care. Five percent spent 61 to 90 days, and an additional 35 percent spent 91 days to 1 year in that setting. Close to one-quarter (24 percent) spent more than 1 year in congregate care. On average, they spent 9 months in a congregate care setting (close to the PIT average of 8 months seen above); over one-third (34 percent) spent more than 9 months.

Children Age 12 and Younger

Child development theory, federal legislation, and best practice confirm what we know intuitively—children should be placed in settings that are developmentally appropriate and least restrictive. For young children, particularly those age 12 and under, it is particularly important for their developmental needs to be met in family-like settings. As such, we would expect to see very low percentages of children age 12 and under in a congregate care setting. Where there are children in these settings, we would expect them to spend short amounts of time in that setting—time for assessment and stabilization that readies them for transition to permanency or family foster care.

Children 12 and younger comprised an unexpectedly high percentage (31 percent) of children who experienced a congregate care setting. This concerning percentage of younger children in congregate care underscores the need for careful examination of this special group of children. Use of congregate care varies by state, and additional information on state practices, policies, and state-specific definitions of congregate care would provide important missing information. Twenty-one states had percentages of children 12 and younger in congregate care that were above the national average of 31 percent. States ranged from 6 to 69 percent of the 2008 cohort who were age 12 or younger and who experienced a congregate care episode. Targeted interventions, coupled with finer data collection, may be needed to justify placement into these group settings.

Children Age 13 and Older

Of the approximately 51,000 children age 13 and older who entered foster care in 2008, about half (25,535) entered congregate care at some point. These older youth comprise 69 percent of the children in congregate care. Among those, more than 4 in 10 entered due to a child behavior problem and no other clinical or mental disability. About one-quarter (24 percent) entered a congregate care setting as their first placement.

Subgroup differences also are apparent in the time children spend in congregate care. For children and youth with no clinical indicators, 21 percent spent 1 week or less compared to only 4 percent of the children with a DSM diagnosis and 12 percent with a child behavior problem only. One in five (20 percent) children with a child behavior problem and 38 percent of children with a DSM diagnosis spent more than 1 year in a congregate care setting compared with 30 percent of children with disabilities and 19 percent of children with no clinical indicators.

Across all subgroups, most children leave foster care to a permanent placement. However, more children with a child behavior problem exited to permanency (72 percent) and fewer emancipated (15 percent) than children in any of the other subgroups. More of the children with behavior problems (6 percent) also were transferred to another agency following discharge from foster care compared to children in the other three subgroups, which may indicate a move to juvenile justice, another state, or another behavioral health system.

Overall, results indicate that children with DSM and child behavior problem indicators may experience a need for higher levels of care than other children in congregate care. Children with a DSM diagnosis were more likely to have congregate care as a subsequent placement, be previously adopted, and have three or more placement moves compared to the other subgroups. Children with a CBP indicator were more likely to enter congregate care as their first placement, have only one or two placement moves, and exit to permanency. These children also were more likely to reenter care and be transferred to another agency, which may indicate a need for longer-term stabilization in an alternate setting.

State Variation in Congregate Care Use

As noted above in the PIT analyses, the number of children in care on the last day of the FFY who were placed in a group home or institution decreased by 37 percent from 2004 to 2013. There was, however, wide variation among the states. Ten-year decreases in the use of congregate care ranged from 7 to 78 percent, and increases ranged from 2 to 70 percent. Twenty-five states decreased their congregate care use by more than 37 percent (the national rate), 22 states decreased by 7 to 36 percent, and 5 states increased their congregate care use.

Additionally, as the overall congregate care population has decreased in the majority of states, the congregate care population as a proportion of each state's total in-care foster care population has also decreased.

QUALITATIVE RESULTS

To supplement the quantitative information and to begin to understand the practices and policies behind the numbers, we synthesized the qualitative information into common themes. We asked states to describe promising practices that they have adopted to reduce their reliance on congregate care and to best match services with the clinical needs of the children under their care and responsibility. Common approaches include:

- Using an alternative placement program that pays family foster homes to keep beds available on an emergent basis to care for children while their needs are assessed and other appropriate foster family home placements can be identified.
- Using early trauma screening, assessments, and treatment that enabled the implementation of tailored mental health services.
- Increasing efforts to find family (kin) placements immediately following a child's removal from home.
- Working with congregate care providers to change the service array.
- Effective leaders that engaged and secured buy-in from agency staff at multiple levels as well as external community partners and stakeholders.
- Developing highly skilled, clinically informed casework staff to work with all children, but particularly for those working with children who may be at risk of congregate care.
- Data collection systems that allow administrative staff to examine the demographic characteristics of children being placed in congregate care, mental and behavior diagnoses, lengths of stay, placement stability, crisis stabilization, and resource availability.
- Creating an assessment and review process was cited by all of the states interviewed as being critical in the care of children with complex needs.
- Developing a multidisciplinary committee process that reviews assessments and placement recommendations.
- Monitoring facilities through their licensing departments and their contract review processes.

Discussion and Recommendations

We encourage jurisdictions to analyze their data to understand the unique characteristics of their own populations that are in and at risk of placement in congregate care and consider these when crafting their policies, practices, and programs. In addition to common approaches to reduce reliance on congregate care, states shared that a number of challenges—financial and staff resources, a supply of alternative placements, workforce development and training, and leadership practices—impact their use of congregate care. We encourage all states to consider these and other challenges that may be unique to their systems and design strategies that can help ensure congregate care is reserved for children who have specialized behavioral and mental health needs or clinical disabilities.

It is important for children to be cared for in the least restrictive, most family-like setting possible. At times, congregate care is necessary to ensure a child's safety and stabilization, but it should be used judiciously, efficiently, and effectively.

INTRODUCTION

Examining trends over the past 10 years, child welfare agencies have made significant improvements that have enabled more children to remain at home safely and reduced the average time children who enter foster care spend away from their families. The number of children in foster care as of September 30 has decreased from a high of 507,555 in federal fiscal year (FFY) 2004 to just over 402,000 on September 30, FFY 2013. This reduction is driven by a number of factors, including fewer entries into foster care, an increase in exits, and shorter lengths of stay.[1]

Federal, state, and local agencies have also focused on the placement settings and services experienced by children and youth who experience foster care. Current federal policy about the appropriate use of placement settings is limited. Federal law mandates that each child's case plan must include a discussion of how the child's case plan is designed to achieve a safe placement for the child in the least restrictive (most family-like) setting available and in close proximity to the home of the parent(s) when the case plan goal is reunification. Case plans must also address how the placement is consistent with the best interests and special needs of the child (section 475(5)(A) of the Social Security Act, CFR 1356.21(g)(3)). However, states have flexibility and discretion to make decisions for a child on a case-by-case basis to ensure that the best placement is made and the individual needs of the child are met.

Although there is an appropriate role for congregate care placements in the continuum of foster care settings, there is consensus across multiple stakeholders that most children and youth, but especially young children, are best served in a family setting. Stays in congregate care should be based on the specialized behavioral and mental health needs or clinical disabilities of children. It should be used only for as long as is needed to stabilize the child or youth so they can return to a family-like setting.

For this analysis, congregate care is defined as a placement setting of group home (a licensed or approved home providing 24-hour care in a small group setting of 7 to 12 children) or institution (a licensed or approved child care facility operated by a public or private agency and providing 24-hour care and/or treatment typically for 12 or more children who require separation from their own homes or a group living experience). These settings may include child care institutions, residential treatment facilities, or maternity homes. Through our research interviews with states, we found that although all states submit placement data gathered in accordance with Adoption and Foster Care Analysis and Reporting System (AFCARS) definitions, many have developed their own levels of care within those categories.

There has been a significant decrease in the percentage of children placed in congregate care settings in the past decade, and this reduction is at a greater rate than the overall foster care population (-37 percent compared to -21 percent). Children also spend a shorter amount of time in congregate care (an average of 8 months) than children placed in other types of settings (an average of 11 months). While these trends suggest that child welfare practice is moving toward more limited use of congregate care, the depth of improvement is not consistent across states, and some cohorts of children and youth have fared better than others. This data brief is designed to help policymakers and advocates at the state and federal level better understand the population of children and youth who are likely to experience congregate care and what, if any, additional supports may be needed to further reduce reliance on it as a placement setting for certain cohorts of children and youth.

In order to provide a basic understanding of the use of congregate care and to paint a picture of the children who are placed in these settings, we analyzed a number of data elements from the Adoption and Foster Care Analysis and Reporting System (AFCARS). There are limitations to using AFCARS including an inability to determine from the AFCARS data whether individual placement decisions were appropriate. However, for those interested in reducing utilization of congregate care, this data can be used to identify predictive factors for placement into congregate care.

In addition to a review of quantitative data, we highlight strategies that a number of state and local jurisdictions have used to increase the effectiveness of congregate care, shorten lengths of stay, and develop alternative placements.

[1] Children in foster care are spending shorter time in care compared to a decade ago. Please see the joint issue brief released by the Children's Bureau and the Office of the Assistant Secretary for Planning and Evaluation, "A Temporary Haven: Children Are Spending Less Time in Foster Care," at http://aspe.hhs.gov/hsp/14/FosterCare/rb_FosterCare.cfm.

Strategies to reduce congregate care placements and improve outcomes of young children include the following:

- Develop and implement a unified statewide strategic plan
- Emphasize leadership and workforce development
- Focus resources on prevention and early intervention
- Strengthen community-based services and reduce barriers to access
- Implement a statewide treatment-focused foster care model
- Allow current congregate care providers greater flexibility in service provision

METHODOLOGY

Quantitative Data

The primary data source for these analyses is AFCARS. The point-in-time (PIT) file is composed of 10 annual files containing foster care records for FFY 2004 through 2013. In addition to the 10-year annual file, a longitudinal file was constructed representing three cohorts of children who entered foster care for the first time in FFY 2006, 2007, and 2008. Each of these entry cohorts were followed for 5 years. This file was constructed by combining 16 6-month files. We found that the analytic results from each cohort were very similar therefore the cohort results throughout the rest of the brief are focused on the 2008 cohort.

All 50 states, Puerto Rico, and the District of Columbia (hereinafter referred to as "states") submit AFCARS data electronically to the U.S. Department of Health and Human Services every 6 months (October 1 to March 31 and April 1 to September 30). These are record-level data on every child[2] served by the state public child welfare foster care system and the children adopted under the auspices of the state public child welfare agency. In order to construct a complete FFY of AFCARS data (i.e., a 12-month period ending on September 30), three consecutive 6-month submissions are used to create unduplicated counts of children in foster care or adopted during the FFY. These three 6-month files include the two 6-month submissions for the FFY plus the first 6-month submission of the next FFY (e.g., FFY 2009 data plus the first 6-month report period for FFY 2010). This information is placed in an aggregated file representing the 12-month period ending September 30.

There are limitations to using AFCARS data in these kinds of analyses. Although the number of placements a child experiences is known, information about the types of placements that occur between the dates of AFCARS submissions is limited to the most recent placement for each 6-month period. This is particularly relevant when constructing longitudinal files such as was done for the FFY 2006, 2007, and 2008 entry cohort files. For instance, there would not be a record of a congregate care placement in AFCARS if a child began the 6-month AFCARS period in a family foster home, was placed into a congregate care facility, and then was placed back into a family foster home by the end of the period. However, we do know by the placement count submitted that the child had an intervening placement move. Therefore, within this research brief, the percentage of children in each entry cohort identified as having experienced time in a congregate care setting may be slightly undercounted.

In cases where a child's record indicated an intervening placement move, we calculated the lengths of time that child spent in a congregate setting using the reporting period end date. This approach to calculating placement time in some cases could have resulted in either a shortened or lengthened amount of time in congregate care. This affects approximately 15 percent of those in the entry cohorts who accumulated time in a congregate care setting over the course of their 5-year follow-up period.

Using descriptive statistics and limited logistic regression analyses to better understand the children who experience time in congregate care, we found that children with a DSM[3] diagnosis, behavioral health issues, or clinical disabilities other than a DSM diagnosis made up a significant proportion of those children who, at some point during their time in foster care, experienced time in a congregate care setting. Using this "Clinical Disabilities"[4] information and the "Child Behavior Problem (CBP)" as a circumstance associated with the child's removal and placement into foster care, we developed four mutually exclusive subgroups for analyses.

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[2] Throughout this brief we use the term "child" or "children" to mean all children and youth in the care and responsibility of the child welfare agency. Generally, ages range from 0 (infants) to age 17, although in some states, children age 18 are reported.

[3] The "Diagnostic and Statistical Manual of Mental Disorders (DSM)" is the standard classification of mental disorders used by mental health professionals in the United States.

[4] The AFCARS definition of clinical disabilities includes mental retardation, visually or hearing impaired, physically disabled, emotionally disturbed (DSM diagnosis), and other medical condition requiring special care (e.g., in most cases, these chronic illnesses requiring ongoing medical care). The operationalized AFCARS definition requires that these disabilities be professionally diagnosed.

Subgroup 1 (No Clinical Indicators): Children who do not have AFCARS indicators of a clinical disability, mental health diagnosis, or reported child behavior problem as a reason for removal from home.

Subgroup 2 (DSM Indicator): Children who have been reported as having been professionally diagnosed with a DSM mental health diagnosis. These children also may or may not have a disability or child behavior problem.

Subgroup 3 (CBP Indicator): Children whose reasons for removal from home include having been identified as having a child behavior problem (CBP) but who have not been reported as having a disability or DSM diagnosis.

Subgroup 4 (Disability Indicator): Children who have been clinically diagnosed by a professional with a disability other than a DSM diagnosis. These children have been reported as being visually, hearing, or cognitively impaired; physically disabled; or having other conditions that require special medical care.

Due to data quality considerations, two states' data were excluded from use in the cohort and subgroup analyses.[5]

Qualitative Data

Qualitative data were collected from a convenience sample (i.e., nonprobability sample) of nine states and document reviews. The sample of states was selected using a two-step process. First, we identified a group of 41 states that had seen decreases in their numbers of children in congregate care from FFY 2008 to 2012. These states were ranked in three tiers—the top tier with a decrease of 5 or more percentage points, the middle tier with percentage point decreases ranging from 2 percent to 5 percent, and the low tier of decreases from less than 2 percent. Second, we then chose five states from the top tier and four states from the middle tier and examined characteristics that would provide a reasonable representation of being geographically diverse and providing a balanced mix of both urban and rural communities.

We interviewed states over the telephone from October through December 2014. Interview participants were selected by the state and included child welfare directors, data managers, and program staff that were identified as being knowledgeable about congregate care policies, practice, and evaluation. These states volunteered to share information on how they use congregate care, what types of children are placed into those settings, and what practice and policy changes they have made to ensure children are placed in the most appropriate out-of-home settings.

Limitations in the qualitative data collection include the small, non-probabilistic sample size and the short duration of the interviews, which limited the depth of information that could be gathered from each state. While these results cannot be generalized to the nation, they do provide a credible picture of the variability among state practices in the use of congregate care and may serve as a pilot examination for future studies.

QUANTITATIVE RESULTS

This brief examines the use of congregate care from both PIT and first-time-entry cohort perspectives. PIT analyses provide a snapshot of child welfare caseloads on any given day, whereas following a cohort provides a longitudinal look at the experiences of children entering care at a particular time to better understand their total time in care. The following PIT analyses allow us to see how congregate care is being used for all children in care on September 30, 2013 (i.e., the last day of FFY 2013). We use these analyses to answer the question "What is the difference between children who do and do not experience congregate care?"

Table 1, on page 4, suggests that children in congregate care may have a different set of clinical needs, and consequently different treatment needs, than children placed in other types of foster care settings. Children in congregate care settings are almost three times as likely to have a DSM diagnosis compared to children in other settings (36 percent and 13 percent, respectively). They also are more than six times more likely than children in other settings to have "child behavior problem" as a reason for removal from home (45 percent, compared to 7 percent). On average, children spent 8 months in a congregate care setting compared to an average time in a particular placement type of 11 months for children in other settings. However, the overall time in foster care was longer for children who spent some time in congregate care, with an average of 28 months compared to 21 months total time in foster care.

[5] New York and Puerto Rico were excluded from the cohort analyses and any analyses involving the identification of subgroups due to missing data and\ or data quality issues. One state's records were missing a substantial amount of the "circumstances associated with removal" information for the years analyzed, whereas the other state had data quality issues. These two states, on average, represent 6 to 6.5 percent of the total "served" foster care population.

Table 1. Demographics and Characteristics of Children in Congregate Care on September 30, 2013, Compared to Children in Other Foster Care Settings

	Congregate Care (n=55,916)	Other Settings* (n=342,566)
Race/Ethnicity		
American Indian/Alaska Native—Non-Hispanic (NH)	1.6%	2.2%
Asian—NH	<1%	<1%
Black or African American—NH	30.1%	23.4%
Native Hawaiian/Other Pacific Islander—NH	<1%	<1%
Hispanic	19.7%	22.0%
White—NH	40.7%	42.0%
Two or More—NH	5.0%	6.4%
Unable to Determine/Missing	2.3%	3.2%
Gender		
Male	62.7%	50.7%
Female	37.3%	49.3%
Age		
Age at entry into current setting	14 (mean) 15 (median)	7 (mean) 5 (median)
Clinical and Behavioral Indicators		
DSM diagnosis	36.4%	12.7%
Child Behavior Problem as one reason for removal	44.9%	6.8%
Length of Time		
Mean time in current setting	8.1 months	10.7 months
Mean time in foster care	27.8 months	21.0 months

*Other settings include pre-adoptive home, foster family (relative and nonrelative) home, supervised independent living, runaway, and trial home visit.

These overall results begin to highlight some of the differences between children in congregate care and those in other settings and to identify potential indicators for placement into congregate care settings. The results also can help identify groups of children for whom congregate care is inappropriately or over used. A better understanding of the characteristics of children in certain types of settings can inform targeted interventions (e.g., gender-specific programming, age-appropriate activities and settings) intended to increase the timely permanency and safety for all children in foster care—and particularly children in congregate care.

Trends in the Congregate Care Population

To understand the magnitude of the congregate care population relative to the overall foster care population, we examined PIT trends in the proportion of and the percent change across years in the numbers of children in congregate care. Proportionately, children in congregate care comprised 18 percent of the foster care population in 2004 and 14 percent in 2013—a notable decrease. Additionally, over the past 10 years, the number of children and youth in the child welfare system on the last day of the FFY declined by 21 percent, from 507,555 in 2004 to 402,378 in 2013. Comparatively, the number of children in care on the last day who were placed in a group home or institution decreased by 37 percent (a decline from 88,695 to 55,916). ***Congregate care use is decreasing at a greater rate than the overall foster care population, which indicates states are making greater strides in reducing the number of children who spend time in a congregate care setting.***

To better understand whether congregate care use is declining for all children or for certain types of children, we compared congregate care use across the four identified subgroups. Table 2 reveals that three subgroups—Subgroup 1 (No Clinical Indicators), Subgroup 3 (CBP Indicator), and Subgroup 4 (Disability Indicator)—did experience at least a small decrease in the *proportion* of children in congregate care, but decreases were more apparent and significant when overall counts were examined. In fact, within every subgroup, congregate care decreased at a greater rate than the overall 21 percent decrease in the general foster care population. In three of the subgroups, that decrease was close to double the foster care population decrease. Subgroup 2 (DSM indicator) was the only subgroup where the congregate care decrease was slightly higher than the foster care population decrease.

Table 2. Distribution of Those in Congregate Care by Fiscal Year (FY)*

	FY 2004 Count	FY 2004 Column N%	FY 2009 Count	FY 2009 Column N%	FY 2013 Count	FY 2013 Column N%	Percent Change From FY 2004 to FY 2013
No Clinical Indicators	25,969	32.3	16,832	29.4	14,923	28.8	-42.5
DSM Alone or in Combination (can include CBP)	23,951	29.8	19,263	33.6	18,588	35.8	-22.4
CBP Alone (excludes ALL disabilities)	21,229	26.4	15,500	27.1	12,973	25.0	-38.9
Any Clinical Disabilities (excludes DSM)	9,319	11.6	5,674	9.9	5,407	10.4	-42.0

*Ten-year trend chart can be found in the appendix.[6]

[6] As noted in the Methodology section, due to missing and/or data quality issues, two states were not included in these analyses. Therefore, the total numbers of children in care as of September 30 do not match those found on the Children's Bureau's website.

While these PIT numbers provide a snapshot of child welfare caseloads on any given day, they can over represent youth who have been in care for longer time periods and youth who enter care toward the end of the FFY. Therefore, in addition to this PIT picture, we followed three cohorts of youth for 5 years from the time they entered foster care for the first time in FFY 2006, 2007, and 2008. This allows for a better understanding of how many "new" entries into congregate care occur in a given year.

Cohort Trends in Congregate Care Use

Although three cohorts were followed for 5 years, there were very small differences in congregate care use between the cohorts or in the distribution of subgroups across the cohorts. In all three cohorts, approximately 20 percent of first-time entrants experienced a congregate care setting at some point during their first removal episode. This (higher) proportion differs from the PIT proportions seen above as it captures the experiences of children who are entering care for the first time. Following children from "day one" allows us to identify when a child enters a congregate care setting—essentially increasing the likelihood that we will capture more children who experience that type of setting as they move through the system. The PIT analyses, however, provide a one-time picture of congregate care use and can miss children who may have had a short stay in a congregate care setting or had been in congregate care in prior years. Consequently, the point prevalence (proportion of children on a given day) is lower than the incidence (new cases) of congregate care use.

Overall Lengths of Stay

Similar to the PIT results above, the majority of the children in the 2008 cohort did not spend long periods of time in a congregate care setting. Thirty-six percent spent 60 days or less in congregate care. Five percent spent 61 to 90 days, and an additional 35 percent spent 91 days to 1 year in that setting. Close to one-quarter (24 percent) spent more than 1 year in congregate care. On average, they spent 9 months in a congregate care setting (close to the PIT average of 8 months seen above); over one-third (34 percent) spent more than 9 months.

While overall more than three-quarters (76 percent) of the children spent less than 1 year in congregate care, a closer examination revealed that there were some differences between age groups. More children age 12 and younger were in a congregate care setting for shorter amounts of time than children age 13 and older (table 3). By the end of 60 days, 42 percent of children age 12 and younger were no longer in a congregate care setting compared to 30 percent of the children age 13 and older. At 1 year, however, there were no real differences between the two age groups with each at or near one-quarter (24 percent) of the children in each category spending more than 1 year in congregate care.

These results provide a general overview of lengths of stay in congregate care but tell little about the children who spend time in these settings. As such, additional analyses were conducted to explore, beyond age, other characteristics that could help further our understanding of how and for whom congregate care is being used.

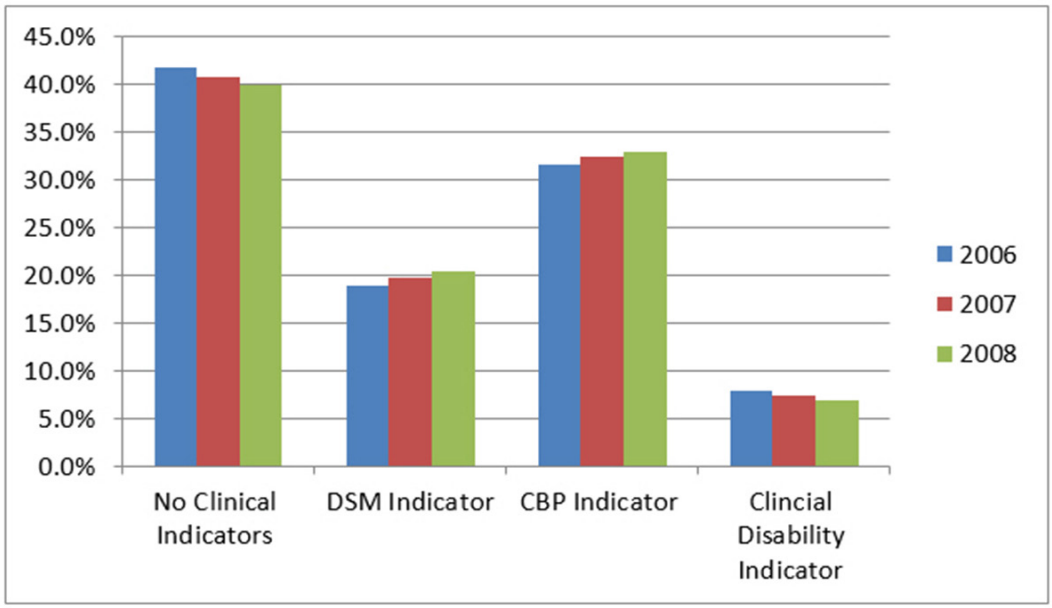
Table 3. Cumulative Time Spent in Congregate Care by Age at Entry Into Foster Care for Children in 2008 Cohort With 5-Year Follow Up

	Age 12 and Younger (n=12,670)	Age 13 and Older (n=25,535)
Less than 1 week	20.7%	13.0%
8–30 days	11.9%	10.0%
31–60 days	9.6%	7.2%
61—90 days	5.1%	5.2%
91–180 days	11.0%	14.7%
181–365 days	14.2%	23.1%
Greater than 1 year	24.1%	23.5%
Missing/ unknown	3.5%	3.6%

Subgroups

As with the PIT analyses, all three cohorts were examined using our four-subgroup divisions. Of those who experienced some time in congregate care, on average about 41 percent were in Subgroup 1 (No Clinical Indicators), 20 percent in Subgroup 2 (DSM Indicator), 32 percent in Subgroup 3 (CBP Indicator), and 7 percent in Subgroup 4 (Disability Indicator) (figure 1). As mentioned in the methodology section, given these similarities among cohorts, additional congregate care analyses are only reported for the most recent cohort (children and youth followed from 2008 to 2013).

Figure 1. Distribution of Subgroups by Entry Cohort

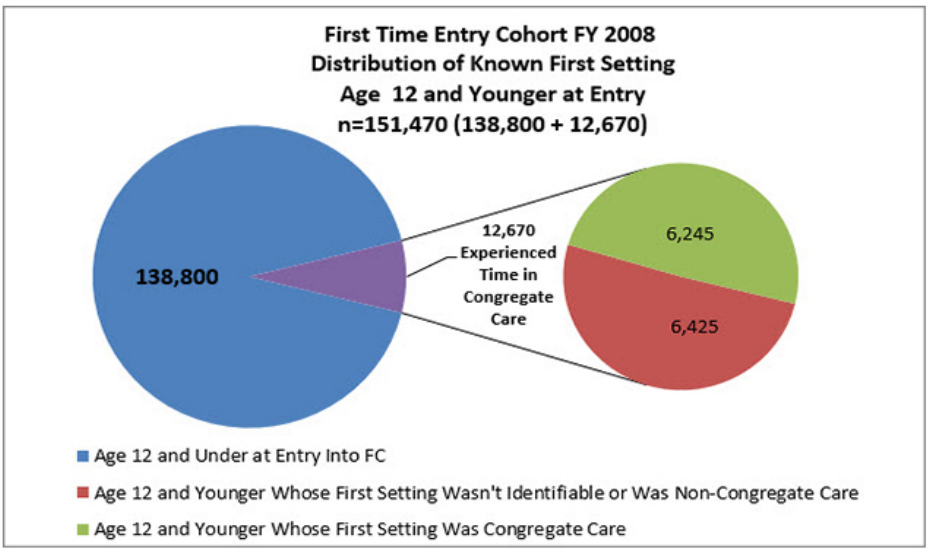


As seen in figure 1, 40 percent of the congregate care children in the 2008 cohort were in Subgroup 1 (No Clinical Indicators). While this is the largest subgroup, when the age of the child is taken into account, the picture begins to change. Mental and behavioral health information in the AFCARS data on younger children in congregate care is limited. Applying the subgroupings identified in this brief does not appear to be an informative approach for children age 12 and under. It is not as common for younger children to have a DSM diagnosis or to have "child behavior problem" as a reason for removal as it is for a younger child to have a diagnosed medical disability. As such, and as suggested by the PIT analyses above that revealed children in congregate care entered at older ages than children in other settings, we divided our results into two age groups—children age 12 and younger and children age 13 and older.

Children Age 12 and Younger

Child development theory, federal legislation, and best practice confirm what we know intuitively—children should be placed in settings that are developmentally appropriate and least restrictive. For young children, particularly those age 12 and under, it is particularly important for their developmental needs to be met in family-like settings. As such, we would expect to see very low percentages of children age 12 and under in a congregate care setting. When placed in congregate care, we would expect them to spend short amounts of time in the setting that would be focused on assessment and stabilization that would prepare them for transition to permanency or family foster care.

Figure 2. 2008 Cohort Children Age 12 and Younger Experiencing Congregate Care as Proportions of the Foster Care and Congregate Care Populations

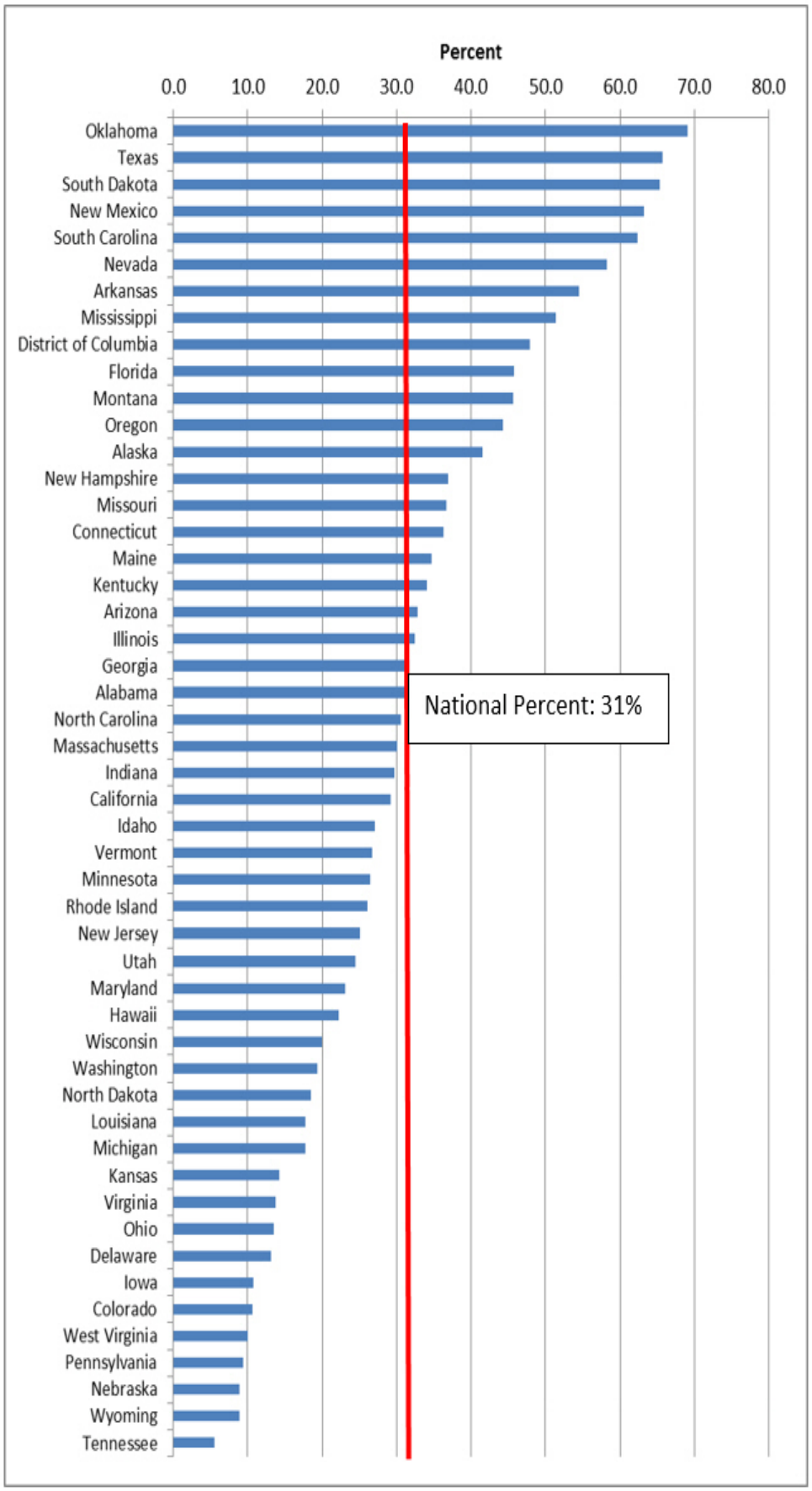


As seen in figure 2, above, of the 207,177 children in the 2008 entry cohort, 151,470 were age 12 or younger at the time of their entry into foster care. Given the structure of the AFCARS dataset, the first placement was identified for just over half (82,472 or 54 percent) of the children age 12 and younger. Of these children, 6,245 (nearly 8 percent) were placed first in a congregate care setting. However, of all children with an identifiable first placement which was a congregate care setting, 35 percent were children age 12 and under.

When analyses are not limited to first-time placements, 12,670 (8 percent) of the 151,470 children who entered care at age 12 or younger experienced time in a congregate care setting at some point during the 5-year follow-up period. As a proportion of all children who experienced time in a congregate care setting, children age 12 and younger comprised slightly less than one-third (31 percent). Of those, 21 percent spent less than 1 week, 22 percent spent 1 week to 60 days, 30 percent spent 61 days to 1 year, and 24 percent spent more than 1 year in congregate care. Sixty-three percent did not have any clinical indicators reported, and only 8 percent were removed from home due to a child behavior problem.Yet, despite these apparent low needs, children younger than 13 comprised an unexpectedly high percentage (31 percent) of children who experienced a congregate care setting. This concerning percentage of younger children in congregate care underscores the need for careful examination of this special group of children.

Use of congregate care varies by state, and additional information on state practices, policies, and state-specific definitions of congregate care would provide important missing information. Twenty-one (40 percent) states had percentages of children 12 and younger in congregate care that were above the national average of 31 percent. States ranged from 6 to 69 percent of the 2008 cohort who were age 12 or younger and who experienced a congregate care episode (figure 3 on page 9). More precise functional and diagnostic data and facility type may help further our understanding of how congregate care is being used for these children. Targeted interventions, coupled with finer data collection, may be needed to justify placement into these group settings.

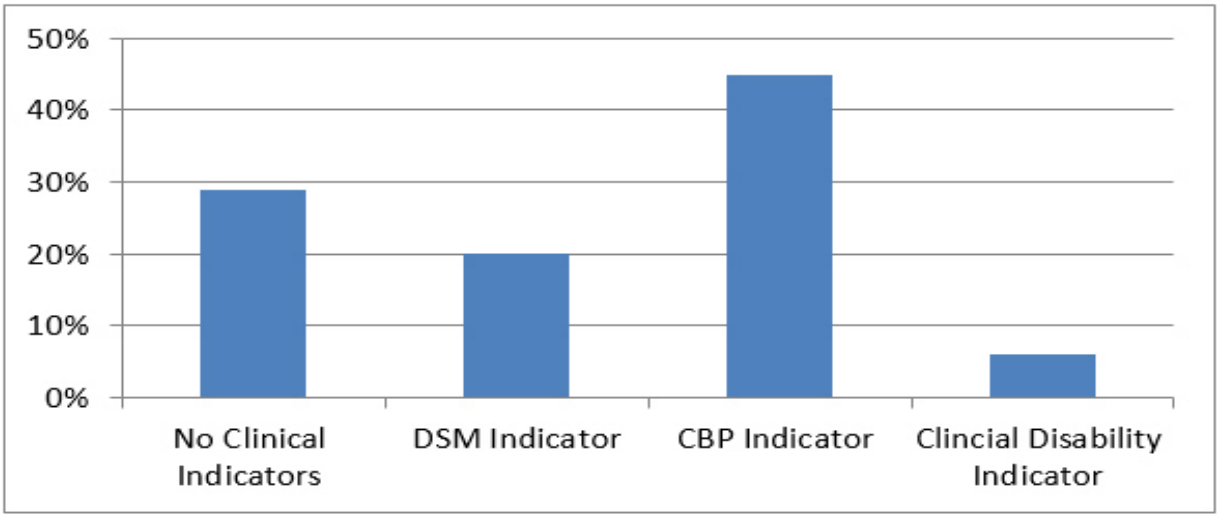
Figure 3. Distribution of Percent of 2008 Cohort of Children Experiencing Congregate Care Who Were Age 12 and Younger at the Time of Entering Congregate Care, by State



Children Age 13 and Older

The literature, best practices, and the data presented in this brief support the position that congregate care is part of a service continuum that should be primarily used, if at all, for children who are age 13 and older. Of the approximately 51,000 children age 13 and older who entered foster care in 2008, about half (25,535) entered congregate care at some point. These older youth comprise 69 percent of the children in congregate care. Among those, more than 4 in 10 entered due to a child behavior problem and no other clinical or mental disability. About one quarter (24 percent) entered a congregate care setting as their first placement (figure 4). Unlike the children age 12 and younger, with this older group of children we have more information with which to gain a better understanding of their mental and behavioral health needs that may have contributed to their time spent in a congregate care setting.

Figure 4. Of the Children in the 2008 Cohort Who Were Age 13 and Older at the Time of Entry and Experienced Congregate Care—Percent Distribution by Subgroup Types



Demographically, there were some notable differences between subgroups (table 4). More children (53.9 percent) in Subgroup 2 (DSM Indicator) than in the other subgroups were White, and there were more Hispanic children (20.4 percent) in Subgroup 4 (Disability Indicator) compared to the other subgroups. The greatest difference between the subgroups is seen in the gender breakdown. In three of the subgroups, there were more males than females; Subgroup 1 (No Clinical Indicators) was the only subgroup where females were in greater proportion. Subgroup 3 (CBP Indicator) had the highest ratio of males to females, where there were twice as many males (67 percent, compared to 34 percent) as females.

Table 4. Distribution of Race/Ethnicity and Gender by Subgroup of Those Age 13 and Older, 2008 Cohort

	No Clinical Indicators	DSM Indicator	CBP Indicator	Clinical Disability Indicator
Race/Ethnicity				
American Indian/ Alaska Native—Non-Hispanic (NH)	1.9%	2.1%	1.2%	1.6%
Asian—NH	1.1%	<1%	1.0%	1.3%
Black or African American—NH	31.7%	25.7%	28.2%	32.0%
Native Hawaiian/ Other Pacific Islander—NH	<1%	<1%	<1%	<1%
Hispanic	16.1%	12.3%	18.4%	20.4%
White—NH	43.1%	53.9%	45.7%	38.8%
Two or More—NH	3.7%	4.0%	2.5%	3.6%
Unable to Determine/Missing	2.1%	1.3%	2.8%	1.9%
Gender				
Male	47.7%	57.3%	66.5%	56.9%
Female	52.3%	42.7%	33.5%	43.1%

First Placement

Table 5 reveals that there is some variation between subgroups in the percent of children who experience congregate care as their first placement setting upon first entering care. Children in Subgroup 2 (DSM Indicator) are more likely to have been placed into a congregate care setting subsequent to a first placement in a family-like setting. In that subgroup, congregate care was a second or higher placement for 59 percent of those children compared to, for example, only 35 percent of the Subgroup 3 (CBP Indicator) children. This may indicate that, as children are assessed and DSM diagnoses are discovered, children are being moved to a group care setting.

Other Factors

The table also includes other indicators that reveal differences *between* the subgroups, but those indicators also provide more information *within* each subgroup that may be used to help explain why children are placed into group care. Notably, of the children in Subgroup 1 (No Clinical Indictors), 10 percent had "sexual abuse" as one reason for removal from home, and in Subgroup 2 (DSM Indicator) 9 percent had been adopted prior to entering foster care, which may suggest underlying mental health or behavioral indicators not captured by AFCARS but contributing to the use of congregate care. Both Subgroups 2 (DSM Indicator) and 3 (CBP Indicator) had higher percentages of children who had been discharged at some point during the follow-up period and subsequently reentered foster care. In Subgroup 2, 13 percent reentered foster care, and 14 percent of Subgroup 3 children reentered care.

Lengths of Stay in Congregate Care

As seen in table 5, on page 13, subgroup differences also are apparent in the time children spend in congregate care. For children and youth with no clinical indicators, 21 percent spent 1 week or less compared to only 4 percent of the children with a DSM diagnosis and 12 percent with a child behavior problem only. One in five (20 percent) children with a child behavior problem and 38 percent of children with a DSM diagnosis spent more than 1 year in a congregate care setting compared to those children with no clinical indicators (19 percent) and children with disabilities (30 percent).

Across all subgroups, most children leave foster care to a permanent placement. However, more children with a child behavior problem exited to permanency (72 percent) and fewer emancipated (15 percent) than children in any of the other subgroups. However, more of them (6 percent) also were transferred to another agency following discharge from foster care compared to children in the other three subgroups, which may indicate a move to the juvenile justice system, to another state, or to another behavioral health system.

Overall, results indicate that Subgroups 2 (DSM Indicator) and 3 (CBP Indicator) had greater proportions of children in categories that may experience a need for higher levels of care. Children with a DSM diagnosis were more likely to have congregate care as a subsequent placement, be previously adopted, and have three or more placement moves compared to the other subgroups. Children with a CBP indicator (Subgroup 3) were more likely to enter congregate care as their first placement, have only one or two placement moves, and exit to permanency. These children also were more likely to reenter care and be transferred to another agency, which may indicate a need for longer-term stabilization in an alternate setting.

Table 5. Foster Care Characteristics by Subgroup Type (Entry Cohort 2008) and Those Children\Youth Who Entered Congregate Care at Age 13 and Older

	No Clinical Indicators	DSM Indicator	CBP Indicator	Clinical Disability Indicator
Placement Setting Number				
Congregate care as first setting	52.3%	41.3%	64.0%	49.3%
Congregate care as second setting or higher	47.7%	58.7%	35.0%	50.7%
Other Indicators				
Sexual abuse	10.3%	7.3%	1.4%	7.1%
Child drugs	4.1%	9.1%	9.0%	13.9%
Ever adopted	4.0%	8.9%	4.1%	6.0%
1 or 2 placements	55.5%	38.1%	70.8%	48.5%
3 or more placements	44.5%	61.9%	29.2%	51.5%
Subsequent reentry into foster care	9.2%	13.1%	14.3%	11.0%
Time in Congregate Care Setting				
1 week or less	21.2%	3.7%	11.9%	7.4%
8–30 days	11.8%	6.2%	10.5%	8.1%
31–60 days	8.5%	5.8%	6.7%	7.6%
61–90 days	5.5%	4.6%	5.2%	5.4%
91–183 days	13.4%	13.7%	17.5%	14.5%
184 days–1 year	16.7%	24.2%	24.9%	21.7%
More than 1 year	19.2%	37.8%	20.0%	30.4%
Discharge Status				
Permanency	64.3%	54.0%	72.3%	51.9%
Emancipation	24.5%	30.5%	15.0%	32.8%
Transfer to other agency	2.8%	3.9%	6.4%	4.1%
Other	2.2%	1.5%	2.0%	2.1%
Still in care	3.0%	6.0%	<1%	4.9%

State Variation in Congregate Care Use

As noted in the PIT analyses, the number of children in care on the last day of the FFY who were placed in a group home or institution decreased by 37 percent from 2004 to 2013. There was, however, wide variation among the states. Ten-year decreases in the use of congregate care ranged from 7 to 78 percent, and increases ranged from 2 to 70 percent (see table 6). Twenty-five states decreased their congregate care use by more than 37 percent (the national rate), 22 states decreased by 7 to 36 percent, and 5 states increased their congregate care use. Additionally, as the overall congregate care population has decreased in the majority of states, the congregate care population as a proportion of each state's total in-care foster care population has also decreased.

These variations indicate a need for additional information on how and when states use congregate care, how congregate care is defined in each state, and what best practices can be shared to help all states reduce their congregate care numbers by ensuring such placements are used only for children whose therapeutic needs make them necessary, and then only for the period needed to stabilize the child and transition them to family settings.

Table 6. Percent Change in Congregate Care Use From 2004 to 2013 by State

State	Number in Congregate Care 2004 (Percent of In-Care Population)	Number in Congregate Care 2013 (Percent of In-Care Population)	Percent Change From 2004 to 2013
New Jersey	2,417 (19.7%)	534 (7.7%)	-77.9%
Maryland	2,060 (18.5%)	548 (12.3%)	-73.4%
Maine	264 (10.2%)	92 (5.1%)	-65.2%
Louisiana	958 (21.8%)	361 (9.1%)	-62.3%
New Hampshire	354 (28.6%)	137 (16.1%)	-61.3%
Virginia	1,683 (24.5%)	673 (15.6%)	-60.0%
North Carolina	2,633 (26.1%)	1,057 (11.7%)	-59.9%
District of Columbia	274 (10.4%)	110 (8.4%)	-59.9%
Nevada	677 (16.8%)	274 (5.7%)	-59.5%
New York	7,643 (22.9%)	3,323 (14.5%)	-56.5%
Oregon	777 (7.7%)	358 (4.4%)	-53.9%
Delaware	223 (26.3%)	104 (14.8%)	-53.4%
Idaho	220 (14.1%)	108 (8%)	-50.9%
Pennsylvania	5,822 (26.5%)	2,964 (20.8%)	-49.1%
Georgia	2,566 (18.1%)	1,320 (17.4%)	-48.6%
Oklahoma	1,750 (14.8%)	914 (8.7%)	-47.8%
Hawaii	133 (4.5%)	70 (6.5%)	-47.4%
Nebraska	1,362 (21.6%)	727 (15.9%)	-46.6%
Wyoming	484 (42.5%)	264 (26.9%)	-45.5%
Massachusetts	2,641 (21%)	1,481 (17.3%)	-43.9%
Indiana	1,893 (19.4%)	1,064 (8.6%)	-43.8%
Rhode Island	854 (35.4%)	488 (27.3%)	-42.9%
Connecticut	1,682 (26%)	973 (22.9%)	-42.2%
South Dakota	422 (26.7%)	248 (19.8%)	-41.2%
Iowa	1,986 (36.9%)	1,203 (19%)	-39.4%
Florida	3,692 (12.8%)	2,354 (13.1%)	-36.2%
Alaska	199 (10.9%)	128 (6.5%)	-35.7%
California	10,498 (12.7%)	6,800 (12%)	-35.2%
Vermont	299 (20.9%)	195 (20.1%)	-34.8%
New Mexico	196 (9.1%)	128 (6.2%)	-34.7%
Ohio	2,574 (14.3%)	1,704 (13.9%)	-33.8%
South Carolina	1,077 (23.2%)	735 (23.1%)	-31.8%
Kansas	474 (7.8%)	325 (5%)	-31.4%
North Dakota	397 (30.2%)	275 (22.4%)	-30.7%
Mississippi	809 (27.1%)	575 (15.2%)	-28.9%
Kentucky	1,768 (25.3%)	1,262 (17.6%)	-28.6%
Montana	283 (13.9%)	208 (9.3%)	-26.5%
Minnesota	1,655 (25.3%)	1,247 (21.8%)	-24.7%
Wisconsin	1,079 (13.8%)	821 (12.6%)	-23.9%
Michigan	3,283 (15.5%)	2,569 (17.6%)	-21.7%
Texas	5,809 (23.7%)	4,687 (15.8%)	-19.3%
Colorado	2,447 (29.9%)	1,997 (34.1%)	-18.4%
West Virginia	1,349 (33.8%)	1,109 (25.3%)	-17.8%
Tennessee	1,567 (16.3%)	1,383 (16.9%)	-11.7%
Arizona	2,279 (24.8%)	2,013 (14%)	-11.7%
Illinois	1,935 (9.7%)	1,723 (10.3%)	-11.0%
Washington	527 (5.6%)	489 (4.8%)	-7.2%
Utah	321 (15.2%)	326 (12%)	1.6%
Puerto Rico	584 (7.6%)	702 (16.7%)	20.2%
Missouri	834 (7.1%)	1,212 (11.3%)	45.3%
Arkansas	502 (16.1%)	738 (19.4%)	47.0%
Alabama	480 (8.1%)	816 (18%)	70.0%

QUALITATIVE RESULTS

To supplement the quantitative information and to begin to understand the practices and policies behind the numbers, we synthesized the qualitative information into common themes. The dialogue with the states provided an opportunity for them to describe promising practices that they have adopted to reduce their reliance on congregate care and to best match services with the clinical needs of the children under their care and responsibility. Results are described by subgroup where appropriate, and then themes that applied to all subgroups complete the results section.

Subgroup 1 (No Clinical Indicators)

Given the large percentages of children who had no apparent clinical indicators, we hypothesized that states may be placing children in congregate care settings due to limited (or no) alternative placements. When asked about this, however, the states we interviewed (that had successfully reduced their use of congregate care) shared that when they have needed to place a child in congregate care who should have been placed elsewhere, they have developed a variety of solutions intended to limit this practice. For example, one state created an alternative placement program that pays family foster homes to keep beds available on an emergent basis to care for children while their needs are assessed and other appropriate foster family home placements can be identified.

In remote rural areas, there sometimes are challenges in finding foster family homes that are in close enough proximity to allow children to maintain relationships with their biological families and attend their home schools. As an alternative, it is important for states to recruit developmentally appropriate resource families for older youth who are in congregate care in both rural and urban communities throughout the state.

One state described the importance of early trauma screening and treatment as a cornerstone for decreasing their use of congregate care as a placement option for children who may best be served elsewhere. As the state's casework staff became more astute at recognizing and managing difficult behaviors of the children in the system, they became better at finding more appropriate community-based supports that allowed them to both divert children from congregate care and more quickly transition them back into their communities.

Kinship Care

Two states we interviewed have concentrated much of their efforts on finding family (kin) placements immediately following a child's removal from home. Although the states were unable to draw direct correlations between the decrease in numbers of children placed in congregate settings and increased kinship-finding efforts, they anecdotally found that as they have placed more children with kinship caregivers, the numbers of children needing this more restrictive level of placement has declined. In order to facilitate kinship placements, one state found it necessary to modify its statutes and policies to allow for the placement of children with kin pending formal licensure.

Subgroups 2 and 3 (DSM Indicator and CBP Indicator)

Although the children in these two subgroups present different behaviors and have different treatment and placement needs, the states interviewed described a common set of tools, processes, and specialized staff designed to assess, provide services for, appropriately place, and monitor both groups.

Changing the Service Array

The states interviewed discussed their efforts to work with congregate care providers to move programs toward more community-based services. State leadership engaged (predominantly private) providers in the creation of transitional, short-term congregate care and community-based programs that met the needs of their respective populations. Although state leaders acknowledged that this change was not without some challenges and that community service providers often needed to restructure their business models, all found that the service providers had the expertise needed to provide effective alternative services. By engaging the providers, states recognized and benefited from provider input that proved instrumental in developing innovative and more responsive programing.

Subgroup 4 (Disability Indicator)

States described the development of successful partnerships and interventions with other systems within their communities to care for children in this category. States described models and interventions in which the

child welfare workers partner with medical case managers and providers to ensure that children's needs are met in family settings. Children with developmental disabilities are often transitioned to other agencies and guardianship services as they age out of the system.

All Children in Congregate Care

The themes discussed below represent some of what we heard during our interviews with the aforementioned states and describe best practices and beliefs that apply to all children in congregate care.

Leadership

Systemic change requires strong leadership both within the child welfare system itself and within the community of providers and stakeholders. Leaders in all interviewed states indicated that effective change requires them to engage and secure buy-in from agency staff at multiple levels as well as external community partners and stakeholders. This engagement leads to a sustained organizational change effort that focuses on how best to ensure the safety of the identified children, their siblings, other children in their communities, and the adults in their lives. States noted that this kind of effort isn't a linear process, but a circular endeavor that requires a feedback loop process with multiple constituencies, changing attitudes, supervision models, and casework practices. Two states we spoke with followed structured models of organizational change to enhance all of their work with children and families.

Workforce

States we interviewed stressed the need for highly skilled, clinically informed casework staff to work with *all* children, but the need was particularly great in working with children who may be at risk of congregate care. These staff were instrumental in reducing the numbers of children in congregate care in multiple ways. They conducted thorough, trauma-informed assessments that enabled the implementation of tailored mental health services; they provided hands-on support to resource families whose states found necessary to maintain children with highly challenging behaviors in family foster homes; and they prepared complex transition plans that engaged family members, resource families (as appropriate), congregate care providers and community support systems.

Budget restraints on training and staff development, hiring freezes, and turnover were described as impediments to working with children with severe challenges. Having small caseloads allowed staff in one jurisdiction to develop and maintain engaged relationships with youth, biological and kinship family members, treatment providers, and community stakeholders important to the child's case. In this jurisdiction's youth evaluation reports, youth articulated that spending more time with their caseworker was of high priority for them. Small caseloads allowed for this continued interaction.

All of the interviewed states described having staff whose function centered on a detailed knowledge of the system's placement resources. These workers had varying responsibilities across jurisdictions, but they were all involved with regularly monitoring children for readiness for transition and in identifying homes appropriate for placement. It is critical to have workers whose primary responsibility centers on a detailed knowledge of the system's resources and to prepare resource families for children with behavioral health challenges.

One state noticed a marked improvement in the process of transitioning from congregate care to foster family care when the two divisions (those responsible for children in congregate care and those in family foster care) were placed under the same leadership team. This organizational change allowed for better coordination and the sharing of resources between two areas of service provision that had previously operated in isolation.

Utilization of Data

Three of the states we spoke with instituted data collection systems that allow administrative staff to examine the demographic characteristics of children being placed in congregate care, mental and behavior diagnoses, lengths of stay, placement stability, crisis stabilization, and resource availability. Analyzing these data at the jurisdictional level allowed for better resource development and allocation strategies that reflected the needs of particular communities. One state used these data to identify staff capacity-building needs to ensure its workforce was adequately prepared to meet the array of needs of children in its particular communities. This state is also using the data to work with its congregate care providers to ensure that the available service array meets the needs of the specific population.

Assessment and Review Processes

Having a thorough assessment and review process was cited by all of the states interviewed as being critical in the care of children with complex needs. These processes were present in all states, but with varying degree of effectiveness. The instruments states used varied, but all had the purpose of thoroughly understanding the child, the trauma the child has experienced, and the complexity of the family system. States' assessments capture educational and community information as well as child behavioral information that includes substance and alcohol abuse, self-harm behavior, and emotional stability. The officials we spoke with believe these types of information are indispensable for a placement matching process that ensures selected placements are able to meet the children's needs.

All interviewed states have some form of a multidisciplinary committee process in place that reviews assessments and placement recommendations. Congregate care is seen as a last resort and is only approved if the placement can meet the child/youth's needs. The cases of children placed in congregate care are regularly reviewed—some as often as weekly, but no less than every 90 days. States differ in the ways they review cases: some convene regular roundtables of child welfare staff, treatment professionals, and community stakeholders to discuss all children placed in congregate care. The membership of placement review committees varies by jurisdiction. Others states review cases more frequently, but somewhat less formally, within the public agency. In these instances, reviews are led by system leaders in placement services and engage casework and treatment providers that are assigned to each child's case. One foster care leader we spoke with maintains an active list of all children in congregate care, reviews them weekly, and is intimately aware of all the details of each child's case.

Evaluation of Congregate Care Providers

There is variation in how congregate care facilities and programs are evaluated across the states interviewed. All of the interviewed states monitor the facilities through their licensing departments and their contract review processes. One state ranks its providers based on their success (or failure) with the youth placed in their care and uses this ranking to make future placement decisions. This practice of ranking placement agencies also had the effect of reducing the supply of congregate care beds over time as the state's need decreased.

One state in particular stood out as leading the field in using evaluation to inform practice. Utah contracted with the University of Utah to conduct a thorough evaluation of its congregate care programs (e.g., outcome measures, qualitative interviews with youth). This evaluation process has the capacity to immediately respond with staff training when the needs of the placed children require it. Much is needed in the development of evidence-informed and evidenced-based treatment programs for children with serious mental and behavioral challenges, and this is a promising evaluation model that can help build evidence for effective practices.

Discussion and Recommendations

The above quantitative and qualitative results reveal a complicated picture of how often congregate care is used, who uses it, and what can be done to ensure it is utilized appropriately as part of a continuum of service for children in the child welfare system. Children and youth in congregate care are not a homogeneous group, and this heterogeneity requires the development of tailored, innovative strategies and programs to ensure that each child is placed in the least restrictive environment possible. Because of these differences within and across states, jurisdictions should understand the unique characteristics of their own populations that are in and at risk of placement in congregate care and consider these when crafting their policies, practices, and programs. ***We heard from states that a number of challenges—financial and staff resources, a supply of alternative placements, workforce development and training, and leadership practices—impact their use of congregate care.*** We encourage all states to consider these and other challenges that may be unique to their systems and design strategies that can help ensure congregate care is reserved for children requiring stabilization and that can help ensure congregate care is reserved for children who have specialized behavioral and mental health needs.

We recommend a tiered approach. First, identify children who may be diverted from congregate care with a small amount of effort. Our results indicate that children who do not stay for long periods of time, who are age 12 and younger, and who do not appear to have high clinical needs may be targeted for resource or kinship family placements. We encourage states to explore innovative options (e.g., holding open beds in family foster homes, as one state has done) to increase their supply of family-like settings for these children.

Second, identify those children with clinical needs who may require stabilization in a congregate care setting and work with providers to design and implement more flexible and trauma-informed treatment programs (e.g., day programs, smaller facilities) that can better serve these children with multiple, higher end needs. We also encourage states to increase recruitment efforts for and training of therapeutic foster homes, strengthen community-based services, and increase access to wrap-around services so that children may be transitioned to a community-based therapeutic setting.

Third, we encourage all states to evaluate their congregate care programs and to implement evidence-informed programming whenever possible. Only by building the evidence can we understand how congregate care is used, for whom it is being used, and how effective it is as a service to children.

It is important for children to be cared for in the least restrictive, most family-like setting possible. At times, congregate care is necessary to ensure a child's safety and stabilization, but it should be used judiciously, efficiently, and effectively.

APPENDIX

Subcategories by Fiscal Year for Those Children\Youth in a Congregate Care Setting

	FY 2004 Count	FY 2004 Column N%	FY 2005 Count	FY 2005 Column N%	FY 2006 Count	FY 2006 Column N%	FY 2007 Count	FY 2007 Column N%	FY 2008 Count	FY 2008 Column N%	FY 2009 Count	FY 2009 Column N%	FY 2010 Count	FY 2010 Column N%	FY 2011 Count	FY 2011 Column N%	FY 2012 Count	FY 2012 Column N%	FY 2013 Count	FY 2013 Column N%
No Clinical Indicators	25,969	32.3	24,773	31.3	23,550	31.4	21,055	30.4	19,034	28.7	16,832	29.4	14,829	28.4	14,651	28.9	14,605	27.6	14,923	28.8
DSM Alone or in Combination (can include CBP)	23,951	29.8	25,147	31.8	24,773	33.1	23,939	34.5	22,811	34.4	19,263	33.6	19,068	36.5	17,848	35.3	19,040	35.9	18,588	35.8
CBP Alone (excludes ALL disabilities)	21,229	26.4	19,975	25.2	18,507	24.7	17,180	24.8	17,824	26.9	15,500	27.1	12,950	24.8	13,034	25.7	13,804	26.1	12,973	25.0
Any Clinical Disablities (excludes DSM)	9,319	11.6	9,231	11.7	8,098	10.8	7,176	10.3	6,634	10.0	5,674	9.9	5,331	10.2	5,093	10.1	5,539	10.5	5,407	10.4
Total in Congregate Care as of Sept. 30	*80,468*		*79,126*		*74,928*		*69,350*		*66,303*		*57,269*		*52,178*		*50,626*		*52,988*		*51,891*	
Total in Care as of Sept. 30	466,447		474,176		467,255		451,824		428,114		387,099		373,969		368,502		368,658		375,206	

Note: Because New York and Puerto Rico are not included in these subgroup analyses (as noted in the Methodology section), the "Total in Congregate Care as of Sept. 30" and the "Total in Care as of Sept. 30" in the appendix table do not match the national totals referenced in the text on page 5 or on the Children's Bureau website.

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