

# *Group Care in the United States: A Brief Review of Prevalence, Problematic Outcomes, and Alternatives*

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## *What is the prevalence of congregate care in the United States?*

- In the United States, approximately 60,000 children are living in congregate care settings, with approximately 34,000 in institutions and 26,000 in group home settings (U.S. Department of Health and Human Services, 2015). This represents 14% of the foster care population in the United States (U.S. Department of Health and Human Services, 2015). For those children and youth who are placed into group care settings, the average length of stay is eight months; however, 34% typically spend more than nine months in group care settings (National Center for State Courts, 2017).

## *Why is group care problematic?*

- *Group care makes it more challenging for children of all ages to develop a secure, healthy attachment to at least one adult.*
  - Attachment during infancy is critical while children's regulatory capabilities are not fully developed. Primary attachment figures help children regulate their physiology, attention, and behavior (e.g., Bowlby, 1969/1982). **Children who develop insecure attachments with their caregivers are at increased risk for problematic outcomes**, including externalizing behaviors (Fearon et al., 2010) and psychopathology (Lyons-Ruth et al., 1997). Secure attachments have been linked with optimal outcomes, such as social competence, self-reliance, and strong emotion regulation (Sroufe et al., 2005).
  - Shift care (even when shifts lasts hours or days) interferes with accessibility to a consistent parent figure (Hawkins-Rodgers, 2007). In group care settings, there are often rules and regulations that prohibit activities that would encourage relationships between staff and youth (Dozier et al., 2014). These experiences make it difficult for children to develop a secure attachment relationship to a consistent adult figure.
  - Children in group care settings report seeing family members less often than children in kinship care. They are also less likely to be reunified with their biological caregivers, and this is particularly true for children between the ages of 6 and 12 (Barth, 2002; Wulczyn, Hislop, & Goerge, 2000).
  - When children are not able to access adults for consistent, emotionally close relationships, they must rely on peers (Kobak, Herres, Gaskins, & Laurenceau, 2012). These peer relationships can be maladaptive when peers have emotional and behavioral problems (Dishion, McCord, & Poulin, 1999).
  - It is also important for adolescents to develop healthy attachments to adults. When adolescents lack a relationship with a parent figure, they are more likely to become susceptible to **deviant peer influence and engage in risky behaviors** (Allen et al., 1998; Dishion et al., 2004). Moreover, living with peers who have behavioral and emotional problems can further compound this risk (Dishion et al., 2004). A committed and invested adult provides resources and support (e.g., providing structure and supervision, encouraging engagement in the future, planning for school) for adolescents that are unique from peers (Allen et al., 1998). These types of support are essential as adolescents transition into adult roles.
- *Group care is not conducive to helping older children develop autonomy.*
  - For older children, a critical developmental task is balancing the desire for autonomy and the need for parental control and regulation. This is a complex process, which begins when children are as young as eight years of age, and involves learning the rules and values of cultures, maintaining close relationships, and becoming self-reliant (Collins et al., 2005; Kobak et al.,

2012; Smetana et al., 2015; Sroufe, 2005). Given the nuances of this developmental task, it is essential that rules and consequences be **tailored to individual children** and that rules are modified as children mature (Smetana, 2011).

- A group care setting that requires standardization (e.g., fixed rules and procedures that are applied to everyone) interferes with the development of autonomy and prevents older children from developing critical planning and decision-making skills. Settings that overregulate older children's lives, particularly in the areas of privacy and personal choices (e.g., leisure and recreational activities), might lead to defiance and decrease children's willingness to disclose information (Dozier et al., 2014).
- ***Group care itself may be associated with an increased risk for problem behavior, academic difficulties, and physical danger.***
  - A large-scale study compared youth in group settings to a sample of youth living in foster care (Ryan et al., 2008). After controlling for race, sex, abuse and placement history, presence of behavior problems, and history of running away, **youth placed in group care settings were 2.4 times more likely to be arrested than youth in foster care** (Ryan et al., 2008). Similarly, a recent systematic review comparing group care and foster care estimated that foster care prevented almost half of the delinquent or criminal acts over the course of 1-3 years (Osei et al., 2015).
  - Compared to children placed into family foster care arrangements, children in group homes are more likely to receive mostly Cs and lower in school, have truancy problems, take remedial classes, and attain lower levels of education (Berrick et al., 1993; Festinger, 1983; Knapp et al., 1987; Mech et al., 1994). Moreover, **children and youth who have extended placements in group homes are also more likely to test below or far below in basic English and math** and drop out of high school (Ryan et al., 2009; Wiegmann et al., 2014).
  - Children in group care settings are at increased risk for maltreatment compared with children placed with families (Euser et al., 2013, 2014). A study comparing the prevalence of maltreatment in foster and residential care to the prevalence in the general population suggests that **sexual and physical abuse occur more frequently in residential care settings** than the general population (Euser et al., 2013). Sexual abuse occurred more frequently in residential care than in either foster care or the general population, whereas the rate of sexual abuse in foster care did not differ significantly from the general population. The rate of *self-reported physical abuse in residential care was almost double that of foster care and triple that of the general population* for same age adolescents (Euser et al., 2013). This violence and abuse might be due to the instability of providers in residential care leading to fewer secure attachment relationships between staff and children, high staff turn-over, and instability of the groups (Alink et al., 2012; Winters et al., 2011).

### ***There are other options...***

- Children are frequently placed into residential care settings due to substance abuse, sexual acting out behavior, and delinquency (Dishion et al., 1999). However, **these problems can most times be treated effectively and safely in the community outside of a residential care setting**. Cognitive-behavioral, family systems, and motivational enhancement therapies are effective treatments for addressing adolescent substance abuse and can be delivered in outpatient settings (Winters et al., 2011). Multisystemic therapy (MST) has been adapted for juvenile sexual offenders and is associated with significant reductions in sexual behavior problems, delinquency, substance use, externalizing problems, and out-of-home placements (Letourneau et al., 2009; Swenson et al., 2010). Multidimensional Treatment Foster Care (MTFC), which is another community-based treatment for serious juvenile offenders, has been compared with group care. Youth who received MTFC had higher completion rates, lower rates of recidivism, and fewer subsequent days in detention centers than youth who received group care interventions (Joseph et al., 2014; Schaeffer et al., 2013).

- **Even children who have histories of abuse and neglect and who have a late placement in foster care are still able to develop secure attachments with a caregiver** (Joseph et al., 2014). Of note, the quality of adolescent-parent interactions is related to the likelihood that a child develops a secure attachment to a foster caregiver. The adolescents who develop secure attachments to their foster caregivers show better behavioral and social adjustment than adolescents who develop insecure attachments (Joseph et al., 2014). Additionally, foster parents demonstrate higher levels of commitment to children living in their homes than staff in group care, and this finding holds when children's externalizing behaviors and the number of children the caregivers had cared for were controlled (Lo et al., 2015).
- The cost of placing children in non-family based placements is **7-10 times higher than the cost associated with family based settings** (National Center for State Courts, 2017). *What about temporary group care while children and youth participate in assessments and treatment planning?* Research suggests that this group care is also significantly **more costly than foster care and is not associated with a significant reduction in likelihood of re-abuse or the number of future placements** (DeSena et al., 2005). Moreover, conducting assessments in the context of group care is problematic because the setting is unnatural and attachment relationships are disrupted.
- Over 40% of children and youth placed into group care do not have a documented clinical or behavioral need that might require such a placement (National Center for State Courts, 2017). Group care should be used as therapeutic treatment in children only when clinically necessary and is the least detrimental alternative. **Group care should never be preferred over family care** (Dozier et al., 2014).

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## ***Questions?***

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