RESIDENTIAL FOSTER CARE ANALYSIS REPORT

Featuring Interviews of Youth with Lived Experience and Recommendations

YOUNG ADULT AUTHORS AND RESEARCHERS:
ELTUAN DAWSON, CAMERON HOOVER, CYNTHIA SCHEPERS, AND JASON SCHEPERS

AUTHORS/RESEARCHERS:
DEBBIE ABREU, MELISSA COLLINS, SHONTELLE DAVIS, SHANNON MOODY, AND NIKKI THORNTON

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INTRODUCTION

The child welfare system in Kentucky has seen welcomed federal and state policy and practice changes over the last few years, as well as significant disruption due to the COVID-19 pandemic that has pushed agencies and organizations to their limits.

One of the most impacted subsystems within the child welfare continuum of care is residential and institutional facilities. These placements are most often used for youth experiencing crises that cannot be addressed in a family-based setting. We know that too often these settings are over-utilized due to lack of family-based care rather than a clinical need for placement. However, the implementation of the federal Family First Prevention Services Act (1) and nominal increases in reimbursement rates on the state level as late as May 2022 have left agencies navigating new expectations and needed innovations.

Many events within the last few years have influenced the conversation around the need for systemic and institutional change as it relates to residential care facilities. From the spread of COVID-19, to the implementation of Family First legislation, to the recent deaths of children in residential facilities, these events and years of findings highlighting the negative effects of institutional settings weigh heavily on the system. The events and trends (2) have created a national debate on whether this type of out-of-home care should continue to be utilized.

The following report was developed by Kentucky Youth Advocates to further the conversation in Kentucky as it relates to the use of institutional and group settings as part of the continuum of services in the child welfare system. This study and subsequent report was modeled after the national Think of Us report, "Away from Home" (2), and was supported by Casey Family Programs in its development. The report references congregate, residential, and institutional care throughout, which are defined as the following: non-clinical group placements and group homes; homes for pregnant and parenting teens; therapeutic residential treatment facilities; shelters and transitional placements; or multiple placements (experience with two or more of the other types of institutions listed).

BACKGROUND

Child abuse, neglect, and dependency are triggers for children coming to the attention of child protective services and engagement with the child welfare system. When children cannot remain safely with their parents and receive services to preserve the family, placement with grandparents or other relatives helps to maintain a strong familial bond and cultural connection, and family-based foster care is the next best option. In 2020, over 8,000 Kentucky children were placed in foster care. (3) Roughly 10% of the children placed in foster care resided in group homes or institutional placements.

IN 2020, over 8,000 Kentucky children were placed in foster care

While it can be argued that many youth are placed in institutional facilities due to their need for structured and controlled environments, depending on the state, however, between 5% and 32% of youth placed in group placements are not there due to their need for intensive supervision, but rather because of the lack of least restrictive options, like family-based kinship or foster care. (4)

FEDERAL POLICY ADVANCING A FOCUS ON FAMILY

Federal legislation suggests that when a child is removed from their home, they should be placed in the least restrictive environment possible. The need for least restrictive placements was further pushed with the adoption of the federal Family First Prevention Services Act in February of 2018. Kentucky was one of the first jurisdictions to implement the Family First Act, which is one of the first major steps towards reducing the number of youth entering group care settings at the federal level. (5) This act focuses on allowing states to re-prioritize funds for preventative services such as mental health services, substance misuse treatment, along with other services that may help parents improve their parenting skills and reduce the use of congregate care settings whenever possible. Another motivation for states to reduce the use of institutional placements is the cost. Congregate care placements can cost ten times as much as keeping a child with their family or fictive kin.(6)

As a result of Family First, federal funding is limited for any placements that are not licensed family foster homes. If a child is placed in a group home for more than two weeks, federal reimbursement funds will only be available if the facility is a qualified residential treatment program (QRTP). QRTPs must meet specific standards to ensure a youth is getting appropriate quality services including, specializing in providing prenatal, post-partum, or parenting supports for youth, a supervised setting for youth ages 18 and older who are living independently, and settings providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims. Evaluations are administered to ensure that youth are not placed in detention facilities when group or residential placement options are limited.

Qualified Residential Treatment Program (QRTP) have the following requirements: (7)

- Individualized child assessments
- Case planning
- Documentation
- Judicial approval
- Ongoing review
- Permanency hearing requirements

The Family First act directly affects older youth and young adults – particularly youth and young adults of color, who tend to be over represented within group home settings. (8) Family First increased the support that older youth and young adults need in order to have more successful transitions out of the system and into adulthood. Such supports include funding available to help these individuals with education, employment, financial management, housing, emotional support, and building connections. (9)

IMPACTS OF INSTITUTIONAL RACISM ON THE CHILD WELFARE SYSTEM

Like many systems developed in the United States, the child welfare system has a history of disproportionately harmful impacts on BIPOC (Black, Indigenous, People of Color) children and families. The vast majority of children removed from their homes are removed due to alleged child neglect. Minoff and Citrin (2022) posit that these removals, which disproportionately impact BIPOC families, and the link between poverty and neglect are a result of historic and present-day racism.(10) Discriminatory policies and practices have thwarted Black, Latinx, indigenous, or immigrant families from accessing employment, housing, quality education, and health care, thus creating a vulnerability around poverty.
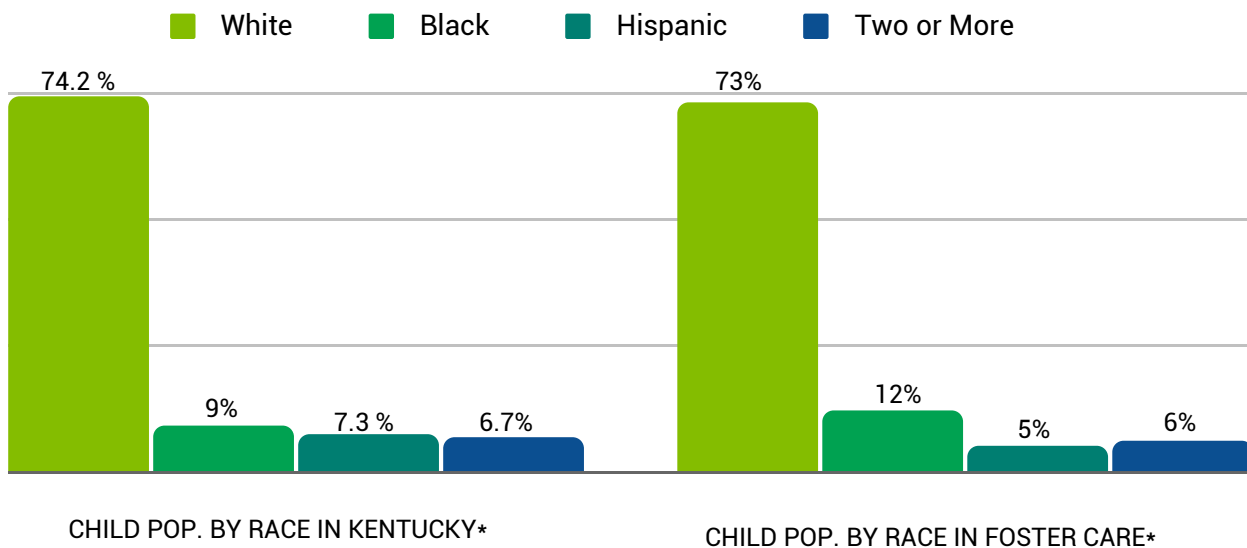
93.3%

of child maltreatment cases in Kentucky involved neglect, according to the 2020 Child Maltreatment Report.

In 2019, the American Bar Association pinpointed five factors that primarily explain the disparities within the child welfare system, which include: correlation between poverty and maltreatment; visibility and exposure bias; limited access to service; geographic restrictions; and child welfare professionals knowingly or unknowingly letting personal biases impact their actions and decisions. (11)

Families of color are disproportionately represented within the child welfare system. African American/Black children account for roughly 13% of the U.S population under the age of 18. However, they make up roughly 23% of children placed in foster care, and 30% of youth placed in group care settings.

In Kentucky, African American/Black children made up 9% of the population in 2020 and around 12% of the children who entered the foster care system that year. (12)

KENTUCKY CHILD POPULATION COMPARED TO POPULATION OF CHILDREN ENTERING FOSTER CARE BY RACE AND ETHNICITY IN 2020 (13)

■ White   ■ Black   ■ Hispanic   ■ Two or More

74.2 %   9%   7.3 %   6.7%

73%   12%   5%   6%

CHILD POP. BY RACE IN KENTUCKY*

CHILD POP. BY RACE IN FOSTER CARE*

*Terminology used is reflected from the National Conference of State Legislatures.

Nationally, Black identified children are also: (14)
- More likely to be placed in multiple placements.
- Less likely to be reunited with their birth families.
- More likely to experience group home settings.
- Less likely to establish a permanent placement
- More likely to have poor social, behavioral and education outcomes.

National trends demonstrate poorer outcomes for kids of color on several measures. While Kentucky follows many of those trends, reunification rates for Black children in Kentucky are higher than for children of other races. This warrants more study to determine whether Black children are being removed in situations where removal could have been prevented with supports to the parent or if reunification efforts are more successful with the population.

EFFECTS OF RESIDENTIAL AND INSTITUTIONAL PLACEMENTS

In 2020, 688 youth exited to emancipation out of the child welfare system in Kentucky (15) Much like youth of color, older youth (13 years and up) are overrepresented in group home settings. Research suggests that individuals who have aged out of care often face a number of barriers including educational attainment, employment, homelessness, as well as involvement in the criminal justice system.(16) Research also suggests there is a major developmental growth period within the brain from adolescence through young adulthood.(17) During this time frame, independence and autonomy within a safe and nurturing environment are key to youth becoming successful. (18) With these structures in place, youth are able to properly heal from past trauma; however, without the necessary stability, youth may face a number of negative outcomes.

Research has pinpointed an array of negative outcomes experienced by youth exiting an institutional or residential care setting. These outcomes seem to affect youth in many different areas of their lives, including issues with physical, mental and emotional health, maladaptive behaviors, schooling, along with a lack of communication and social skills. For example, youth who have spent time within institutional or residential settings are not given as many opportunities to develop life skills, are less likely to graduate high school, and have poorer educational outcomes. (19)

USE OF RESTRAINTS

Though verbal de-escalation tactics are preferred, many congregate facilities train their staff in physical and mechanical restraint tactics like those employed in Safe Crisis Management (SCM). In Kentucky, agencies for the 2021/2022 reporting timeframe provided by the Children's Review Program, physical management data is made available to the public on their website. It is "computed as a ratio of the number of physical managements to the number of 100-day units for those residents present in the reporting period." Of the 46 agencies reporting physical managements, eight reported zero physical managements while four identified with "worse than average" physical managements and 34 "within average range." (20) According to the SCM website, when done properly, SCM is "focused on preventing and managing crisis events, and improving safety in agencies and schools," and it is also meant to build "positive relationships with individuals." (21) Although these mechanisms are used for safety purposes, their application does come with a risk of harm. According to a study by Dalton, et al., patients who had been restrained reported feeling lonely, humiliated, and as if they were imprisoned. (22) The use of physical restraints also leads to an increased risk of physical injury to both staff and clients.

In extreme cases, the use of restraints has resulted in the death of individuals. Two recent examples were covered in the media, including an incident in Kentucky. On July 17, 2022, seven-year-old Ja'Ceon Terry, a child in a residential placement in Louisville, died after from "positional asphyxiation." While there are limited public details about the incident and it is still under investigation, two staff members were fired and the death was ruled a homicide. Another example of this is with 16-year-old Cornelius Fredericks. On April 29, 2020, Cornelius was put into a prone restraint by several staff members in a Michigan residential facility after reportedly throwing a sandwich in the cafeteria. A prone restraint is an intervention method where a person's face and frontal part of their body is placed in a downward position, while the individual's arms and legs are secured. (23) Cornelius was reported to have screamed out, "I can't breathe" as he was held down. He went into cardiac arrest and was pronounced dead two days later on May 1, 2020. (24)

METHOD

The overall goal of the study was to understand how young people were impacted by their stays in residential or institutional settings and to identify needed change. An important component of this research methodology included collecting input directly from youth and young adults who have had recent experiences in residential placements and that the research process was led from start to finish by young adults with lived experience in the child welfare system. Our research serves the purpose of ensuring that the youth's perspectives and experiences are heard and that they are also given a chance to discuss ideas for improvement.

Kentucky Youth Advocates and True Up Kentucky, with the support of Casey Family Programs, conducted in-person and video interviews with various groups in order to better understand their experience within institutional and residential care settings. These groups included young adults between the ages of 18-26 who have received services in institutional/residential settings within Kentucky; stakeholders engaged in services related to these settings; and caregivers who have had children receive services within these settings. Verbal consent was obtained by all participants before participation in the data collection.

Before the research began, four young adults with foster care experience were identified to serve as project leads to assist with the development of interview questions, facilitate focus groups and interviews, and support outreach to young adults with residential care experience. The research team was made up of these four young adults with foster care experience and staff members from Kentucky Youth Advocates (KYA) assisting with note-taking support, guidance on process, as well as communications and engagement. It should be noted that the young adult researchers had personal experience with residential and institutional settings either experiencing placement themselves and/or employment in those settings. Lead staff from KYA included those who previously worked in residential care or worked in the child welfare system in some capacity. The research team also took a collaborative approach to analysis of the data once collected.

For this research, qualitative data was collected from each interview and analyzed by coding interview transcripts. These codes were then grouped into common themes, such as readiness for independence, safety, and relationship/social needs, etc. By identifying the most common themes, our researchers were able to pinpoint individual and systemic issues that arise within residential and group placements and identify recommendations to address these issues.

Common themes that were observed during various interviews with young adults, residential staff and stakeholders are discussed in the following section.

RESULTS

The young adults who participated in the focus groups and interviews had a wide array of personal experiences and reflections on their time in residential care. In total, there were 46 young adults who took part in an interview or focus group. The participants were diverse in race and ethnicity, gender, and sexual orientation as well as geographic location of residential placements. Some participants had experienced multiple placements in the child welfare system, including multiple foster homes and/or multiple residential/institutional settings. One participant stated they had between 15-16 institutional placements. Participants were also asked for recommendations for ways their experiences would have been better – find several of the individuals' recommendations or solutions within the following sections.

SAFETY

> "*I came from one environment where I wasn't safe, only to be put in another environment where I don't feel safe…. So why am I here? You should have left me at home*"
>
> -Participant (AC1)

Concerns for safety was a recurring theme discussed in focus groups and interviews throughout our study. In reference to their residential care experience, one participant stated, "I made it out alive" (KM1). Another participant stated, "I came from one environment where I wasn't safe, only to be put in another environment where I don't feel safe…. So why am I here? You should have left me at home" (AC1). Many participants cited both physical and psychological safety concerns when disclosing information about their stays in residential care facilities.

PHYSICAL SAFETY

Participants referenced experiences during their time in residential care facilities in which their physical safety was a serious concern. Participants cited instances of physical safety concerns in interactions with both peers and staff, as well as incidences of self-harm.

Participants shared frequent fear for their safety due to the prevalence of fights and other physical altercations that broke out between residents in the facilities. In addition, participants cited rooming situations as being particularly concerning in regard to safety. One participant stated, "[Residents] often felt afraid of the other youth entering their room, taking their stuff, trying to harm them with handmade weapons, etc. Youth did not feel like staff could keep them safe" (BG2). Not only did participants discuss times when they felt unsafe due to their peers, they also endured physical harm from staff members.

Several participants cited instances of physical abuse from facility staff members. Participants recalled that staff members would often resort to using unnecessary physical holds and restraints on residents as opposed to utilizing verbal de-escalation tactics. One interviewee cited instances of sexual abuse from a staff member during their time in residential care after being sexually abused while in a foster home prior to that placement. In discussing their time in residential care, one participant stated they were "enduring abuse with no escape" (KM2). The participant went on to state, "I was literally trapped and had to go through this" (KM2). Several participants recounted running away from their residential care facilities explaining that the desire to escape the environment outweighed the risk of harm.

PSYCHOLOGICAL SAFETY

When disclosing information related to psychological safety concerns, many participants referred to lacking a sense of trust in regard to their resident-staff relationships. Participants cited that they were often scared to seek out help because they were afraid staff members would use the information against them. One participant stated, "[I] feel like everyone is against me" (KM1). The inability to trust adult figures ultimately deepens feelings of psychological insecurity in residents. Participants also referenced the trauma of witnessing suicidal attempts of their peers. The witnessing of such traumatic experiences, while many also referenced enduring their own ongoing battles with self harm, made the residential care facility an even more difficult environment to cope and heal. Participants discussed witnessing the self-harm and suicidal ideation of their peers, which further exacerbated their own inability to cope.

- Aim to transform traditional residential placements into centers for family well-being, providing opportunities for family therapy, supervised visitation, wraparound services, and other needed supports to keep families and children connected and safe, and as a catalyst for reunification
- Place children and youth in family-based settings whenever possible and reduce the likelihood of placement in residential or institutional care by increasing the pool of family-based care options available with effective recruitment and support for targeted populations
- Utilize staff training on verbal de-escalation skills to reduce the likelihood of physical management or restraints
- Establish an independent Ombudsman that provides oversight of the child welfare system by investigating concerns of safety and well-being, identifying systemic issues related to administration or practice, and making recommendations for improvements
- Reduce the overall use of physical holds/restraints by employing practices that reduce intense emotions during crisis intervention (eg. Geoffrion, S. et al., 2021)
- Post a copy of the Foster Youth Bill of Rights in a visible area of every residential facility

MENTAL AND BEHAVORIAL HEALTH

A primary focus of institutional and residential placements is crisis stabilization or therapeutic treatment. Connected to physical and psychological safety, a theme that the researchers identified was related to the physical and mental health care of the youth. Throughout interviews, the experience the youth had and the impact of their treatment was largely based on the specific agency they were in and who was working there at the time. The quality of staff and treatment teams make the difference between whether youth feel supported and safe or unsafe and potentially further traumatized. Generally, participants discussed the need for persistence and self-advocacy to ensure both physical and emotional health needs were met.

Several participants stated that their mental health needs were not taken care of while in residential settings, and reported they are worse off from having spent time in a residential facility. Participants reflected on their mental health conditions, such as depression, anxiety, and post-traumatic stress disorder (PTSD), and attributed their time in residential care to the development or exacerbation of those disorders. It was perceived by the young adults that some staff did not take suicide or self-harm seriously enough. One participant discussed that their therapists didn't stay long and couldn't make a connection, and after seeing 7-10 therapists the participant gave up on therapy while in care stating, "I would just ask them to read me the goals they have set for me and just let me answer them, so I could be on my way," (EM1). Some of the young people interviewed had expressed feelings of being misunderstood by clinicians and staff. One young adult reported that staff "weren't able to empathize with what I'd been through." Another stated, "I wasn't able to express my medical needs with them [staff]. I didn't have that comfort with them," while one participant said, "My voice isn't really important to them, which it should be."

On the other hand, some participants reported having healing and transformative experiences, where they learned coping skills that they still use today. One young adult mentioned that they benefited from the Eye Movement Desensitization and Reprocessing (EMDR) therapy received at the facility. Other participants mentioned helpful types of therapy that were used within the group homes, such as art therapy and having a therapy dog visit.

Some youth felt that residential care was a good option for them and that their mental health needs were better cared for in a congregate setting as they received regular therapy. Staff at certain placements would make the difference for a youth when they would patiently help them de-escalate. One young adult mentioned they enjoyed the safety of the controlled environment that residential care offered and said it was less traumatic. Another young adult (TY1) stated, "Residential was a better option than involvement in the criminal justice system."

MEDICATION

A major discussion as part of their treatment plan in care was the use of medication. Many participants reported that youth were over-medicated, that their psychological needs went unheard, were prescribed medication due to their past, and seemed as if it were used in a punitive way. One participant mentioned that doctors would bring up their past actions to justify why they needed to stay on the medication instead of giving them the opportunity to advocate for themselves, even when the medication was making them feel worse than before. Some participants said they had to be dishonest with their doctors for fear that they would be put on medication they didn't want.

> "I went into the facility on an allergy pill and left on 13 medications within six months"
>
> -Participant (EM1)

Regarding the overabundance of medication one participant stated, "I went into the facility on an allergy pill and left on 13 medications within six months" (EM1).

According to participants, some facilities took care of the youth's basic needs but when it came to mental health needs, they felt neglected. One young person mentioned that they had attention-deficit/hyperactivity disorder (ADHD), and that treating it changed their life. But it wasn't until they left residential placements that they could begin to do that because the treatment staff didn't identify the diagnosis. Another youth reported that they were hospitalized and almost died because they were given incorrect dosing of their mental health medication.

Related to individual treatment, one young person said that they surveyed the whole floor and discovered that 18 out of 25 of their peers were on at least two of the same medications. It seemed that even when the therapists and doctors were treating residents, in some places they were providing one generalized treatment to the entire unit. In most interviews, youth agreed that there were plenty of group activities, but that individual treatment and care was lacking. Participants recalled they were not given adequate mental health resources to continue working on their treatment after leaving care.

RECOMMENDATIONS

- Require training for residential and other non-clinical facility staff in Mental Health First Aid, including common symptoms and appropriate responses
- Ensure agencies are held accountable for achieving the identified treatment goals of young people

PHYSICAL HEALTH

During focus groups, participants were asked about their physical health needs, particularly focused around nutrition and physical activity. Several participants reflected on the impact of medications and food choices. One participant remarked, "residential facilities made me fat. I gained 40-50 pounds" (BG2). Others discussed significant impacts related to weight loss or weight gain due to their medications, physical activity, and nutrition, as well as the long-term implications for their physical health and wellness.

NUTRITION/FOOD

A wide array of experiences related to food and nutrition were discussed by participants. Many young adults stated that they felt manipulated with food. In care, food was often used as a means of reward or punishment. Positive behaviors would result in access to sugary or salty snacks, extras during meal time, or "splurge" days for residents on caloric restrictions. If their behaviors did not meet the expectations of staff, they could be given alternative meals, have food restricted for a time frame, or even have rewarding foods taken away. Some participants discussed meals that were generally perceived as nutritious and others reflected on food that was processed or didn't meet dietary needs. While the participants discussed opportunities to acquire skills related to cooking, there were no mentions of conversations related to healthy eating or nutrition.

> Based on young adult reflections, their current unhealthy boundary/relationship with food could have been fueled by food restrictions and the incentivizing of food during their residential placements.

Eating disorders and unhealthy relationships with food were mentioned many times during our interviews with young adults. Based on young adult reflections, their current unhealthy boundary/relationships with food could have been fueled by food restrictions and the incentivizing of food during their residential placements. Youth were put on strict diets by medical staff if they were identified as overweight. The food restrictions that participants experienced lead to behavioral patterns, such as hiding food in their room and overeating once they were out of the facility. These young adults mentioned having to learn how to develop healthy boundaries with food. However, many of them acknowledged that it is something that they still struggle with today.

PHYSICAL ACTIVITY

Similar to the reflection on nutrition, physical activity experiences also varied widely. Participants discussed opportunities to go to the gym for play or exercise daily, exercise initiated by staff, and sometimes exercise outdoors even in very high temperatures. Participants also mentioned that in some circumstances, physical activities would depend on the motivation of the staff member and whether or not they desired to take them to the gym, even if it was part of their daily schedule. Access to the gym or physical activity space was also dependent on other factors like the participants' history of running away or inadequate staffing to support transitions to other buildings. Some young people shared their desire to engage in sports, dance, or other physical activities that would have benefited them at the time and into adulthood.

- Extend access to healthcare coverage beyond age 26 for young people who have residential/institutional placements due to dependency, neglect or abuse
- Increase opportunities for youth in care to engage in physical activity based on their level of ability for a minimum of 30 minutes a day
- Increase opportunities for youth to access whole foods and exposure to information on nutrition, food portions, and how healthy foods can affect mood and energy

SOCIAL NEEDS AND NORMALCY

Key to successful functioning in a community is connecting to individuals and maintaining healthy relationships. In interviews and focus groups, a focus on relationships and social needs became a prevalent theme of concern for young adults with lived experience in residential care. One participant reported that they wished, "communication skills were focused on – and how to communicate effectively." It was repeatedly reported that more opportunities to socialize could have been beneficial to the effectiveness of treatment and independence readiness: "That's why a lot of kids get out in the real world and lack social skills" (KG1).

Young adults reported having a sense of community "in this dysfunctional way", while experiencing residential care. The young adults shared appreciation for off-campus activities and opportunities for socialization among peers through sports, activities, groups, outings, and visits from volunteers at the facility. However, the socialization varied widely, as some participants discussed feeling isolated and were often kept from interacting with residents from other cottages or sections of the facility, even prior to the COVID-19 pandemic. In some cases, the socialization was seen as inappropriate as a participant shared that at the age of 14 they were roomed with a seven year old (TP1).

Participants desired opportunities to learn different skills to engage socially in the community. Positive feedback reflected that mentorship opportunities were helpful to young adults while in residential care. "I met good people that I still have bonds with today. I had a really good mentor."

FAMILY INTERACTIONS

Many of the young adults discussed a lack of connection with family members or individuals they previously had a connection to before entering a residential setting. Participants discussed a lack of or prohibition on sibling visitation. A top priority of the Kentucky Department of Community Based Services is the reunification of families. Yet, there were reports of staff in residential facilities making it difficult for youth to maintain connections with family which, in many cases, has led to a disconnect in those relationships.

> *"I struggled a lot with missing my family. I hardly contacted them and they weren't able to understand or empathize with what I was going through."*
>
> -Participant

One young adult reported that, "I struggled a lot with missing my family. I hardly contacted them and they weren't able to understand or empathize with what I was going through." One young adult was encouraged to maintain contact with her mom which was also a treatment goal, however this young adult lost the privilege to call their mom after a riot at their placement. Several former foster youth interviewed recalled their access to their families would be limited for poor behavior.

Visitation with family is a very important part of meeting social needs. One former youth stated, "… Visitation was taken away. It was 10 minutes until my visitation and it was taken." Losing access to support systems outside of the residential facility has the potential to damage or strain relationships.

RECOMMENDATIONS

- Increase opportunities for youth in residential or institutional care to enter into relative or fictive kin placements with robust transitional supports for the youth and their families, like the Kinship Treatment Foster Care Initiative
- Improve programming for youth in foster, kinship care, and other placements around defining, discussing, and helping youth set healthy boundaries with peers and adults
- Ensure youth have access to activities that increase socialization with peers and family members or trusted adults, like screened volunteers, in their daily routines
- Provide opportunities for youth to be matched with a mentor outside of the residential facility when possible

EDUCATION AND READINESS FOR INDEPENDENCE

Youth who transition to adulthood out of foster care are usually leaving due to their age and not their level of independence readiness.(25) Studies evaluating outcomes following discharge from foster care settings have found that foster youth are more likely than their peers to experience houselessness, have drug and alcohol dependence, experience health and mental health problems, encounter the criminal justice system, experience economic instability, and not have a high school or postsecondary degree.(26) During interviews, many of the young adults, along with some staff, noted that the lack of independence readiness is associated with a deficit in preparation for life outside of residential placement, including life skills training, general and post-secondary education, and resources available for youth after exiting the system. It is a bittersweet moment for the youth when they get a release date because there's a mix of being happy to leave. There is also a paralyzing fear of the outside world, especially if they are transitioning into adulthood at the time of discharge. Multiple youth mentioned that as they transitioned out of the residential facilities, they were not prepared in many ways.

EDUCATION

Young adults that were interviewed stated that they did not feel as if they received the same quality of education on-campus at a residential facility, compared to what they would have at an off-campus public or private school. One young adult interviewed stated that they felt as if on-campus schooling did not prepare them for off-campus schooling. "I was lost" (MJ1). While attending school on campus they felt as if they were "the smart kid," however, after attending public school, realized that they "knew nothing" (MJ1). This transition seemed to be a shock to the young adult and others who had the opportunity to experience both on campus and off campus schooling.

Due to staffing shortages, many youth are put into classrooms with youth of different ages. "In residential you're in 10th grade but sometimes sitting in a room with 5th and 6th graders" (KM2). Because of this, the material did not always challenge or meet the educational needs of the older youth. One young adult described on campus schooling as a "dumbed-down version of public school" (CS1). Other young adults stated that they were given packets, watched movies, and did coloring sheets which seemed more like busy work, instead of learning.

> "In residential you're in 10th grade but sometimes sitting in a room with 5th and 6th graders"
> -Participant (KM2)

Another common trend noted during our interviews was youth not being able to graduate or receive their high school diploma due to missing credits. One young adult mentioned that they did not receive their high school diploma because they ended up with too many credits in one subject and were missing one credit needed to graduate (KM2). Another one of the young adults interviewed stated that when they transferred to school off campus they were supposed to be in the 12th grade. However, their credits were lost and they ended up being placed in 9th grade (AC1). The young adult decided to get their GED instead.

Furthermore, lack of preparation for post-secondary education was also a trend during interviews. One young adult stated that they were hesitant to attend college because they were afraid that they did not learn what other kids got to learn in "regular school" (LS1). One young adult stated that "there was no discussion about college or post-secondary opportunities," while another felt "prepared to get out of residential, other than education."

LIFE SKILLS AND INDEPENDENCE READINESS

> "(I was) dropped off at a gas station with a binder that had no ID, no birth certificate, and nothing else. Took a year and a half to get my social security card."
>
> -Participant

Youth reported a lack of learning sufficient and essential life skills. One participant stated, "I felt like I was institutionalized and didn't know how to survive outside of structure." Several youth reported being taught some basic life skills: "They taught us cooking, cleaning, and how to take care of our hygiene." However, others felt that these basic life skills were insufficient: "Basic needs were met, but other needs that would have prepared me for life were not met." One participant summed the issue up by saying, "A problem with residential care placements is that youth can't always gain independent living skills when they're not treated as young adults."

Another theme that emerged was that youth did not have the needed documents, such as social security cards, birth certificates, and health insurance cards when they left care.

One participant stated that they were "dropped off at a gas station with a binder that had no ID, no birth certificate, and nothing else. Took a year and a half to get my social security card." Participants also reported being unaware of their Guardian at Litem (GAL) and additional resources needed to succeed on their own. One participant stated, "I didn't know where to start. I didn't have any resources or information about aftercare," while another reported, "I resorted to prostitution because I was unaware of how to do anything else." When resources were provided, participant reported that they weren't always helpful: "They would give you resources for their location. I had a lot of resources for Louisville, but none for my hometown." As a result, many participants were left to navigate adult life on their own. One participant stated, "There aren't too many success stories. Most of them are sad."

RECOMMENDATIONS

- Ensure that education programming for youth in state care (A6 programs) is accountable and equitable in terms of finance, governance, and learning outcomes and take into account provisions included in the Every Student Succeeds Act (ESSA)
- Provide youth the opportunities to attend schools that match their talents and interest, such as schools that have academies, magnet schools, optional schools, etc.

- Ensure that education programming for youth in state care (A6 programs) is accountable and equitable in terms of finance, governance, and learning outcomes and take into account provisions included in theEvery Student Succeeds Act (ESSA)
- Provide youth the opportunities to attend schools that match their talents and interest, such as schools that have academies, magnet schools, optional schools, etc.
- Require teachers at A6 programs within residential/institutional placements to receive trauma-informed care training
- Ensure that youth are informed about post-secondary education options and educational resources from Cabinet for Health and Family Service, including the state's KYRISE website, and invest in supports for post-secondary transitions
- Hold agencies accountable for completing required transitional planning meetings with youth prior to turning 18 years old and require the completion of the LYFT curriculum provided by the Cabinet for Health and Family Services

STAFF, FORMER STAFF, AND STAKEHOLDER PERSPECTIVES

> "The problems that put kids in residential care are not solved in residential care. But we don't have enough social support structures in place to give kids and families what they need to be able to thrive."
>
> -Participant (ES1)

The overall goal of this study was to gather the perspectives of young adults with an institutional care experience in the child welfare system. The young adult researchers and contributors thought it would be valuable to also hear from those who play a role in the care of young people in these settings. The researchers interviewed 8 individuals representing current and former direct service providers, program leadership, and a foster parent to solicit additional information about the experiences of young people based on stakeholder perceptions.

STAFF TRAINING ON PHYSICAL HOLDS

One of the biggest concerns in residential placements are the safety of staff and clients. Nearly all of the staff and residents interviewed had some instances where they recalled being in an unsafe situation.

A common theme from the staff interviewed was the lack of training in the use of physical restraints. Lack of training and confidence in the proper use of physical restraints can lead to more injuries and further traumatization of the staff and residents.

Moreover, interviewees recall times where physical holds would not have been necessary, had the staff been able to verbally de-escalate the situation. Studies have shown that staff trained in crisis prevention and de-escalation seem to show more caution and awareness compared to the untrained when it comes to using restraint techniques, as well as being less supportive of physical holds in crisis situations. Not only does the use of verbal intervention keep the residents from further traumatization and injuries, it also decreases financial liability of the residential placements. A juvenile facility in Montana found that after one year of implementing crisis prevention, worker compensation claims were reduced by 82%.

Another way to reduce incidents is to ensure the staff to resident ratio is being met. The staff interviewed discussed concerns about their capacity to keep the residents safe from themselves due to unsafe behaviors.

Interviewees reported that there were unsubstantiated and substantiated cases of abuse when staff and youth were alone together. Some of the residents could become violent toward the staff, putting the staff in danger. Having adequate staffing would decrease or prevent the chance that a staff member and a resident are unsafe when alone together.

Staff interviewed also acknowledged the power dynamic between direct support staff and leadership within the organization. One staff member noted that they could not do as much as they wanted for the youth within the facility because they needed funds and permission from a supervisor.

> Staff trained in crisis prevention and de-escalation seem to show more caution and awareness compared to the untrained when it comes to using restraint techniques, as well as being less supportive of physical holds in crisis situations.

This staff member reported wanting to do fun and engaging activities with the youth that would actually be beneficial to them, as opposed to the simple activities that were provided to keep them busy. Another staff member explained that following the pandemic, it appeared as if staff were more aggressive with youth. They stated that when they stood up and spoke about the things that were taking place, it was either blown off or they were put on probation.

STAFF SUPPORT, WELL-BEING, AND RETENTION

Though the pandemic worsened staffing issues, it has been difficult to retain direct-care workers in residential facilities for many reasons. According to Casey Family Programs, the annual turnover rate in Kentucky prior to the pandemic was approximately 33%. (27)

Staff member interview participants shared that their decision to exit from working in a residential facility were systemic issues, including a lack of employment incentives. Many felt like they were under-paid, under-appreciated, and did not have opportunities to advance in their careers. One of the interviewees worked at their organization for six years, only to leave for "a better opportunity." Six years is a relatively long tenure for a direct-care worker in residential care. Pay isn't just an issue for experienced employees, but is also a challenge in recruiting and retaining new employees. One staff reported, "during orientation training, they told [new hires] that they would not see the fruits of their labor and were told they had to make peace with that." Another said that it's "not a sustainable job."

> "I always felt like when I was home I had to recover enough to prepare for my next shift. My off-hours were always in the service of my on-hours"
> -Participant (ES1)

Another contributing factor to high turnover among staff was the stress associated with the job and its impact on their overall mental health. Some felt like they weren't able to maintain a healthy work/life balance. One participant stated, "I always felt like when I was home I had to recover enough to prepare for my next shift. My off-hours were always in the service of my on-hours" (ES1). Staff reported they would have to be on-call, even on their days off and they were not able to have their work be fully separated from their home.

Staff reported they would have to be on-call, even on their days off and they were not able to have their work be fully separated from their home.

Many staff have experienced vicarious trauma from hearing about the trauma or witnessing what residents experienced. One staff member recalled consistent nightmares due to the reality of the situation and felt like perhaps working there was unethical. While referring to having to put the residents in physical holds, they said, "once it was over, I would realize 'oh my gosh, I restrain kids for a living'" (ES1). In an interview with a former staff member, it was stated that "kids are overly medicated in residential and it's for the convenience of staff" (ES1). Many of the interviewees also recall feeling helpless and wished they could do more to help the youth that have to stay in these facilities. As one of them put it, "I felt a deep sense of powerlessness at the futility of being in residential care" even going so far as to say, "kids shouldn't be in residential [facilities] at all; it shouldn't be legal" (ES1).

Other perceived contributions to staff-turnover and burnout were systemic and had to do with the individual organizations. While some were happy with the amount of support they got from other staff and administration, this was not always the case. Favoritism, nepotism, honesty, accountability, and disruption in the chain-of-command were mentioned in the interviews. Many of these employees were peer-trained, so the distrust of peers and dynamics made their work environment more stressful and meant there was less focus on the care of the residents.

RECOMMENDATIONS

- Review and study the current Medicaid reimbursement rates provided for needed services to ensure children have access to high-quality services provided by high-quality staff
- Identify and implement staffing and training standards that reduce the likelihood of retraumatization or physical harm for youth involved in programming

Casey Family Programs offers a variety of additional strategies and jurisdictional approaches to decrease and prevent high turnover rates. We recommend individual agencies utilize these resources to identify the current problems within their agencies, and redesign their approaches to recruitment and retention of their employees. In addition to that, simply emphasizing the importance of the roles the direct-care staff have in the lives of these children will help them work towards the common goal: to help nurture the success and well-being of Kentucky's most vulnerable children.

CONCLUSION AND RECOMMENDATIONS

The child welfare system's reliance on residential and institutional care has created an entangled mix of challenges and potential solutions that are complex, will necessitate incremental change, and at the root require a focus on the outcomes of the children rather than the bottom line of budgets.

The recommendations provided a variety of solutions that can be implemented with ease as well as solutions that are much more complex and require persistent efforts. To sum up the overarching, clearest recommendations, we simply urge decision makers to consider the following:

Put the outcomes of children and families first when making decisions so that if they must enter the child welfare system, they are better off when exiting. That means prioritize family-based out-of-home placements, provide treatment with demonstrated success in the least-restrictive setting, and, whenever possible, reduce the time a young person spends in residential or institutional settings by creating pathways to community-based services.

RECOMMENDATIONS

For state policy change:

- Establish an independent Ombudsman that provides oversight of the child welfare system by investigating concerns of safety and well-being, identifying systemic issues related to administration or practice, and making recommendations for improvements
- Require training for residential and other non-clinical facility staff in Mental Health First Aid, including common symptoms and appropriate responses
- Extend access to healthcare coverage beyond age 26 for young people who have residential or institutional placements due to dependency, neglect or abuse
- Increase opportunities for youth in residential or institutional care to enter into relative or fictive kin placements with robust transitional supports for the youth and their families, like the Kinship Treatment Foster Care Initiative
- Ensure that education programming for youth in state care (A6 programs) is accountable and equitable in terms of finance, governance, and learning outcomes and take into account provisions included in the Every Student Succeeds Act (ESSA)
- Require teachers at A6 programs within residential or institutional placements to receive trauma-informed care training
- Review and study the current Medicaid reimbursement rates provided for needed services to ensure children have access to high-quality services provided by high-quality staff

For practice or program change:

- Aim to transform traditional residential placements into centers for family well-being, providing opportunities for family therapy, supervised visitation, wraparound services, and other needed supports to keep families and children connected and safe, and as a catalyst for reunification
- Place children and youth in family-based settings whenever possible and reduce the likelihood of placement in residential or institutional care by increasing the pool of family-based care options available with effective recruitment and support for targeted populations
- Utilize staff training on verbal de-escalation skills to reduce the likelihood of physical management or restraints
- Reduce the overall use of physical holds or restraints by employing practices that reduce intense emotions during crisis intervention
- Ensure agencies are held accountable for achieving the identified treatment goals of young people
- Increase opportunities for youth in foster care to engage in physical activity based on their level of ability for a minimum of 30 minutes a day
- Increase opportunities for youth to access whole foods and exposure to information on nutrition, food portions, and how healthy foods can affect mood and energy
- Improve programming for youth in foster care, kinship care, and other placements around defining, discussing, and helping youth set healthy boundaries with peers and adults

RECOMMENDATIONS

- Ensure youth have access to activities that increase socialization with peers and family members or trusted adults like screened volunteers in their daily routines
- Provide opportunities for youth to be matched with a mentor outside of the residential facility when possible
- Provide youth the opportunities to attend schools that match their talents and interest, such as schools that have academies, magnet schools, optional schools, etc.
- Ensure that youth are informed about post-secondary education options and educational resources from Cabinet for Health and Family Service, including the state's KYRISE website, and invest in supports for post-secondary transitions
- Hold agencies accountable for completing required transitional planning meetings with youth prior to turning 18 years old and require the completion of the LYFT curriculum provided by the Cabinet for Health and Family Services
- Post a copy of the Foster Youth Bill of Rights in a visible area of every residential facility
- Identify and implement staffing and training standards that reduce the likelihood of retraumatization or physical harm for youth involved in programming

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