CHILD PROTECTION SERVICES
STANDARDS FOR EFFECTIVE PRACTICE

STANDARDS FOR OUT-OF-HOME CARE SERVICES

6.11 CONGREGATE CARE

Council on Accreditation Standards
The Council on Accreditation Standards S26 (Group Living Services) and S27 (Residential Treatment) link to and support Standard 6.11 *Congregate Care*.

Administrative Code
The Ohio Administrative Code Rules 5101:2-9 (Children's Residential Centers, Group Homes and Residential Parenting Facilities); 5101:2-5 (Administrative Rules for the Public and Private Agencies); and 5101:2-42-65 (Visitation In Group Homes and Children's Residential Centers) address Standard 6.11 *Congregate Care.*

I. Philosophy

CFSAs recognize that there are children who, due to severe social, emotional, or physical disabilities, require extensive treatment and rehabilitative services in non-family like settings. For this population, a high level of supervision, structure, and therapeutic services are necessary to overcome behavior which may threaten the safety of the individual, individual's family, or community. For these children, congregate care (group homes and residential settings) is a placement option. The goals of congregate care are:

- to enable children to overcome problems through participation in services as identified in their individual comprehensive treatment plans; and
- to assist children to move to a less restrictive community placement with plans toward eventual reunification with their own family, permanent placement with another family, or an independent living situation.

To assure goal attainment, a comprehensive assessment and a detailed treatment plan with measurable outcomes must be developed by a treatment team.

II. Outcome

Children in congregate care achieve the goals established in their treatment plan to function successfully within the least restrictive environment, which meets their needs.

III. Evaluation

FACSIS events, CPOE and the Federal Health and Human Services outcomes may be considered when evaluating this standard. In addition, the CFSA may consider the following:

- number of children initially placed into congregate care settings;
- number of children placed into congregate care settings at some point during placement;
- the median length of stay for children in congregate care settings prior to another type of placement;
- the median length of stay for children in congregate care settings prior to termination of care;

- number of moves while in care compared to number of moves in care for children placed into foster care only;
- number of staffings held prior to placing children into congregate care settings;
- number of cases where concurrent planning began immediately;
- number of face-to-face visits (minimum monthly visits with child in facility).

IV. Standards for Implementation

A. Criteria for Congregate Care Placement

1) A child who may benefit from, and be considered for, congregate care services will be a child with one or more of the following, but not be limited to:
    a. emotional and/or behavioral disturbances;
    b. psychiatric disorders;
    c. developmental disorders;
    d. mental retardation;
    e. substance abuse;
    f. medical disorders.

2) Examples of a child who may be considered for placement in congregate care should include, but not be limited to, a child:
    a. who is or has been recently released from a hospital or detention facility;
    b. who exhibits mental retardation and/or a variety of developmental disabilities, which preclude the child's ability for self-care and independence;
    c. whose physical and emotional well-being is at risk due to drugs or alcohol abuse or addiction, thus requiring a structured environment, close monitoring, frequent counseling, medical visits, and a well-coordinated network of medical support;
    d. who exhibits emotional problems such as, but not be limited to, depression, anti-social behavior, and/or suicidal tendencies, requiring the constant attention of a caregiver;
    e. who exhibits a moderate-to-severe degree of maladaptive behavior, acting-out behavior, such as verbal and physical aggressiveness, delinquent behavior, incorrigibility; and/or
    f. who exhibits complex medical disorders which require special services, technological supports, constant nursing care, or some other form of intensive medical support.

B. PCSA Congregate Care Determination Process

1) At the time the CFSA considers that a congregate care placement may be the most appropriate setting for the child and in the best interest of the child, the staff should follow the agency's procedure for obtaining a comprehensive child assessment. The assessment should be completed by a certified or licensed healthcare professional and a certified or licensed practitioner of behavioral science.

2) Upon receipt of the assessment, the CFSA should schedule a staffing (see Standard 3.10, *Team Desicion Making*). The purpose of the staffing is to determine, based on available information, if everything possible has been, or is being, done to maintain the child in the least restrictive setting. Individuals invited to attend the staffing may include, but not be limited to, the following:

    a. the child (age and developmentally appropriate);

  b. the CFSA's staff (including the custodial CFSA staff), supervisor and/or manager;
  c. the child's parents and other significant family members or kinship connections;
  d. the child's current caregivers (if applicable);
  e. representatives from the medical and mental health community and/or juvenile court;
  f. any community professionals involved with or having information concerning the child under review;
  g. the county's Family and Children First Coordinator;
  h. the Guardian Ad Litem; and/or
  i. any others as identified by the CFSA.

3) The staffing should include a review and discussion of all available information including, but not limited to and not in order of importance:
  a. agency risk assessment matrix and the case plan and amendments;
  b. the adequacy and availability of current services and other placement options;
  c. a psychological/psychiatric assessment and history of psychotropic medications;
  d. the comprehensive family social history;
  e. the summary of child's history of abuse/neglect;
  f. the child's placement history and their adjustment to those placements;
  g. the child's juvenile court record;
  h. the child's medical history including previous and current medications;
  i. any reports from other service providers;
  j. the child's educational history; and
  k. any other relevant information available.

4) When the decision has been made that congregate care is in the child's best interest, the staffing participants should decide on available and appropriate facilities that can best meet the needs of the child. The CFSA should then refer the child to the appropriate facility with consideration for:
  a. the ability of the provider to meet the child's individualized needs including safety;
  b. the location and proximity to significant family members and/or kinship connections; and
  c. the ability of the provider to enhance the likelihood of reunification, when appropriate.

5) If facilities cannot meet the individualized needs of the child, the CFSA should network with facilities and/or other placement settings to brainstorm how they will creatively meet the individualized needs and safety of the child who they may not normally serve.

C. CFSA Responsibilities for Children in Congregate Care

1) At the time of placement, CFSA worker will actively participate in the development of a treatment plan and signs off on plan.

2) The CFSA should immediately begin concurrent planning (see Standard 3.15, *Concurrent Planning*).
3) Within 5 days of placing the child in the facility, the CFSA worker should have a face-to-face visit with the child in the facility.

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4) The CFSA should schedule and conduct at minimum monthly face-to-face visits with the child in the facility.

5) The CFSA should attend scheduled review meetings in conjunction with the facility and regularly monitor and review the child's progress in the facility. The CFSA should support the child's family, other significant family/support members, kinship connections and/or child's foster family in attending and actively participating in, the scheduled review meetings. CFSA should make every effort to assure the family's participation (i.e., transportation barriers).

6) CFSA should arrange and support a regular ongoing visitation plan between the child and his/her family and other significant family/support members, the kinship providers, and/or the child's foster family (refer to Standard 3.13, *Visitation*).

V. Financial Implications

Costs associated with Standard 6.11, *Congregate Care* are included in a variety of other standards.

Additional costs include the cost of care of the congregate care facility.

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