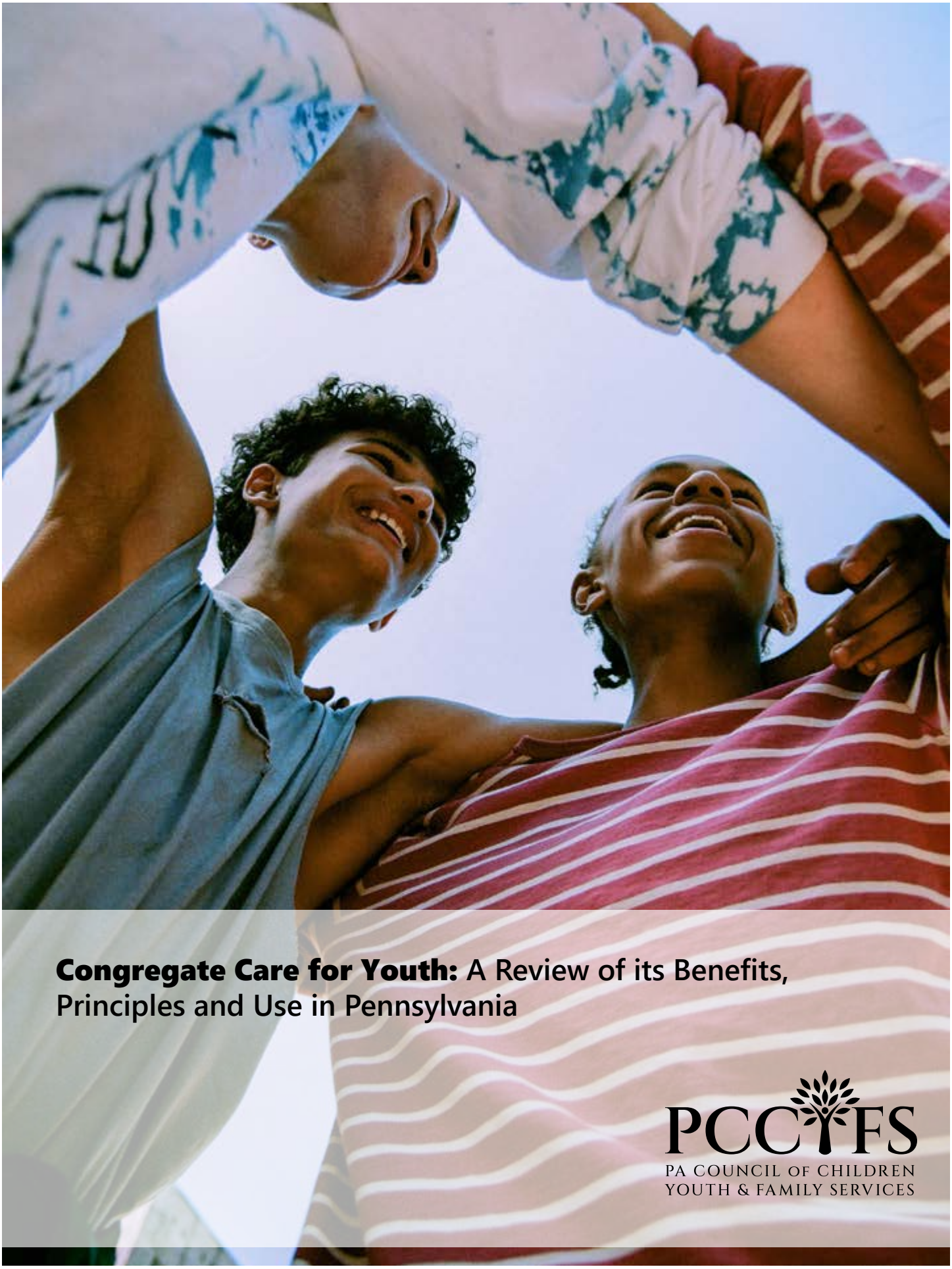

Congregate Care for Youth: A Review of its Benefits, Principles and Use in Pennsylvania

PCCYFS
PA COUNCIL OF CHILDREN YOUTH & FAMILY SERVICES

Background, Principles, and Oversight

In Pennsylvania the children's behavioral health system follow Child and Adolescent System Service Program (CASSP) Principles[1] as best practice when identifying appropriate services, which include:

Child-centered
Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

Family-focused
The family is the primary support system for the child, and it is important to help empower the family to advocate for themselves. The family participates as a full partner in all stages of the decision-making and treatment planning process including implementation, monitoring, and evaluation. A family may include biological, adoptive, and foster parents, siblings, grandparents, other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

Community-based
Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies but also social, religious, cultural organizations and other natural community support networks.

Multi-system
Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

Culturally competent
Culture determines our worldview and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of a particular group of people.

Least restrictive/least intrusive
Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

The last pillar, least restrictive setting, is integral when determining appropriate placement and service options for a child. Providing support and services for youth and their families in the community allows them to manage themselves in the environment in which they reside and mitigate some of the disruption and trauma that can occur for families engaging with these systems. Further, community-based, outpatient, or in-home services may be considered as the least restrictive setting when home and community resources/support are equipped to appropriately maintain the safety and well-being of the child.

[1] Department of Human Services. (2023). Child and Adolescent Service System Program. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/CASSP.aspx

In some instances, however, barriers and/or lack of adequate resources can place the youth at risk for ineffective treatment and/or adverse outcomes. It is in these instances that congregate care settings may be considered as the most appropriate setting for maintaining safety and well-being. Placing a youth in a more restrictive level of care such as a Medicaid Behavioral Health Managed Care Organization (BHMCO) funded Psychiatric Residential Treatment Facility (PRTF) or a Pennsylvania Department of Human Services (DHS) Office of Children Youth and Families (OCYF)-funded residential program, OCYF group home setting, or shelter may be necessary. Compared to in-home care, congregate care provides a higher level of care as youth are immersed in regimented services and routines, which are provided by direct service and clinical support staff. These congregate settings are governed at the state level through 55 Pa. Code 3800[2], known more commonly as Chapter 3800 Regulations. Congregate Care settings are out of home settings such as group homes, residential programs (to include child welfare/juvenile justice), residential treatment facilities, shelter, and transitional living programs.

OCYF conducts annual congregate care setting inspections to ensure compliance with Chapter 3800 regulations. PRTFs, as well as all other congregate care settings, are also audited on an annual basis through other entities, including the counties with which they may contract. The Office of Mental Health and Substance Abuse Services (OMHSAS) also certifies PRTFs because they deliver medically necessary Mental Health treatment as part of their programming and offer services to Medicaid-eligible children and youth.

In addition to the Chapter 3800 regulations, PRTFs must comply with standards outlined in policy bulletins, regulatory compliance guides, state guidance, county contractual obligations, and federal regulations from the Centers for Medicaid and Medicare Services (CMS)[3], which further requires PRTFs to be licensed by an accreditation organization. Accreditation organizations are widely known for setting rigorous standards by which facilities are required to abide in order to sustain their accreditation on an ongoing basis. The Code of Federal Regulations (CFR) Title 42[4] outlines staffing requirements, treatment planning, and other guidelines with which PRTFs also need to comply. Many congregate care facilities are required to have medical professionals, including physicians and psychiatrists, training requirements, and individualized planning for a young person in care, among other requirements.

> “Family First model brings together systems to identify potential discharge resources at time of admission. The agency works from day one towards that goal through Treatment Team Reviews every 30 days.”

Although drafted with a focus on community-based prevention services, the federal Family First Prevention Services Act (FFPSA)[5], also recognizes the need for time-limited placements within congregate care settings. Pennsylvania implemented FFPSA with particular recognition for Specialized Settings[6], a category of placement for youth who may be at risk of sex trafficking; are pregnant, parenting, or expecting; and/or are 18-21 years old and transitioning to adulthood. Providers must meet standards described in Pennsylvania’s guidelines, which outline that length of stay is individualized based on the needs of the youth and discharge planning must be realistic, applicable, and involve all members of the team. Further, the increased provision of resources for in-home prevention and treatment services has been crucial for improved child welfare outcomes and, ultimately, does not invalidate the continued need for congregate care placement. Even with FFPSA provisions for in-home, resource home[7], and community-based services, there is still a greater need for the continued and increased investment in lower levels of care before the call for reduction in congregate care can be answered.

When Would a Youth Require a Type of Congregate Care Placement?

Nationally, there is a trend towards prioritizing placements in family-like and community-based placements, as young people generally see better outcomes in familiar settings. But a sudden elimination or significant reduction of congregate care use would leave Pennsylvania's children services systems in greater crisis for alternative options for children who have serious and complex behavioral health needs that cannot be addressed, especially without greater investment in resource home and community-based services.

Pennsylvania Council of Children, Youth & Family Services (PCCYFS) recommends that congregate care living and institutional placements are short-term – meaning they are utilized as needed to stabilize a child so they can return to a family-like setting. These placement needs may arise when:

- The youth and their family/caretakers have exhausted all less restrictive and accessible levels of care (e.g., outpatient therapy, medication management, Intensive Behavioral Health Services (IBHS), Family Based Mental Health Services (FBMHS), etc.) yet no significant improvement in mental health symptoms and functioning has occurred.
- The youth demonstrate behaviors and needs that cannot yet be safely managed in the community.
- An evaluation conducted by a psychiatrist affirms medical necessity for a PRTF level of care.

Determining placement is a team effort that includes the perspectives of youth, their family/guardian, the network of professionals at the congregate care facility, mental health professionals, the insurance company, community-based supports, and additional service needs to help make the stay in a setting as effective and as time limited as possible. The goal of any mental health service is to transfer skills and gradually transition or discontinue services.

Mental Health America (MHA)[8], the nation's leading national nonprofit dedicated to the promotion of mental health, well-being, and illness prevention, also agreed that when a less restrictive, community-based placement is not available or appropriate to meet a youth's needs, a 24/7 residential placement may be necessary. MHA recommends that congregate placements consist of a short term stay at a residential with family involvement and links to aftercare services to be most effective.

[2] 55 Pa. Code Chapter 3800. Child Residential and Day Treatment Facilities. (2023). https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter3800/chap3800toc.html

[3] Centers for Medicare and Medicaid Services. Psychiatric Residential Treatment Facility Providers. (2021). https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/PRTFs

[4] 42 CFR Part 441 subpart d -- Inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs. (2023). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-D

[5] PA Department of Human Services. (2023) Family First. https://www.dhs.pa.gov/KeepKidsSafe/FamilyFirst/Pages/default.aspx

[6] Pennsylvania Department of Human Services. (2023). Specialized Settings. https://www.dhs.pa.gov/KeepKidsSafe/FamilyFirst/Pages/Specialized-Settings.aspx

[7] "Resource Home" throughout this paper is to be defined as a foster care or kinship care setting.

What Needs Do Congregate Care Settings Currently Fill?

The U.S. Department of Health and Human Services, Administration for Children and Families[9], Children's Bureau conducted a Point in Time (PIT) count on September 13, 2013. The PIT count reported the following:

- Out of 402,378 youth in the care and custody of a Children and Youth agency, 55,916 were placed in a congregate care setting, signifying a decrease of 37 percent since 2004.
- Thirty-one percent of the youth in the PIT count in a congregate care setting were twelve and under and 69 percent were 13 and older.
- There were also more males than females with 63 percent to 37 percent, respectively.
- These youth spent an average of 8 months in such a setting compared to an average of 11 months in other settings and most had a mental health diagnosis as compared to youth placed in other settings.
- The number of youth in congregate care is slowly declining over the years, as stated in this study, with the number of youth placed going from 26.5 percent in 2004 to 20.8 percent in 2013.
- An average of 30.1 percent of youth in congregate care were Black or African American and 40.7 percent of youth in congregate care were White.

Additionally, according to Pennsylvania DHS OMHSAS, in 2015, 2,995 individuals were placed in a RTF[10]. More recent data from a 2019 Philadelphia Youth Residential Task Force report[11] further show that as of April 30, 2019, 861 Philadelphia youth were placed in residential placement. Out of that number 426 were in child welfare (dependent) residentials, 244 were in juvenile justice (delinquent) placements, and 191 in PRTFs. And out of the 191 in PRTFs, 83 were also adjudicated dependent or delinquent. And in Fiscal Year 2018, Philadelphia DHS had 2,183 youth in residential placement with many having had received services prior to placement in residential.

The data shows that congregate care settings continue to be needed placement options in Pennsylvania, especially for young people with complex case planning needs.[12] Congregate care is also a temporary alternative when youth need a higher level of care to reach stabilization and cannot be safely managed in a resource home. The youth in these homes typically have a history of trauma and at times require hospitalization or a temporary congregate care placement to help them learn to manage their symptoms in a safe and appropriate manner and then return to their family-like setting. Even highly trained resource families cannot safely care for these children when in-home and community-based therapeutic supports are either unavailable or waitlists for needed services are 3-6+ months long. Congregate care access can be temporary but necessary to help a family remain together while obtaining the support that cannot be otherwise accessed in the community.

When needed, congregate care placements have become less attainable for youth due to inadequate funding or workforce shortages and the overall shift away from congregate use. In the child welfare system, community-based placements such as resource homes have seen an increase in referrals for children with complex needs (e.g., medical, diagnostic, etc.). If resource homes can support the needs of these youth, they will, but they frequently encounter 3-6+ month waitlists for community-based mental health services.

Resource home provider agencies have had to turn down referrals due to an inability to safely support the youth and resource parents' needs. If a resource home provider accepts these referrals, they potentially increase risk for themselves, their resource parents, and the young person in care.

> "Many of our resource homes struggle to access this critically important care for their children which can lead to future placement disruptions. Supporting these programs is necessary to ensure that children receive the full array of services needed to heal and thrive."

In fact, diverting these young people to resource homes has impacted providers' ability to recruit and retain resource parents who are able to support young people with complex needs in their homes. Resource parents report feeling unsupported, undervalued, and overwhelmed by a youth whose needs they cannot fully support. Providers report losing some of their long-term reliable resource parents for this reason, resulting in a loss of institutional knowledge and support. Simultaneously, a young person is left with an avoidable placement disruption, which can be a distressing event for all parties. In Pennsylvania, the number of licensed resource parents has steadily declined from 19,781 in 2018 to 12,880 in 2022 – a trend that is echoed nationally.[13] Overall, resource parents attribute their decision to leave the system to various unmet needs for support.[14] Entirely eliminating congregate levels of care without creating greater supports among community-based services and resources will only place the youth, families and providers at greater risk.

[8] Position Statement 44: Residential Treatment for Children and Adolescents with Serious Mental Health and Substance Use Conditions. (June 3, 2015). Mental Health America.
https://www.mhanational.org/issues/position-statement-44-residential-treatment-children-and-adolescents-serious-mental-health
[9] A National Look at the Use of Congregate Care in Child Welfare (May 13, 2015) U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.
https://www.acf.hhs.gov/sites/default/files/documents/cb/cbcongregatecare_brief.pdf
[10]PA DHS OMHSAS, (2022) PeopleStat https://public.tableau.com/app/profile/peoplestat/viz/NewOMHSAS_0/Dashboard1
[11]Report and Recommendations (2019) City of Philadelphia Youth Residential Placement Task Force,
https://www.phila.gov/media/20210805122144/Youth-Residential-Placement-Task-Force-report-and-recommendations.pdf

Survey Results & Findings

PCCYFS sought to better understand the composition and needs of the children in Pennsylvania and the populations who are being supported by congregate settings in Pennsylvania. PCCYFS issued a survey to congregate care providers regarding their Fiscal Year 2021-2022 data.

Provider Responses

In a survey of approximately twenty providers:

- Fifty percent (50%) consisted of group home providers, licensed through OCYF.
- The remaining were either PRTFs (thirty-five percent – 35%), OCYF residentials (thirty-five percent – 35%), or another type of congregate care such as shelter/transitional living program/substance use disorder program (thirty percent – 30%).

Youth Served

Among the twenty providers, the number of youth they had in their congregate care setting in FY2022 ranged from 14 to 289.

- Most served youth ages 12-18.
- Ninety-five (95%) percent of these providers served males and 80 percent served females.
- Fifteen percent (15%) had programming and policies in place to serve transitioning, non-binary, and/or transgender youth.
- The average length of stay in congregate care was between 6-12 months.

Successful Discharges

Ninety-five percent of congregate care providers reported that about 15 or more youth successfully discharged in Fiscal Year 2022, and sixty-two (62%) percent reported 1-5 youth experienced re-entry after discharge.[15] From those youth who successfully discharged from congregate care settings, the following were reported:

- Sixty-two percent (62%) had attempted less restrictive services prior to congregate care placement (primarily outpatient therapy, resource home placement, or family based mental health services).
- Diagnoses of youth successfully discharged ranged from Attention Deficit Hyperactivity Disorder (ADHD), Depression, Post Traumatic Stress Disorder (PTSD), trauma, Reactive Attachment Disorder (RAD), sexual maladaptive issues, Oppositional Defiant Disorder (ODD), and mood disorders.
- Youth were discharged to services such as outpatient therapy (ninety percent – 90%), kinship (fifty-five percent), foster care (sixty percent – 60%)[16], family based mental health services (FBMHS; fifty percent – 50%), Multisystemic Treatment (MST; thirty percent – 30%), Intensive Behavioral Health Services (IBHS; twenty-five percent – 25%), or other services deemed necessary for success.

The surveyed care providers emphasized that caring for youth in a collaborative fashion, involving all members of the treatment team including the youth on a regular basis, and focusing on discharge plans while working to meet goals on the treatment plan resulted in the most successful discharges. Youth in congregate care are offered all-inclusive support from a wide variety of staff.

Conclusion

Congregate care can often be a very comprehensive treatment option for youth when less restrictive services are not an option or have been exhausted. This may be the only level of care from which some youth can benefit, including many with the diagnoses listed above. If delivered intensively, for a time-limited term, and with the affirmation that skills will be transferred, young people can discharge successfully to an appropriate, familiar, and supportive resource.

> “
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> Various personalities of the staffing complement allow for connections with hard-to-reach residents… Various treatment modalities are offered so it is easy to find something that works for each resident. Medical & dental appointments, psychological evaluations, family counseling, drug/alcohol, and medication management are all taken care of by staff. Surrounding each youth with a team of quality human beings who role model pro-social skills can only help them be their best.
>
> Group counseling offered every day-this is a proven positive format for adolescents. A treatment team approach can resolve any issues that come from the individual, group, and family counseling. heir time spent with us was a time they could heal, focus on themselves and their own goals, and that we worked closely with their family and/or permanent discharge person(s) and they were part of the planning.
>
> ”

Additionally, in order to sustain successful discharges, minimize time spent in congregate settings, or prevent unnecessary congregate care intervention, Pennsylvania must make meaningful investment into the services necessary to sustain young people at other levels of care. Until then, congregate care must remain an option for our most vulnerable population of young people.

[12] Department of Human Services. (2023). Complex case planning.
https://www.dhs.pa.gov/Services/Children/Pages/Complex-Case-Planning.aspx
[13] Rexroad, J., Adams, H., & Scraggins, T. (2022). Who Cares: A National Count of Foster Homes and Families 2018-2022.
https://www.fostercarecapacity.com/data/total-licensed-foster-homes
[14] Fostering CHAMPS. (2019). CHAMPS Research Highlights Policy Goals.
http://fosteringchamps.org/wp-content/uploads/2019/01/CHAMPS-Research-Highlights-for-Policy-Goals.pdf
[15] “Successful discharges” was defined as the youth completing the stated goals on their treatment plan, having a program or services arranged prior to being discharged, and/or being stabilized. Successfully discharged youth also had key people involved with their treatment beginning day one of placement such as parents/guardians, a children and youth agency, mental health providers, family members.
[16]“Kinship and Foster Care” are utilized in the survey outcome reporting as it was written using those titles in the survey distributed.

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