

Chapin Hall & Chadwick Center

COLLABORATING AT THE INTERSECTION
OF RESEARCH AND POLICY

POLICY
BRIEF

JAN 2016

Chadwick Center and Chapin Hall are pleased to collaborate to bring together research, implementation science and evidence-based practices to guide child welfare systems in thoughtful and cost-effective practice and policymaking. By combining their assets, including Chapin Hall's Multistate Foster Care Data Archive and Chadwick Center's California Evidence-Based Clearinghouse for Child Welfare, policy briefs created under the collaboration will show decision makers how to leverage data, rigorous research, and evidence to ensure that each child receives services that are proven to effectively meet individual needs and are delivered with fidelity.

CHADWICK CENTER

Chadwick Center, a division of Rady Children's Hospital - San Diego, has its origins in 1976 when pediatrician Dr. David Chadwick convened the first interagency multidisciplinary team to coordinate the community response to child abuse. Chadwick Center is a fully accredited member of the National Children's Alliance and the Child Advocacy Center for San Diego, working closely with law enforcement, prosecutors, and child welfare professionals to provide child sexual abuse and physical abuse exams and forensic interviews. The Center is a state, national and international leader in providing training and implementation support to agencies and jurisdictions in their efforts to improve services to children and families affected by trauma, and manages the California Evidence-Based Clearinghouse for Child Welfare, a critical tool for the identification, selection, and implementation of evidence-based practices used by over 190 nations. The Chadwick Center also works with communities on screening and assessment of trauma, as well as developing trauma informed child welfare systems.

CHAPIN HALL

Chapin Hall is an independent policy research center at the University of Chicago focused on providing public and private decision-makers with rigorous data analysis and achievable solutions to support them in improving the lives of society's most vulnerable children. Chapin Hall partners with policymakers, practitioners, and philanthropists at the forefront of research and policy development by applying a unique blend of scientific research, real world experience, and policy expertise to construct actionable information, practical tools, and, ultimately, positive change. Chapin Hall directs the Center for State Child Welfare Data and the Multistate Foster Care Data Archive, a longitudinal database containing records of approximately 3 million foster children nationwide. Established in 1985, Chapin Hall's areas of research include child and adolescent development; child maltreatment prevention; child welfare systems; community change; economic supports for families; home visiting and early childhood; runaway and unaccompanied homeless youth; school systems and out-of-school time; and youth crime and justice.

Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved with Child Welfare

INTRODUCTION

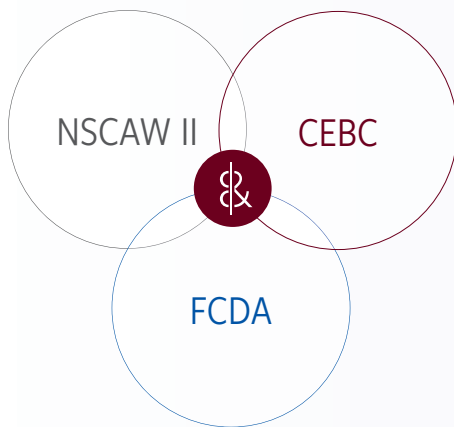
The child welfare system's use of congregate care is in a period of rapid transition. Building on years of professional interest in offering more home-like placement options, legislative and administrative pressure at the state and federal levels is accelerating the pace of change. Congregate care has long been viewed as a viable placement alternative for children and adolescents, especially those whose histories, mental health needs, and current behavior render them difficult to manage in home-based settings. In our current fiscal and cultural climate, the appropriateness and effectiveness of congregate care is increasingly being called into question. Changing federal and state policies, as well as clinical guidelines, now suggest that congregate care be reserved for the short-term treatment of acute mental health problems to enable stability in subsequent community-based settings (Blau et al., 2010). In response to these changing expectations, the demand for congregate care will likely decline. From a public policy perspective, it is vital that we establish the infrastructure necessary to support the type of children and youth often served in group and residential care in more home-like environments.

To do this—and to be able to define the specific levers for strategic innovation and systems change—we must first understand the

- 1 population of youth involved with the child welfare system who are in need of more intensive services,
- 2 strategies that may be available to support these youth in home-based placements, and
- 3 variation in patterns of current congregate care placement across the country.

This process will allow us to make purposeful decisions about the use of congregate care as a treatment option, as well as to identify and spread community-based treatments that may reduce the need for congregate care placements among youth who can, with proper support, be treated and maintained in community settings.

Our broad look at this issue will focus on population characteristics and utilization trends. We will then apply a clinical, trauma-informed, well-being focused lens to an examination of evidence-based practices that may be used to deflect youth from congregate care, and frame our understanding of the population, their needs, and available treatments in the context of regional variation.



Chadwick Center and Chapin Hall are uniquely positioned to collaborate on seeking the answers to these questions with the use of pooled data holdings and analytic expertise. The **Multistate Foster Care Data Archive (FCDA)**, the **National Survey of Child & Adolescent Well-Being (NSCAW II)**, and the **California Evidence-Based Clearinghouse for Child Welfare (CEBC)** together provide an array of resources that can be applied to understand the challenges faced by state agencies, treatment providers, and policymakers, as well as to generate innovative solutions.

KEY FINDINGS

- The overall use of congregate care has decreased by 20% since 2009, but there is substantial variation among states even in this trend (suggesting detailed analysis is needed to understand local trends).
- Some states rely heavily on congregate care as a first placement (suggesting capacity building for foster homes is needed).
- Youth placed in congregate care and therapeutic foster homes have significantly higher levels of internalizing and externalizing behaviors than those placed in traditional foster care (suggesting that increased access to services that effectively address internalizing and externalizing behaviors are essential to safely reducing the use of congregate care).
- Compared to youth whose clinical needs are met through therapeutic foster care, youth placed in congregate care are more likely have externalizing problems (suggesting that strategies for serving these youth in home-based setting should focus on preparing those homes to respond by de-escalating difficult behaviors).
- The California Evidence Based Clearinghouse for Child Welfare (CEBC) contains tested strategies for disruptive behavior problems, however, many of them have not been tested for use with the child welfare population (suggesting that support is needed for implementation and evaluation of interventions that may stabilize foster care placements).

I Understanding Youth Placed in Congregate Care

Using data from NSCAW II, we compared youth involved in the child welfare system who remained in their own homes or were placed in non-congregate care out-of-home settings (such as kinship or traditional foster care), with those in congregate care, in order to derive a focused clinical picture of the youth for whom effective interventions can be identified using the California Evidence-Based Clearinghouse for Child Welfare (CEBC). Analyses were conducted using data from the Child Behavior Checklist (CBCL) (Achenbach & Rescorla, 2001). The CBCL/1.5-5 was administered to caregivers of

young children and the CBCL/6-18 was administered to caregivers of older children. The CBCL was “designed to provide standardized descriptions of behaviors rather than diagnostic inferences.” A score of ≥ 64 is considered clinically significant.

In the NSCAW II sample, 56% of children were initially placed in congregate care after entry to child welfare services. Youth who experienced congregate care were significantly older than youth who remained in their homes or only experienced placement in foster care. There were no significant differences between the congregate and non-congregate care groups by a child's gender or race/ethnicity.

When the CBCL results were examined using detailed congregate care subgroups (see Figure 1), the data show that youth placed in emergency shelter care more closely resemble their home-based counterparts in terms of mental health need, and youth in congregate care settings are clinically similar to youth in therapeutic foster homes. These findings suggest potential levers for achieving reductions. First, the lower level of clinical problems among youth experiencing emergency shelter care paired with the frequency of congregate care as first placement among this group suggests the need for front door *strategies that*

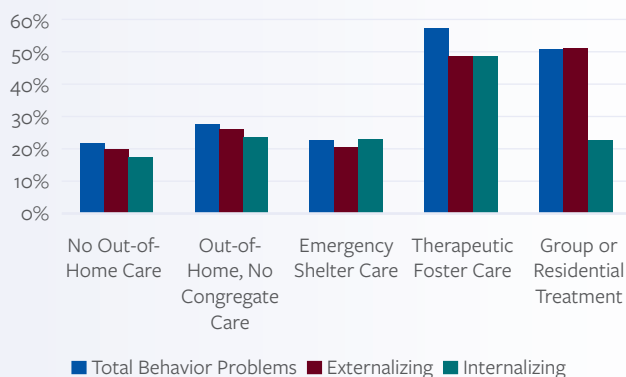
build capacity for initial home-based placements. Second, the comparable clinical profiles among congregate care and therapeutic foster care youth suggest the potential for intensive intervention provided in home-based settings that are prepared to support and address the needs of youth with complex and challenging diagnostic profiles as either an alternative to the use of congregate care altogether or as a back door, step-down approach.

Like youth placed in therapeutic foster care youth residing in group homes or residential treatment centers are predominantly older (ages 11+) and likely to exhibit externalizing behaviors (51-57%). However, several NSCAW II findings underscore the idea that youth with comparable clinical characteristics are more likely to be placed in congregate care than therapeutic foster care to manage their behavioral risk. These youth are more likely to exhibit externalizing behaviors (such as aggressive behavior, oppositionality, and conduct problems). Among those youth requiring higher levels of care, those with internalizing problems (e.g. depression & anxiety) are more likely to be placed in therapeutic foster homes than

The **National Survey of Child and Adolescent Well-Being** (NSCAW II) is a longitudinal study of youth referred to US child welfare agencies for whom an investigation of maltreatment was completed between February 2008 and April 2009. Initial interviews were collected within approximately 4 months of completed investigations. NSCAW II used a national probability sampling strategy. Analyses used data from interviews with caregivers and child welfare workers about children ≥ 18 months of age.

FIGURE 1

Percent of Youth above the CBCL Clinical Cut Point by Placement Type



The figure shows that youth in group or residential treatment settings are clinically similar to youth in therapeutic foster homes, and have nearly twice the rate of clinical problems as those in traditional out-of-home care. Youth placed in emergency shelter care more closely resemble their home-based (no out-of-home care) counterparts. (Data source: NSCAW II)

congregate care settings. *This suggests that investments in interventions focused on stabilizing affect and behavior, de-escalating conflict, and promoting mindfulness and stress reduction could be used to make more home-based placements available to youth with externalizing behaviors.*

Identifying Strategic Levers for Reducing the Use of Congregate Care

Reducing congregate care utilization by addressing youth mental health needs will require a two-pronged approach:

- 1 **evidence-based interventions** to target the needs of youth, and
- 2 **services and supports for their home-based caregivers.**

ALTERNATIVE TREATMENTS FOR YOUTH DEFLECTED FROM CONGREGATE CARE SETTINGS

Given the high rate of clinical needs in children who become involved with child welfare services, regardless of placement (see Figure 1 above), it is crucial that all children entering the system be screened for mental health needs, including post-traumatic stress symptoms, and referred for assessment when indicated. A thorough, trauma-informed assessment of the youth's mental health needs should be conducted by a licensed mental health professional prior to the initiation of mental health services; the assessment should clearly drive the treatment plan and interventions should be aligned with the youth's specific mental health needs.

Careful screening and assessment should be used on all youth entering the child welfare system to identify their individual needs and ensure that placement decisions are data driven using standardized measures and favor the least restrictive placement that meets the child's needs. It should be noted that while the CBCL scores indicate higher levels of mental health need than in the general population, there are likely still a number of children and youth in congregate care settings who do not have elevated scores (estimated to be 2 out of 5 in Treatment Foster Care and Group or Residential Treatment). These youth may be most amenable to immediate deflection or discharge from congregate care. Periodic reassessment of youth already in care should be conducted to ensure that placement settings are appropriate for current levels of need.

The use of evidence-based interventions for youth with mental health needs not only effectively addresses those needs, but also aims to reduce the use of congregate care. The CEBC has reviewed the evidence

base for a number of mental health treatments and broken them out by diagnostic group. In general, these services are delivered in an outpatient setting or in family homes while children are living with parents or other caregivers; they do not require out-of-home placement. Increasing the use of treatments that are shown to be effective will require partnering with public mental health systems, as they may be the primary funder and delivery source for youth in child welfare.

The **California Evidence-Based Clearinghouse for Child Welfare (CEBC)**, funded by the California Department of Social Services, is a registry of programs that can be utilized by professionals serving children and families involved with the child welfare system. The programs, organized by topic area, are described in detail and rated using the Scientific Rating Scale to determine the level of research evidence supporting each practice. As such, the CEBC serves as a key resource for identifying evidence-based alternatives to congregate care.

While the CEBC provides information on several mental health topic areas, given the prevalence of externalizing behaviors in the congregate care group, interventions in the CEBC's **Disruptive Behavior Treatment** topic area (<http://www.cebc4cw.org/topic/disruptive-behavior-treatment-child-adolescent>) may be appropriate for consideration. This topic area focuses on the treatment of youth with a diagnosis of a disruptive behavior

DISRUPTIVE BEHAVIOR TREATMENTS

CEBC Rating of: 1 | Well Supported by Research Evidence

Coping Power Program

ages 8–14 | child and parent components

Multi-Systemic Therapy (MST)

ages 12–17 | family-focused intervention

Parent-Child Interaction Therapy (PCIT)

ages 2–7 | parent-focused intervention

Parent Management Training, Oregon Model (PMTO)

ages 2–18 | parent-focused intervention

Positive Parenting Program® (Triple P) Level 4

ages birth–12 | parent-focused intervention

Problem Solving Skills Training (PSST)

ages 7–14 | child-focused intervention with some parent involvement

Promoting Alternative Thinking Strategies (PATHS)

ages 4–12 | often conducted in a school setting

The Incredible Years (IY)

ages 4–8 | parent-focused intervention with child component

Treatment Foster Care Oregon – Adolescents (TFCO-A)

ages 12–18 | parent and child components

disorder including Oppositional Defiant Disorder (ODD), Conduct Disorder, and Attention-Deficit/Hyperactivity Disorder (ADHD), or youth without a diagnosis who are exhibiting similar behaviors. Common symptoms may include arguing and refusing to obey rules, frequent defiance of authority, aggression, destruction of property, lying, theft, failure to take responsibility for behavior or mistakes, hyperactivity, inattention, and impulsivity. This group of behaviors is consistent with the characteristics of the youth placed in congregate care identified in the NSCAW II data.

Nine programs are identified as **1 | Well-Supported by Research Evidence**, the highest scientific rating level used by the CEBC, which requires that at least two randomized controlled trials have shown the practice to be effective and that sustained effect has been seen 12 months after the end of services, as compared to a control group.

BUILDING CAPACITY TO REDUCE USE OF CONGREGATE CARE AS A FIRST PLACEMENT/SHELTER

In conjunction with addressing the needs of the youth themselves, ***it will also be important to provide additional services and supports for the home-based caregivers of these youth to reduce the risk of placement disruption or step up to congregate care and to facilitate step down from higher levels of care.*** **Placement Stabilization Programs** are defined by the CEBC as programs that aim to reduce the number and frequency of disrupted out-of-home placements. Services that seek to keep placements intact include those focused on enhancing the caregiver's sense of competency in parenting the child (i.e., managing difficult behaviors, encouraging positive caregiver-child interactions, helping the caregiver develop proactive and reactive responses that reinforce positive behaviors, and providing a safe and nurturing environment for the child). In order to be rated in the Placement Stabilization Programs topic area, there must be research evidence (as specified by Scientific Rating Scale) that examines outcomes related to placement stabilization, such as placement disruptions, exits from out-of-home care, or moves to more restrictive levels of care.

The only placement stabilization program rated by the CEBC as **1 | Well Supported by Research Evidence** is **Treatment Foster Care Oregon – Adolescents (TFCO-A)**, previously

referred to as Multidimensional Treatment Foster Care – Adolescents. TFCO-A is a model of therapeutic foster care for children 12-18 years old with severe emotional and behavioral disorders and/or severe delinquency. TFCO-A creates opportunities for youth to successfully live in families rather than in group or institutional settings, and simultaneously prepares their caregivers to provide them with effective parenting. TFCO-A can be used as a front door approach to prevent entry into congregate care, as well as a back door approach to facilitate step-down from congregate care.

TFCO-A has a strong caregiver component involving regular contact and support of the caregiver in individual and group formats. TFCO also has versions for preschoolers and school age children; the preschool version is rated as **2 | Supported by Research Evidence**. It should be noted that TFCO-A is also rated as **1 | Well-Supported by Research Evidence** in the **Disruptive Behavior Treatment** topic area described above.

Several other interventions have been reviewed by the CEBC and rated as **3 | Promising Research Evidence** on the CEBC in the **Placement Stabilization Programs** topic area. While these do not have the level of research evidence necessary for the higher rating levels, all have examined outcomes related to placement stabilization through controlled studies and found effect.

Communities will need to examine which of these are most appropriate for the needs of their unique population by analyzing the characteristics of the youth in congregate care in their community/state and examining the features of each model to determine the best service mix for the community. Next, jurisdictions must determine whether any of these evidence-based interventions are currently available in the community and how accessible they are for child welfare children and youth. The introduction of new practices needs to be done in a thoughtful, data driven way to ensure success. Communities are encouraged to apply the principles of implementation science to this process (Walsh, Rolls Reutz & Williams, 2015).

PLACEMENT STABILIZATION PROGRAMS

CEBC Rating of: 1 | Well Supported by Research Evidence

Treatment Foster Care Oregon – Adolescents (TFCO-A)

at least two randomized controlled trials have shown the practice to be effective and that sustained effect has been seen 12 months after the end of services, as compared to a control group.

CEBC Rating of: 3 | Promising Research Evidence

Family Group Decision Making (FGDM)

several controlled studies have shown effect on placement stability

KEEP Keeping Foster and Kin Parents Supported and Trained
several randomized controlled trials have been conducted and shown effect on placement stability.

Neighbor to Family Sibling Foster Care Model

one comparison study showed effects on placement stability

Wraparound

one randomized controlled trial, with no post-intervention follow-up, showed effect on the rate of placement change

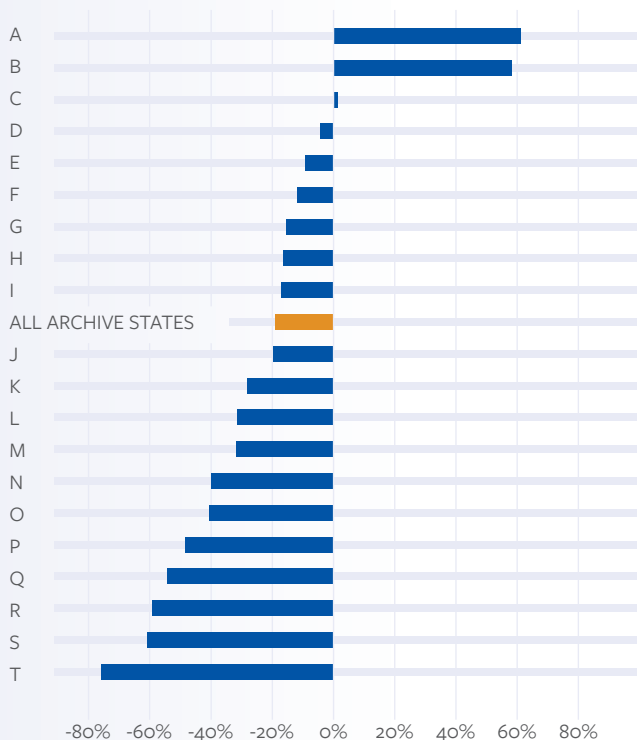
| Understanding Variation in the Use of Congregate Care

An understanding of the population of youth requiring intensive interventions must be paired with an understanding of how states allocate and utilize high-end treatment and placement resources. To understand the variation in state and local utilization of congregate care, we use evidence from 25 states in the Chapin Hall Foster Care Data Archive (FCDA). The data —*Children in Congregate Care; Children Placed in Congregate Care; Transfers From and Into Congregate Care; and Time Spent in Congregate Care*—illuminate the opportunities that states and providers face when choosing strategies for effectively managing their use of congregate care, such as reducing placements into congregate care or reducing the time spent in congregate care.

Discussions focused on managing the use of congregate care often start with evidence showing how many children are in congregate care and whether that number is changing with the passage of time. Evidence from the FCDA reveals the nuance behind that basic question. According to Figure 2, although the number of children in congregate care within the FCDA states dropped by nearly twenty percent in the seven-year period that started in 2009, state-level changes vary dramatically, from nearly 80% fewer to 60% more young people living in congregate care.

FIGURE 2

Percent Change in the Number of Children In Congregate Care By Archive State: 2009 to 2015



This figure shows the change in congregate care use between 2009 and 2015. States to the left of the center line lowered their use of congregate care; states to the right increased their use of congregate care. The average of all the states combined is displayed in orange. (Data Source: FCDA)

The average for all the FCDA states indicates that about 14% of all initial placements start in a congregate care setting (including emergency shelters). As with overall utilization, the tendency to rely on congregate care as an initial placement varies substantially. In states at the high end, about 43% of initial placements are in a congregate care setting, whereas at the low end of the range, initial placements in congregate care account for just 4% of all first admissions to out-of-home care. Variation also occurs within states; when counties within high- and low-use states are compared, there is an even broader range of proportions of first placements in congregate care (2-80%). **Reducing reliance on group shelter care as a first placement requires an entirely different capacity-building response than that needed to reduce the use of congregate care among children placed there to address clinical needs.**

The FCDA data on lateral moves and transfers reveal additional differences in the utilization of congregate care by jurisdiction. For the purpose of portraying how states differ with respect to transfers into congregate care settings, Figure 3 highlights three transfer types: Lateral moves between congregate care (CC) placements [shown as CC to CC transfers] and step up transfers from family settings [foster care (FC) to congregate care and kinship care (KC) to congregate care]. The findings, when aggregated across all the archive states, indicate that just under 30% of children placed initially in a congregate care setting left that placement through a lateral move to another congregate care setting. In states where lateral moves are more common, the rate was as high as 50%; in states where lateral moves are less common,

just under 25% of initial congregate care placements end with a lateral move. Rates of step-up transfers are generally quite low across the states, ranging across the states from about 2-7%.

The overall use of congregate care is also a function of how long children stay in congregate care settings. Historically speaking, while some young people do spend considerable time in congregate care when compared with other placement types (e.g., foster and kinship care), congregate care placements tend to be shorter on average than either foster or kinship placements (Wulczyn, Chen, & Hislop, 2007). The *median duration*—the time by which half the admitted population leaves initial congregate care placement—ranges from less than 30 days to more than 115 days.

Reducing the use of congregate care for children and youth involved in the child welfare system will require that we address two different patterns of congregate care service use:

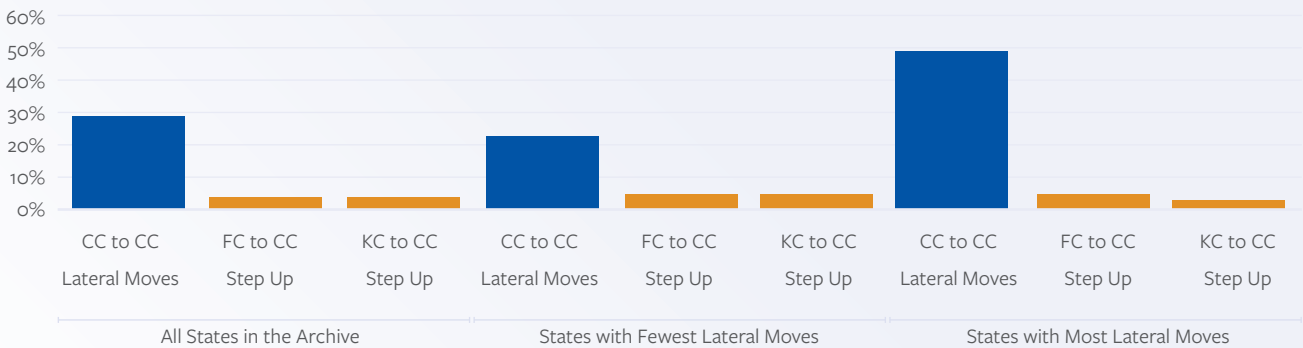
- 1 youth without clinical impairment who experience emergency shelter care as an initial placement, and
- 2 youth (described above) with clinical mental health needs who enter congregate care either as an initial placement or after home-based placements have been disrupted.

Paired with the support and placement stabilization strategies discussed above, **addressing the use of emergency shelter care as the first placement will require that child welfare agencies build capacity for initial home-based placements.** These front door strategies may include the development of emergency shelter foster homes, in which children are placed in a foster home for a short period of time while a more appropriate caregiver can be located. Care should be taken in this planning to address the short-term educational needs of the children and youth, such as transportation back to their current school, as well as to meet the health care needs of children and youth entering care. In addition, the recruitment of a larger pool of regular foster care homes, as well as a more timely process to identify and screen kinship caregivers, would ensure that sufficient home-based placement options are available to reduce initial entry in congregate care. These efforts are largely procedural on the part of child welfare and will require policy and practice changes including additional funding to recruit, train, and support caregivers of all types, whether foster or kin. *Clearly, no single approach to congregate care reform is appropriate for all.*

The **Multistate Foster Care Data Archive (FCDA)** is a longitudinal archive containing the foster care records of approximately 3 million children in 25 states (includes approximately 60% of the youth in foster care in the US). The FCDA contains both child and spell data that allows us to identify the characteristics of child welfare spells including placement changes, types of placement including congregate care, and spell duration. For the purpose of this research, congregate care includes group home, shelters, and residential treatment (all non-family settings).

FIGURE 3

Lateral Moves and Step Up Transfers Following an Initial Placement in Out-of-Home Care



When children change placement, they may move between congregate care (CC) settings or they may transfer from foster care (FC) or kinship care (KC) into a congregate care placement. This figure shows those patterns. Moves between CC settings are noted in blue. Moves from KC and FC into CC settings are shown in orange. (Data Source: FCDA)

IN SUMMARY

The federal government is likely to revise the policy guidelines that regulate state use of congregate care. Legislatures in some states, like California, already have mandated reductions in the use of congregate care. Governmental action is motivated by the realization that congregate care is expensive, does not have an evidence base to support its efficacy, and is not necessarily well-aligned with the clinical and developmental needs of young people.

The evidence presented here suggests that

- 1 the use of congregate care varies between and within states,
- 2 there are a number of levers that can be used to reduce the use of congregate care, and
- 3 there are clinically effective alternatives to congregate care that should be considered.

In principle, any effort to reduce the use of and support for congregate care must be paired with steps to establish the infrastructure to meet the needs of children now in

group placements who will be served in more home-like settings. Failure to do so may result in a host of unintended consequences including the increased disruption of foster and kin placements, higher demands on hospital emergency rooms and psychiatric hospitals, and increased use of far more restrictive juvenile justice settings (Ainsworth & Hansen, 2005).

Based on the analyses in this brief, we provide the following recommendations for reducing the unnecessary use of congregate care. It should be noted again that, as shown in the data presented above, each state uses congregate care differently and thus the response should be different in each state. It will be crucial that each community examine their unique needs to determine which changes will result in the greatest improvements and ensure that strategy selection is driven by the rigorous analysis of administrative and placement data matched to the needs of the children and youth served. For example, a community that has a high entry rate into congregate care with short overall stays in congregate care will require a different solution than a community with a lower rate of overall entry into congregate care and long lengths of stay in congregate care.

RECOMMENDED ACTIONS

Customize strategies for reductions in the use of congregate care.

Because the data show that states differ in their use of congregate care resources, it will be important for policymakers, state agencies, and treatment providers to work collaboratively toward customized solutions that are tailored to the unique patterns of each jurisdiction. These solutions should include strategies to prevent placements in congregate care by stabilizing and fortifying community placement resources as well as strategies to shorten length of stay in congregate care settings by facilitating step-downs and discharges to permanency.

Differentiate intensity of treatment from restrictiveness of placement.

The longstanding view of the placement continuum as comprising a progression of restrictiveness on a single dimension has resulted in a system in which some youth “fail up” to higher levels of placement after experiencing instability at “lower” levels and others who begin their spells in high levels of care are more likely to remain or

return. Parsing the service/placement continuum into two dimensions – one for intensity of services and another for restrictiveness of placement – will allow practitioners and policymakers to consider whether more intensive services may be provided in less restrictive settings, with foster parents equipped to manage behavior that was previously thought to be the indication for congregate care placement.

Incentivize increasing capacity for skilled and/or specialized home-based placement.

If congregate care placements are to be averted, it will be necessary to substantially increase the capacity to provide home-based placements, especially for youth entering child welfare at ages older than 11 years. This capacity development must be pursued strategically in order to ensure that foster parents are appropriately prepared to meet the needs of older youth as well as other specialized populations being diverted or transitioning from congregate care, such as children and youth with sexual behavior problems and those with chronic medical needs.

Support access to evidence-based interventions designed to help stabilize placements and/or enhance clinical outcomes for youth in foster and kin placements.

In addition, plans must be developed to ensure that support continues across placement changes, including after reunification, so that all caregivers have the necessary skills to address each child's needs and re-entry to care is prevented.

Provide both direct and indirect resources for the implementation of evidence-based approaches to deflect youth from congregate care settings.

Currently, several states have underway pilot implementations to test the ability of community-based treatments, implemented with specialized foster homes, to deflect youth from higher-end costly congregate care placements. These pilots should be monitored carefully to assess the potential of these programs for broadening the continuum of placements and shifting youth to less restrictive settings. The evidence-based practices identified in this brief may be used to bolster these placements.

Enhance access for child welfare systems to technical assistance for selecting and successfully implementing evidence-based practices.

The CEBC has worked with numerous child welfare agencies that have experienced failure on previous efforts to implement new practices. This results in wasted financial resources, as well as diminished hope among agencies and staff for the potential of systems change. Often the failures have resulted from poor program selection and planning during the early stages of implementation. To support agencies, the CEBC has developed technical assistance materials that are publically available [[www.cebc4cw.org/implementing-programs/tools/technical-assistance-](http://www.cebc4cw.org/implementing-programs/tools/technical-assistance-materials/)

[materials/](#)], but more hands-on, data-driven support may be needed to select and implement programs successfully and sustainably.

Promote research on these interventions, especially in child welfare settings.

As previously noted, few of the mental health treatments described above were designed for use in child welfare-involved populations and as such, research is needed to ensure that the efficacy of these interventions transfers to the complex populations served by child welfare. Limited federal research dollars have been dedicated to child welfare populations, resulting in fewer rigorous studies involving this population.

Develop funding streams that support flexibility in the delivery and intensity of outpatient services.

To step-down youth who have benefited from congregate care, especially residential treatment, to a community-based home-like setting may require a combination of intensive evidence-based or evidence-supported treatments and support services to stabilize placements before disruption. To support some of the high-need children and youth in home-like settings, states may need to allow more frequent (more than once a week) clinical contacts; expanded use of follow-up services in the home in combination with center-based therapy; day treatment or therapeutic day care; direct clinical care for caregivers; or clinical contacts for a longer duration than current reimbursement rules allow, such as weekly treatment sessions for the duration of the placement versus the usual limitations in a jurisdiction (which might be as few as a 13-session maximum). This may require modification of existing Medicaid State Plans or other funding stream reimbursement rules.

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COLLABORATING AT THE INTERSECTION
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