

Introduction

All families with children need support. Raising children, managing a household, ensuring adequate income to meet family needs, establishing and maintaining caring relationships among family members—all are tasks and responsibilities that challenge the healthiest of families. All families can benefit from information, guidance, and help in connecting with resources as they meet the challenges of parenthood and family life. For families that face additional challenges, the need is even greater, yet they may have fewer supports from family members, friends, informal networks, and community institutions.

CWLA's *Standards of Excellence for Residential Services* emphasizes the importance of a family-centered, community-based approach to helping children* and families address serious life challenges. The needs, strengths, and resources of children and their families are at the heart of this effort. Building from this, residential service providers, working within a larger system of support and services for children and families, can provide a source of support, stabilization, and healing for children and families.

Historical Highlights

The Development of Residential Services

Growing out of the orphanage movement of the 19th Century, residential services provided safety, care, and supervision for

* Throughout this chapter, the terms *child* and *children* are intended to describe children of all ages including youth. The term *youth* is used in those instances where the standard applies specifically to adolescents receiving residential services.

those children who did not have families to care for them. The increasing use of adoption and family foster care, especially in the latter half of the 20th Century, was based on the premise, supported by research, that children requiring basic care away from their birthfamilies could benefit most from a familylike setting. This change in direction led to a diminished use of residential services to provide basic care and the rearing of children, and prompted the residential care field to search for a new mission.

During the 1950s and 1960s, the use of group care settings gained favor for the treatment of children with emotional and behavioral issues. Two models emerged: the residential treatment center and the community-based group home. Although these services overlapped to some extent, they were still viewed as two unique, mutually exclusive forms of group care. When the deinstitutionalization movements of the 1960s in mental health and juvenile justice developed, residential service agencies diversified to meet the needs of a multifaceted population, greatly expanding their offerings by incorporating new services such as in-home supports, family foster care, and independent living services.

Today, residential services are provided by both public and private nonprofit and private for-profit child welfare organizations. Programs and services are delivered in a wide array of settings, including community-based apartments, community-based group homes, campus-style facilities, self-contained group care settings, and secure facilities. Within these settings, a mix of services is provided to children and families, including in-home services, counseling, education, recreation, health, nutrition, daily living experiences, behavioral health care, independent-living skills, reunification services, aftercare services, and advocacy. Services and programs today are viewed as part of a comprehensive, integrated system designed to support and assist families and ensure safety, permanency, and well-being for children.

Legislation

In addition to the deinstitutionalization movement of the 1960s, other major legislative and policy initiatives have shaped the

development of residential services. Beginning in the mid-20th Century, researchers including Maas and Engler (1959); Goldstein, Freud, and Solnit (1973); and Fanshel and Shinn (1978) called attention to the impact of separation and loss on child development and well-being, the negative impacts of “foster care drift” on children, and the child’s need for a permanent family. This led to efforts in the 1970s to provide services to families toward reunification, adoption, or another permanent family for the child.

Several federal legislative efforts recognized the importance of families and culture for children. The Indian Child Welfare Act of 1978 (P.L. 95-608) and the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) required greater attention to, and involvement of, the child’s family, community, and culture in decisionmaking. Each of the acts also established a clear responsibility on the part of the child welfare agency to support and preserve families, whenever possible, and to create other, permanent alternatives for children if family preservation or reunification could not be achieved.

The Indian Child Welfare Act is intended to protect the best interests of American Indian children in the context of promoting the stability and security of American Indian tribes and families. The act was passed in response to studies that documented the widespread removal of American Indian and Alaska Native children from their homes and their placement in institutions and with non-Native families. The act establishes a number of procedural standards to strengthen tribal sovereignty and end transracial placement practice (Mannes, 1993). It brings special requirements with respect to the identification and provision of services to American Indian children and their families, including placement preferences, additional legal protections, and the authority of the child’s tribe to intervene legally, to provide services, and to direct service planning.

P.L. 96-272 introduced the idea of preventing unnecessary placement of children outside the home, reunifying families whenever possible, and finding adoptive families for children who could not return home. During the early 1980s, P.L. 96-272 and the emerging permanency planning philosophy began to have an impact on the numbers of children in out-of-home care. Initially, reductions were achieved through more innovative adop-

tion planning for children unable to return to their birthfamilies and through increased reunification efforts. Additionally, many public and private agencies began to develop innovative services aimed at preventing unnecessary placement while strengthening families in their caregiving roles. Many agencies providing out-of-home services adapted their policies and practices to ensure that services were consistent with the intent of P.L. 96-272. In addition, agencies began shifting from a child-only focus to a family focus, from a single service to an array of services, and from working alone to working within a network of child and family service providers (CWLA, 1990).

Although major child welfare legislation in the late 20th century has emphasized the importance of family and culture, efforts have also been made to lessen the prominence of family, culture, and ethnicity in child welfare decisionmaking. A first theme, stressing the importance of permanency over preservation of cultural or ethnic ties for children, is articulated legislatively in the Multi-Ethnic Placement Act of 1994 (MEPA) and the 1996 provisions on Removal of Barriers to Interethnic Adoption (IEPA). This legislation seeks to (1) decrease the length of time children wait to be adopted, (2) facilitate the identification and recruitment of adoptive and foster families who can meet the needs of available children, and (3) eliminate discrimination based on the race, color, or national origin of the child or the family involved (Adoption and Race Work Group, 1997).

A second theme has been a growing concern over the last decade regarding child safety. This concern is expressed legislatively in the amendments to the Child Abuse Prevention and Treatment Act of 1974 (CAPTA) (P.L. 104-235) and in the Adoption and Safe Families Act of 1997 (ASFA). Since its enactment, CAPTA has been amended several times to strike a balance between protecting children and preserving the rights and privacy of families. ASFA also emphasizes child safety and well-being and shortens the time frames for making permanency decisions, in effect giving parents less time to make the changes necessary to be reunified with their children.

The focus on safety also has been directed toward children in out-of-home care settings. In the late 1990s, a number of highly publicized deaths of youth in out-of-home care increased pub-

lic awareness about the risk of improper use of restraint and seclusion. As a result, numerous bills were introduced in several states and the U.S. Congress. The prominent piece of legislation to come out of this movement was the Children's Health Act of 2000, which reauthorized the Substance Abuse and Mental Health Services Administration (SAMHSA) and established requirements regarding the use of restraints and seclusion in certain facilities. Two sections of the Children's Health Act address physical intervention: Part H applies to "a public or private general hospital, nursing facility, intermediate care facility, or other health care facility that receives support in any form from any program supported in whole or in part with funds appropriated to any federal department or agency," and Part I applies to "nonmedical community-based facilities for children and youth."

The Center for Medicare and Medicaid Services, formerly the Health Care Financing Administration, was assigned the responsibility of promulgating rules and regulations for the use of restraint and seclusion in Part H facilities, including psychiatric residential treatment facilities for individuals under age 21. SAMHSA was named as the agency responsible for promulgating rules and regulations for the use of restraint and seclusion in Part I facilities (CWLA, 2002b).

Focusing on the safety and well-being of youth in the child welfare system, the Foster Care Independence Act of 1999 (P.L. 106-169) provides additional resources for supporting youth transitioning out of foster care, including residential care, as well as youth who have left care but have not reached age 21. The act reinforces the idea that learning to live independently is a lifelong process. It eliminates any lower limit on the age at which independent-living services may be provided to children in care (Allen & Nixon, 2000).

The John H. Chafee Foster Care Independence Program, the core of the act, provides funds for assisting children and youth who are likely to remain in care to age 18 in obtaining training and services necessary to gain employment and prepare for postsecondary education, giving personal and emotional support to youth aging out of care, and providing a range of services and support to youth ages 18 to 21 (Yu, Day, & Williams,

2002). In 2002, Congress added a new voucher program to the Chafee Program for education and training for youth aging out of foster care and youth adopted from foster care at age 16 or older (Promoting Safe and Stable Families Amendments of 2001, P.L. 107-133). The Chafee program provides new and important resources for residential care providers to assist youth returning to the community from residential care.

Finally, the last decade has seen increased emphasis on self-sufficiency for poor families. In 1996, the federal government passed sweeping welfare reform legislation, the Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193). The act replaced the federal guarantee of cash assistance to certain families living below the poverty line (Aid to Families with Dependent Children or AFDC) with block grants to the states (Temporary Assistance to Needy Families or TANF). Although the long-term effects of this change have not been fully documented, the increased emphasis on personal responsibility and decreased emphasis on government support for poor families with children have undoubtedly impacted families. Further, as a result of TANF, service providers have begun to pay increased attention to helping families with work and self-sufficiency issues. With more people transitioning into workplace settings, agencies have needed to adapt work schedules and hours to be responsive to the new demands on families.

The Impact of Changing Social and Economic Conditions on Families and Children

Changing social and economic characteristics have a profound impact on children and families and on the delivery of child welfare services, including residential services. Over the last 10 to 20 years, a number of critical changes and trends have occurred.

Changing Family Structure

One of the most profound changes in American society over the last three decades has been the change in family structure. The proportion of single-parent families, blended families, and

families in which both parents work outside the home has dramatically increased. In 1980, about 21% of children in the United States lived in a single-parent family. By 2000, 31% of all children were living in a single-parent family (U.S. Census Bureau, 2003a). Moreover, ethnic differences are seen in family structure. In 2000, 26% of white children, 34% of Hispanic children and 61% of black children lived with a single parent (U.S. Census Bureau, 2003a).

Single parenthood increased significantly during the latter part of the 20th Century as a result of an increase in divorce, separation, and births outside of marriage. During this time, the number of divorced persons doubled, from 9.9 million in 1980 to 19.8 million in 2000 (U.S. Census Bureau, 2003a). Other factors also have affected family formation. Substance abuse and incarceration of parents, among other causes, have led to an increasing number of grandparents and other kin who are providing temporary or long-term care for their relative children. According to the 1997 National Survey of America's Families, 1.8 million children were living with relatives with neither of the parents present in the home (Ehrle, Geen, & Clark, 2001). Although not unique to single-parent and kinship families, such factors as inadequate financial support, lack of access to affordable health care and child care, and stressful relationships with noncustodial parents may place a greater burden on these families in their efforts to care for their children.

Changing Roles and Responsibilities

The number of married couples with children in which both the husband and wife are in the labor force continued to exhibit an upward trend. Over the past 15 years, the number of such families increased from 14.6 million to 17.1 million (U.S. Census Bureau, 2001). To accommodate the increasing number of families in which both parents work, the roles and responsibilities of family members have changed. Research suggests that mothers, when present in households, still tend to fulfill the primary caregiving role but that the overall time mothers and fathers spend with children and their roles during such time are changing (Bond, Galinsky, & Swanberg, 1998).

In addition, both fathers and mothers are working longer hours per week than 20 years ago (three and five hours longer, respectively) (Bond et al., 1998). With parents working longer hours, child care arrangements are often strained. The 1997 National Survey of America's Families reported an estimated two out of five children (38%) had more than one regular child care arrangement each week (Capizzano & Adams, 2000). The 1999 survey found that 10% of 6- to 12-year-olds regularly spent time alone or with siblings younger than 13 while their parents were employed (Sonenstein, Gates, Schmidt, & Bolshun, 2002). When parents are unable to arrange for quality, reliable care and supervision, children and youth are at increased risk.

Changing Demographics

The demographics of families in America are changing due to the mobility of families, immigration, and differential birthrates. Between 2000 and 2001, almost 40 million Americans moved (U.S. Census Bureau, 2003b). Not only was there movement within the country, there was also movement of people from abroad. In 2002, the foreign-born population numbered 32.5 million, representing 11.5% of the U.S. population (Schmidley, 2003). In addition, an estimated 7 million unauthorized immigrants were residing in the United States as of January 2000 (Immigration and Naturalization Service, 2003).

Birthrates in the country have increased slightly after several years of steady decline. The number of births increased almost 4% between 1997 and 2001 (Martin et al., 2002). Over the past several years, the trend in number of births by race and ethnicity has varied. From 1991 to 2001, both non-Hispanic white and non-Hispanic black births declined in number by 10% and 11%, respectively. During the same period, the number of births for American Indians, Asians, and Hispanics increased by 8%, 38%, and 37%, respectively (Martin et al., 2002).

With the differing growth of families across race and ethnicity, American families are becoming increasingly diverse. These changes in the race, culture, and ethnicity of families, along with changes in family structure, challenge residential service agencies to redesign service delivery approaches to better address the needs of diverse families and communities.

Poverty

The economic condition of families today is unstable, and it is the young who bear the heaviest burden. In 2001, 16.3% of the children in the United States lived in poverty. Although children make up 25.6% of the total population, they represent 35.7% of the poor (Proctor & Dalaker, 2002). The stress created by living in poverty may play an important role in child safety and well-being (Gil, 1970). Parents who experience prolonged frustration in trying to meet their family's basic needs may be less able to cope with even normal childhood behavior problems. Those parents who lack social support in times of financial hardship may be particularly vulnerable (Thompson, 1995).

During times of economic weakness, poor families are hit the hardest. A 25-city survey conducted by the U.S. Conference of Mayors reported that requests for emergency food assistance increased by an average of 19% in 2002. Of the people requesting food assistance, 48% were members of families (children and their parents). During 2002, requests for shelter by homeless families increased by 20%, with 38% of these requests going unmet. In addition, requests for assisted housing by low-income families and persons increased in 88% of the cities surveyed. All the city officials surveyed believed the nation's weak economy would have a negative impact on hunger and homelessness in the future (U.S. Conference of Mayors, 2002).

In addition, recent changes in federal and state policies have placed new pressures and demands on poor families with children. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which replaced AFDC with TANF, emphasizes personal responsibility and limits government's role in supporting needy families.

There is evidence that some families benefited from TANF participation in the early years of implementation, during good economic times. Other data suggest that many newly employed families are no better off than before.

Many working families also struggle to make ends meet. According to the National Survey of America's Families, one in six nonelderly Americans lived in working poor families in 1996. The primary earners in working poor families held jobs that offered less pay, less stability, and fewer benefits than earn-

ers in nonpoor families. More nonpoor families (88.6%) than working poor families (54.3%) received health insurance through an employer. Compared to the nonworking poor, the working poor were less likely to receive Medicaid and food stamps (Acs, Phillips, & McKenzie, 2000).

Race and Ethnicity

Families of color face added challenges as a result of racial and ethnic discrimination and poverty. Families of color experience racism and are more likely to be poor (Hill, 1999; McAdoo, 1998; Padilla, 1997; Scannapieco & Jackson, 1996; Vega, 1995). The child poverty rate is highest for children of color. In 2001, 30% of black children and 28% of Hispanic children lived below the poverty level compared with 9% of non-Hispanic white children (Proctor & Dalaker, 2002).

Children of color often attend public schools that are less academically challenging and may live in communities that have increased rates of crime and violence due to poverty, unemployment, and lack of opportunity (Hill, 1999; McAdoo, 1998; Vega, 1995). Families of color face obstacles when seeking support to help them cope with these challenges. In more recent years, they have endured reductions in services, lack of health insurance, inadequate health care, and lengthy waits at publicly funded clinics (McAdoo, 1998; Padilla, 1997; San Miguel, Morrison, & Weissglass, 1998; Scannapieco & Jackson, 1996).

Specific groups face different and individualized challenges. For example, immigrant families must cope with the stresses of acculturation, a lack of English proficiency, issues arising from their immigration status, and generally lower levels of educational and occupational status (Padilla, 1997; Vega, 1995). Yet the experience of each immigrant group and individual within each group will be different.

Because of the diverse needs and experiences of families in our country, it is the responsibility of service agencies and providers to know and understand the issues of specific populations and to hire and train staff that can work effectively with them. Agencies must be committed to providing culturally competent services, including services to non-English-speaking families, and must allocate the resources and organizational sup-

ports necessary to ensure that families are served in a culturally competent way.

Substance Abuse

In 2001, an estimated 6 million children in the United States lived with at least one parent who abused or was dependent on alcohol or other drugs (Office of Applied Studies, 2003). Although substance abuse has been present in families for centuries, the spread of crack cocaine, amphetamines, and other illegal drugs, in combination with the abuse of alcohol, has brought an increasing number of families to the attention of the child welfare system.

Families experiencing substance problems are particularly vulnerable to disruption, including placement of their children in out-of-home care. An estimated 40% to 80% of families in the child welfare system have problems with alcohol and other drugs that are serious enough to affect parenting (Young, Gardner, & Dennis, 1998). Accessible and affordable treatment options are often in short supply, and when available, time frames for effective treatment may be inconsistent with the permanency needs of children.

Substance abuse is not just a problem for the adults in the family. Alcohol and illicit drug use among young people remains widespread. Among 8th, 10th, and 12th graders, 54% have tried an illicit drug by the time they finish high school, and four out of every five have consumed alcohol before graduating from high school—nearly half by 8th grade. More teens than ever before report getting drunk monthly, and the gender gap that once existed in teen alcohol use has closed, especially among younger girls. This is of particular concern because girls are more vulnerable than boys to alcohol and drug abuse because they become addicted faster and are impacted by the consequences at faster rates (National Center on Addiction, 2003).

Violence

Societal violence has created an additional stressor for children and their families. Children are exposed to violence in their homes, in their communities, and from the media. The

impact of exposure to violence depends on various factors such as a child's age, the frequency and type of violence exposure, neighborhood characteristics, community resources, support from caregivers or other adults, experience of previous trauma, proximity to the violent event, and familiarity with the victim or perpetrator (Osofsky, 1997).

Youth violence is considered a public health concern and an ongoing national problem (U.S. Department of Health and Human Services [U.S. DHHS], 2001). Although youths' use of guns and rates of committing fatal violence have declined in recent years, the self-reported proportion of youth involved in nonfatal violence has not declined (U.S. DHHS, 2001). Youth gangs continue to thrive, particularly in large jurisdictions. Youth not only commit violent crimes but are the victims of violence as well. In 2000, homicide was the second leading cause of death for youth ages 15 to 19 years old.

Bullying also impacts children and youth in a variety of ways. Nearly 30% of all youth ages 11 to 15 have been a victim or perpetrator of bullying. Youth who bully others are more likely to smoke, drink alcohol, and perform poorly in school. Youth who are bullied are often insecure, depressed, and lonely (Nansel et al., 2001).

Although domestic violence has received increased attention in the past 15 years, it remains an issue for families today. In 2001, almost 692,000 incidents of nonfatal violence against a current or former intimate partner occurred. The majority of the victims (85%) were women (Rennison, 2003). Between 1993 and 1998, almost 70% of intimate partner violence against men and against women occurred at or near the victim's home. Children under 12 years of age lived in 43% of the households where intimate partner violence occurred (Rennison & Welchans, 2000).

The presence of domestic violence is a significant factor in parental functioning. It also plays a role in child maltreatment and in the emotional well-being of children now and in the future. Parents who are victims of domestic violence need sensitive and skilled support and assistance in addressing domestic violence issues and maintaining their children's safety. Families that have learned patterns of violence need assistance to learn new patterns of interaction. Families also can benefit from

mutual support, including victim support groups and more generic parent and youth support groups; assistance in meeting housing, health, and other basic needs; and opportunities to participate in normalizing experiences, such as recreation, meals, and social time.

Incarcerated Parents

In 1999, approximately 721,500 state and federal prisoners were parents to 1.5 million children under the age of 18. From 1991 to 1999, the number of minor children with a parent in prison rose by 500,000. Prior to their incarceration, 46% of parents were living with their minor children (Mumola, 2000).

Children of incarcerated parents disproportionately live in poverty and their parents' incarceration makes the situation worse (Wright & Seymour, 2000). One-third of mothers (31%) and 4% of fathers in prison had been living alone with their children prior to their arrest (Mumola, 2000).

Additional Factors

An estimated 22% to 23% of the U.S. population—about 44 million people—have diagnosable mental disorders in a given year (U.S. DHHS, 1999). Women experience depression about 1.5 to 3 times more frequently than men. Major depression affects a mother's ability to respond to her children and is a risk factor for children experiencing developmental difficulties (Lennon, Blome, & English, 2001).

The mental health of children and youth is also a critical issue. In the United States, 4 million children and youth suffer from a major mental illness that significantly impairs functioning at home, at school, and with peers (U.S. Public Health Service, 2000). Between 75% and 80% of children and youth, however, do not receive the mental health specialty services they need (U.S. DHHS, 1999). Nowhere is this more evident than in the children who have been placed in out-of-home care. Research shows that more than 80% of children in foster care have developmental, emotional, or behavioral problems (American Academy of Pediatrics, 1994; 2001). Additionally, youth suicide continues to be the third leading cause of death among youth 15 to 24 in the United States. Among persons ages 15 to

19 years, firearm-related suicides accounted for 62% of the increase in the overall rate of suicide from 1980 to 1997 (Kaplan & Sadock, 2000).

Rates of adolescent pregnancy and juvenile delinquency have declined in recent years, yet they continue to remain issues for many families today. Overall, the birth rate for teenagers fell 26% from 1991 to 2001. Teenage birth rates continued to decline for non-Hispanic White, non-Hispanic Black, and Hispanic teenagers. In 2001, however, there were almost 446,000 births to adolescents aged 15 to 19 years old (Martin et al., 2002). Children of teen mothers are more likely to have lower birth weights, to perform poorly in school, and to be at greater risk of abuse and neglect (George & Lee, 1997; Maynard, 1996; Wolfe & Perozek, 1997).

Juvenile arrest rates for all offenses declined 23% from 1996 to 2000, however, law enforcement agencies made 2.4 million juvenile arrests in 2000 (Office of Juvenile Justice and Delinquency Prevention, 2002; Snyder, 2002). From 1993 to 1997, serious violent crimes (rape, sexual assault, robbery, aggravated assault) by juvenile offenders dropped 33%; only 42% of serious violent crimes by juveniles, however, are reported to law enforcement. Between 1980 and 2000, the juvenile female arrest rate for all offenses increased 35% while the juvenile male arrest rate decreased 11% (Snyder, 2002). Violent crimes by juveniles peak during afterschool hours on school days and evening hours on nonschool days (Snyder & Sickmund, 1999).

The Strengths and Resiliency of Families, Children, and Youth

The social and economic conditions described above can compound and intensify other challenges families are experiencing, such as the death or illness of a spouse or other family member, the loss of a job, mental or physical illness, the disability of a parent, the loss of support from relatives or friends, or the unmet developmental needs of a parent. How families fare and how well they are able to manage and safely care for children depend on many things, including the availability of family and community supports, and the strengths, resources, and resiliency of the family.

Although families face many challenges, they also possess many strengths and resources, including their own cultures. Fami-

lies possess protective factors, which are strengths that enable them to successfully adapt to stressful life events or circumstances. Examples of protective factors include the ability to endure hardship, love for their children, the capacity to nurture, the ability to cooperate with agency and other helpers, knowledge of what a parent should do, the ability to delay gratification, and the ability to be assertive (Cole, Day, & Steppe, 1994).

In addition, Hodges (1995) presents a list of personal characteristics and skills that serve as protective factors in children and youth. Examples of personal protective factors include the following:

- responds quickly to danger;
- creates and nurtures relationships that provide support in times of crisis;
- desires to learn as much as possible about potentially harmful people or situations;
- exhibits behavior that is more mature than the expected age; and
- possesses a positive, hopeful attitude that protects against negativism and depression.

Resiliency can be defined as the ability to “bounce back from stress and crisis” (National Network for Family Resiliency, 1996). With the development of the following traits, resilient children and youth can overcome risks and adversity:

- social competence (responsiveness, cultural flexibility, empathy, communication skills, sense of humor),
- problem solving (planning, help seeking, critical and creative thinking),
- autonomy (sense of identity, self-efficacy, task mastery, self-awareness, distancing from negative messages and conditions), and
- a sense of purpose and belief in a bright future (goal direction, educational aspirations, optimism, faith and spiritual connectedness) (Benard, 1999).

The communities and cultural experiences of families also provide a reservoir of strength and support. Often people do not recognize strengths and attributes of cultures different from their own. For example, families of color and immigrant families draw

on relationships with extended family members as a means of social support. Families of color and different cultures also derive strength from their strong religious orientations and their connection to religious institutions and communities (Cross, 1998; Hill, 1999; McAdoo, 1998; San Miguel et al., 1998).

Community Responsibility for Children and Families

Although families have the primary responsibility for protecting and raising children, communities also are central to the health and well-being of children. Communities provide the context for daily life, the cultural lens for translating information and experience, and the network of supports and connections that help children and young people to overcome difficulties and become contributing members of society. Communities can assist families by making supports and services widely available and by making children and families a priority in planning, funding, and policy decisions. Communities can ensure that children are provided the opportunity for safe, healthy exploration and learning to support their ongoing development.

It is in the best interest of communities to protect children and support families. Healthy children and families give back to their communities in many tangible and intangible ways. They contribute to the vitality and longevity of the community itself and enhance the quality of life for those living in the community. The community as a whole must invest in the supports and services required to ensure the well-being of all of its children and their families, including those who could benefit from residential services.

Moving to a Community, Neighborhood-Based Approach to Supporting All Children and Their Families

In the last decade, attention has increased to the context that families find themselves in—their neighborhoods and communities—and how communities can be mobilized to support and strengthen families. This move in the direction of an inclusive, participatory approach to supporting families and protecting

children is an affirming one. It recognizes what is already working well in families and communities and is consistent with CWLA's Framework for Community Action (Morgan et al., 2003). CWLA's Framework for Community Action is a resource to support agencies and communities in improving child and family well-being. The Framework envisions "an America where every child is healthy and safe and where all children develop to their potential," becoming adults who are "able to make positive contributions to family, community, and the nation" (p. 1). Children and youth have five universal needs that must be met to ensure their survival and to promote their healthy development:

- "the basics," such as proper nutrition, economic security, adequate shelter and clothing, a basic education, and primary and preventive health and mental health care;
- nurturing relationships with parents, kin, and other caregivers, caring relationships with community members, and good relationships among children and youth themselves;
- Opportunities and experiences that motivate and equip children to succeed, to develop talents and skills, to contribute to their families and communities, and to make positive connections to their cultures, traditions, and spiritual resources, as well as early assessment and intervention to prevent later, more serious problems;
- protection from harm, such as abuse and neglect by caregivers as well as witnessing or being victimized by family, school, or community violence, and protection from the harms of discrimination, media violence, Internet victimization, environmental toxins, and accidental injury; and
- easing of the impacts of harm through ensuring immediate and ongoing safety, supplying immediate and continuing emotional support, assessing the need for and providing medical, mental health, and other needed services, and making amends through restorative justice practices (Morgan et al., 2003).

To meet the universal needs for all children requires people working together in a comprehensive approach, guided by a common set of principles. These core principles should guide agency and community actions in behalf of children and youth:

- **Supporting families:** By supporting families in nurturing their children, professionals and community members can help to ensure that parents, other relatives, and caregivers have the skills and resources to raise healthy and well-adapted children.
- **Promoting prevention:** Programs and practices that nurture and protect children in their earliest development, that prevent abuse and neglect, and that detect and intervene at the earliest possible indication of risk should be available to all families.
- **Advancing social justice:** All children, regardless of gender, ability, economic status, and ethnic, racial, spiritual, and cultural background, have an equal right to have their universal needs met. All community partners can advocate for the ideals and values of social justice both locally and globally.
- **Working collaboratively:** When people come together, collective capacities emerge that individual partners do not possess. Communities can harness this synergy to solve shared problems and work toward the common good.
- **Respecting and valuing diversity:** Diverse cultures, traditions, and perspectives are sources of strength and creativity that community partners can draw on to nurture healthy families and children.
- **Building capacity:** By recognizing and nurturing the assets and strengths of children, youth, families, and communities, we tap into sources of energy and creativity that have the greatest potential for meeting children's needs and encouraging their optimal growth.
- **Nurturing leadership:** Leadership requires dedication, passion, and a willingness to take risks. It comes from those willing and able to inspire and guide others to get things done in behalf of families and children.

- Utilizing evidence-based strategies: Applying knowledge of factors and strategies that contribute to or impede healthy human development can help community partners to design and implement policies, practices, and programs that are effective in helping children to thrive.
- Measuring results: Using clear outcome measures to guide and evaluate our efforts increases the likelihood that our work will result in positive results for children, youth, and families (Morgan et al., 2003, pp. 6–7).

The Role of Residential Services in the Community Approach to Supporting All Children and Their Families

The residential service provider plays a vital role in ensuring that children and families are provided quality services within a community context, including:

- creating an environment that promotes respect for cultural diversity;
- linking and coordinating effectively with other resources, to help children and their families access needed services;
- promoting children’s development and supporting families in caring for their children; and
- advocating for the creation of new services and system changes to meet identified unmet needs.

These roles call on the residential service provider to be as active in promoting and advocating good parenting and supporting families before a breakdown occurs as it is in its protective and rehabilitative roles. This philosophy also requires that the provider give attention to empowering parents to take control over their own lives, thus allowing them to better fulfill their parenting role.

The community approach to child welfare practice requires the residential service provider to be increasingly involved with other community agencies and institutions that support children and their families, and to take a formal role in service de-

livery systems. It calls on the provider to establish more formal partnerships across the service system, marshaling the support of mental and physical health care, employment, substance abuse treatment, housing, and income support systems, as well as other community institutions such as schools, faith-based groups, recreational organizations, and voluntary organizations. The residential service provider should take part in galvanizing the relevant agencies in the community to work collaboratively toward the common goal of providing a comprehensive system of services to enable all families to care for their children.

The Purpose of Residential Services

The primary purpose of residential services is to provide specialized therapeutic services in a structured environment for children with special developmental, therapeutic, physical, or emotional needs. Residential services may be provided in a variety of settings and should:

- provide children with a safe, nurturing, protective therapeutic environment that promotes cultural and ethnic identities, while addressing their unique educational, social, behavioral, developmental, medical, and emotional needs;
- help children and families marshal their strengths to accept, reduce, or eliminate the conditions or the behaviors in the parent and/or the child that have been obstacles to successful family life;
- help children and their families establish improved family relationships, connections, and, whenever possible, family reunification;
- help children and families learn to deal effectively with the impact of the mental health and/or substance abuse issues of each family member;
- offer children and their families opportunities for respite, thus allowing them time to clarify and weigh the options available to them;
- prepare children and their parents for alternatives to reunification when return home is not possible or is not in the child's best interests;

- help older youth leave residential care with improved skills, connections to family, and the economic, emotional, social, and community supports necessary to allow for a successful transition to adulthood;
- help in the establishment of long-term community supports and linkages needed for a successful life after the residential experience; and
- advocate for systemwide changes to increase and ease access to services for children and their families.

The residential service provider should plan for the transition and independent living of youth in the residential program. Successful residential care programs plan for a youth's transition and prepare the youth for independent living through teaching social, coping, and living skills (U.S. General Accounting Office [GAO], 1994). This should include advocating for children and youth who should pursue higher education and making sure they have the knowledge and skills to access the specialized services they might need in the adult service system.

Desired Outcomes of Residential Services

Increasingly, child welfare agencies are moving toward a performance-based system of services and using concepts from the managed care movement to deliver these services (Mordock, 2002; Wells & Johnson, 2001). Managed care emphasizes the cost-effectiveness of services, looking at cost and outcomes. With a focus on outcomes, public and private child welfare agencies are being held accountable for achieving results. The link between outcomes and performance measurement moves agencies to focus on outcomes in the context of quality assurance and improving the agencies' performance (Casey Outcomes Decision-Making Project, 1998; Cozens, 1999; Mordock, 2002).

Principles of Family-Centered Residential Services

Family-centered practice is at the heart of good residential services. According to a GAO report, one of the key elements to a successful residential care program was the involvement of family members in the formal treatment approach (1994). Family

involvement is important in achieving family reunification and helping children and families maintain an optimum level of reconnection (Ainsworth, Maluccio, & Small, 1996).

The following principles guide the work of family-centered residential services:

- recognizing that families have strengths and can change;
- respecting the diversity of family life;
- ensuring consumer and stakeholder involvement in planning, delivering, and evaluating services, and emphasizing youth and family empowerment;
- directing services toward strengthening the family within the context of the culture and the values of the community where the family resides;
- working with families to achieve goals of safety, permanency, and well-being;
- providing services that minimize family disruption and separation, strengthen the family, and promote the family's potential to function independently;
- wrapping services around the child and family, when necessary, to support the child's remaining safely within the family and community;
- searching for family, including "fictive" kin and involving all appropriate family members and professional disciplines in the decisionmaking, planning, and implementation process;
- providing consistent support and structure for children and families to minimize or eliminate problematic behaviors and build personal and family competencies and well-being;
- separating children from their families only when child, family, or community safety cannot be assured, and reunifying children with families whenever possible;
- providing the least restrictive environment appropriate to the child's needs when out-of-home care is needed;

- helping children and families maintain the optimal level of connection during out-of-home care;
- ensuring sufficient program options to respond to a range of child and family needs and strengths; and
- operating the treatment, evaluation, and administrative components of agency programs in an integrated manner (adapted from Braziel, 1996, p. 241).

Residential Services, Early Intervention, and Permanency for Children

A foundation of early intervention and developmental services, along with a range of more specialized services for those children and their families who are experiencing problems, can provide support to strengthen parents' capacities to care for their children and increase the likelihood of preserving families. Even with an enriched service system for children and their families, however, some parents will not be available or able to protect or adequately care for their children. Also, some children may have special needs that require supervision, monitoring, or treatment in excess of what a family can provide. These children and their families may best be served by the appropriate use of some form of out-of-home care. An array of out-of-home service settings should be made available for these children and their families within every community.

Out-of-home care settings should encompass kinship care, family foster care, treatment foster care, and residential care. Residential care settings include emergency shelter care, apartments, community-based group homes, campus-style facilities, self-contained group care settings, and secure facilities. Within these settings, children and their families should be able to obtain an appropriate mix of services, provided in the out-of-home setting as well as the family's home and community, including counseling, education, health, nutrition, daily living experiences, independent-living skill building, reunification services, specialty services such as mental health and substance abuse treatment, aftercare services, and advocacy. These services may be provided in coordination with other service providers when not provided directly by the residential service provider.

Residential services should emphasize a philosophy and practice-oriented toward supporting and preserving families whenever possible and in the best interests of the child. Out-of-home care should be seen first as a support service for children and their families, not as a substitute for families.

Finally, for those children in out-of-home care for whom return home is not appropriate because of continuing concern for their protection, or where placement does not result in the changes necessary for the successful reunification of the family, the child's need for stability must be paramount. Permanence, stability, a sense of connectedness, cultural identity, and familylike support are all critical elements in the development of children into healthy adults. The agency providing residential services should endeavor to provide these critical elements in every service plan, and assure their availability to every child in its care.

Recent Developments in Residential Services

Children in Out-of-Home Care

The number of children placed in all forms of out-of-home care has increased dramatically since the 1980s. In 1985, an estimated 276,000 children were in out-of-home care; by 1993, that number had risen to 449,000 (Braziel, 1996). In 2001, 542,000 children were in out-of-home care, with approximately 48% in nonrelative family foster care and 18% in residential care (group home and institution) (U.S. DHHS, 2002b). Children of color make up about 58% of the out-of-home care population, significantly higher than their representation of 36% of the total child population (Federal Interagency Forum on Child and Family Statistics, 2002; U.S. DHHS, 2002b).

In many states, children enter foster care as preadolescents or adolescents. In 1999, 31 states reported the highest percentage of entries in foster care was in the 11- to 15-year-old age group (U.S. DHHS, 2002a). Over the past decade, however, the number of children under age 5 in foster care increased by 110%, compared to a 50% increase for all children (Dicker, Gordon, & Knitzer, 2001). In 1999, the median percentage of children who were 12 years old or younger when they were placed in group

homes or in institutions was 8.7%. States reporting high percentages of placements of younger children in either group homes or institutions indicated this was due to placing children in emergency shelters for short periods of time (U.S. DHHS, 2002a).

The reasons for the increased use out-of-home care are complex. A continuing need exists to respond in a protective manner to children who have been abused or neglected. Data from 2001 reveal that child protective service agencies receive more than 50,000 referrals alleging child abuse or neglect each week. Nationally, about 67% (or 1.8 million) of these referrals are screened in for investigations or assessments. An estimated 903,000 children were found to be victims of child abuse and neglect (U.S. DHHS, 2003a). In response to high-profile child deaths and child maltreatment cases, federal, state, and local laws and policies also have placed a stronger focus on child safety, leading workers to place children outside the home as a protective response instead of pursuing in-home solutions.

Recent research has shed further light on the emotional and cognitive difficulties experienced by children and youth referred for residential care. Findings in infant brain development show that such development happens rapidly and extensively from birth to 3 years. Studies have documented the impact of early experiences and early relationships on brain development in infants and young children (Shonkoff & Phillips, 2000). Early childhood experiences affect the basic organization of the child's brain (Missouri Department of Social Services, 1999; Shonkoff & Phillips, 2000). Children who do not experience stimulation to support optimal brain development are at an intellectual disadvantage compared with children who are raised in stimulating environments (Hawley, 2000).

Children's early development is also dependent on their relationships with their parents. Secure relationships with their parents provide children with a solid foundation for emotional development and can protect them from stresses they may face (Hawley, 2000). Without a secure relationship, a child's development is disrupted, which can lead to lasting negative consequences (Shonkoff & Phillips, 2000).

Young children (under 3 years of age) are at a particular disadvantage because they are more vulnerable to the effects of abuse

and neglect (Silver et al., 1999). The experience of trauma and stress negatively impacts how their brains develop (McCart & Bruner, 2003). The early care and education of infants and young children can influence whether a child will mature into a well-adjusted adult (Carolina Abecedarian Project, 1999; Shonkoff & Phillips, 2000). Conversely, if children and families are not assisted early on, the impact of early deprivation and trauma can have long-lasting effects that are difficult to remediate (McCart & Bruner, 2003).

Over the past 20 years, research studies have demonstrated that children in foster care are at risk for maladaptive outcomes, such as socioemotional, behavioral, and psychiatric problems, that require mental health treatments (Landsverk, 2000). Additional studies have shown that children in foster care use mental health services up to 15 times more than other children in the Medicaid system (Landsverk, 2000). This increased level of care that children in out-of-home care require was evident in a CWLA survey of its member agencies. In 2000, CWLA asked its member agencies what situations have become worse for children and families within the three years preceding the survey. Both public and private agencies reported seeing more severe children's behavioral problems and more mental health problems in children and youth as the first and second most frequently identified situation that has become worse (CWLA, 2000).

Among children receiving residential services, studies found behavioral and emotional issues such as chaotic behavior, poor impulse control, inappropriate sexual behavior, and a history of felonies. In addition, children were diagnosed with serious emotional disturbances, clinical depression, and major impairments in global functioning (Quinn & Epstein, 1988; Savas, Epstein, & Grasso, 1993; Whitaker, Archer, & Hicks, 1998). Some states participating in an Urban Institute survey of state fiscal year 2000 expenditure data reported that an increased use of more expensive residential treatment centers was due to an increase in the number of children with multiple needs (Bess, Andrews, Jantz, Russell, & Geen, 2002). Additionally, residential service providers describe the need to develop differential programming for children with a variety of special needs, including but not limited to:

- children committing serious crimes who are being charged as adults and are therefore being placed in locked facilities;
- children in care for whom English is not their first language;
- children needing a higher level of medical attention and monitoring, including children with diabetes, HIV/AIDS, eating disorders, special nutritional needs, etc.;
- sexual offenders, sexually acting out children, or sexual abuse–reactive children; and
- children experiencing sexual identity issues, including gay, lesbian, bisexual, transgendered, and questioning youth.

With a population of children with increased needs, states are experiencing difficulty in meeting those needs. In 2001, Child and Family Services Reviews were conducted in 17 states. Of those states, 16 did not achieve substantial conformity for the outcome “children receive adequate services to meet their physical and mental health needs.” With regard to addressing the mental health needs of children specifically, 16 states were rated as “needing improvement” on this indicator (Children’s Bureau, 2002).

Workforce Issues

Although children are entering and remaining in out-of-home care in record numbers, the child welfare workforce continues to be inadequate. Public and private nonprofit agencies report that the greatest concern for the child welfare field is the lack of qualified staff to respond to the increasing number of children needing services (CWLA, 2000). Child welfare agencies experience turnover that frequently exceeds 50% per year, and position vacancy rates often surpass 12% (Drais-Parillo, 2002). Without an adequate workforce, agencies are not able to adhere to national service and caseload standards, maintain a climate that supports the delivery of high-quality services, or adopt evidence-based practices (CWLA, 2002c, p. 1).

According to the survey, numerous workforce issues have emerged that may impact the quality of services provided:

- **Staff qualifications and selection:** Most staff do not have formal social work education.
- **Work environment and support:** The physical setting that agencies provide is inadequate. The organizational resources made available to support multiple tasks and responsibilities of staff, such as supervision, autonomy, and flexibility, is lacking.
- **Workload:** Child welfare agencies, including all public agencies and those private agencies with “no-reject/no-eject” contracts, have little ability to control intake.
- **Salaries and promotional opportunities:** Salaries in all areas of child welfare tend to be lower than in other jobs of comparable difficulty.
- **Professional development:** Both in-service training and continuing education opportunities are often greatly reduced or eliminated in times of fiscal austerity.
- **Public image and professional respect:** The poor image of child welfare agencies has an adverse effect on morale and the ability of agencies to recruit and retain qualified employees.
- **Personal safety and liability:** Concerns about staff safety have grown over the past two decades as agencies report working with an increasingly needy and disturbed client population (CWLA, 2002c).

Systemic Issues

In addition to persistent workforce issues, residential service agencies are faced with a number of other developments that have impacted service quality and agency capacity, both positively and negatively. They include:

- **Reimbursement rates are insufficient:** Agencies continue to be asked to do more with less, and no recognition is given to the specialized skills required to provide services to this specialized population of children, adolescents, and their families.

- The emphasis on accreditation has increased, with some states mandating accreditation for all contracting agencies.
- Case decisions, such as length of stay, are increasingly driven by budget constraints, managed care requirements, and state funding allocations.
- ASFA permanency timelines and requirements are impacting individual case planning and decisionmaking.
- Managed behavioral health care, in addition to creating new policies for the placing agency and residential service provider around intake and criteria for admission, continued stay, and discharge, has forced further standardization of roles, responsibilities, and programmatic and administrative requirements for credentialing.
- Increased mergers and acquisitions have brought different agencies together, often forcing major change on one or both agencies and causing different philosophies and service approaches to blend or change.
- There has been an increased focus on behavior management, especially with respect to restraint and seclusion, with significant variation from state to state.
- There has been decreased access to acute inpatient hospitalization, a need to get children into more intensive services quickly, and a shortage of psychiatrists in many areas.
- There has been an increased provision of specialized services providing other related treatment services, such as substance abuse services and treatment services for adolescents with co-occurring mental health and substance abuse issues.
- The mental health and/or substance abuse systems have different licensing and accreditation requirements than the child welfare system, even though the same residential services are being provided.
- There has been an increase in the intensity, severity, and complexity of the emotional, mental, and behavioral health problems of adolescents being served in residential care.

- There has been an increased emphasis on monitoring, continuous quality improvement, client information systems, data collection, and outcome measurement.
- The need continues for strong supervision and training of line workers, with a focus on competencies, and for improved, standardized evaluation of training.
- Ensuring a safe environment for staff as well as children and families, and the health and safety of workers, have become major concerns.
- Increased role of child care workers in administering medication, including training of staff to administer medication, has increased.
- The needs of rural and small agencies, including access to staff with proper credentials and difficulty in complying with requirements, are becoming apparent.
- The use of collaborations to address resource and specialization needs of rural and smaller agencies has increased.
- Changes have occurred in caseload and staff ratios, and maximum number of children in residential settings.

Scope of the Standards

The *CWLA Standards of Excellence for Residential Services* describe best practices in an array of residential settings and programs. The standards present an array of services that should be available to children and families, as needed, to assist them in addressing challenges that threaten child and family safety and well-being. The array of residential services includes in-home supports, specialized services, aftercare services, transitional services for youth, as well as the range of residential services.

These standards describe:

- the process by which the needs of children and their families are identified and addressed through residential services,

- the range of residential services and the unique features of each,
- the service elements and programs of service provided in the various service settings,
- the administrative supports necessary for the operation of the programs, and
- the roles of residential service agencies as members of the greater community.

Chapter 1 of these standards describes the array of residential service settings. Chapter 2 describes the process of service delivery. Chapter 3 describes the elements of service and treatment. Chapter 4 describes the administrative aspects of residential services. Chapter 5 describes the service environment for residential services, and Chapter 6 addresses the important role of the community in supporting and assisting children and families receiving residential services.

The standards are intended for a broad audience, including public and private child welfare agencies, residential service agencies, administrators, courts, juvenile justice, health and mental health professionals, legislators, educators, community members, consumers, family members, and all others concerned with building and maintaining healthy children, families, and communities. The standards are complemented by a number of CWLA “best practice” products, intended to build on the standards framework and provide detailed guidance in particular areas of practice. These resources are listed in the reference section to this volume as well as online at www.cwla.org.

