WHERE DO WE BELONG?

Profiles of “High Acuity” Adolescents in Congregate Care and The System’s Struggle to Meet Their Needs

CHILDREN'S LEAGUE OF MASSACHUSETTS

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1. Executive Summary

While reliance on congregate care in child welfare has been slowly declining in Massachusetts, these care settings continue to play a variety of important, specialized roles. However, the reduction in the number and types of care setting spaces and more selective removal of children has resulted in a higher concentration of adolescents whom we think of as "high acuity" residing in congregate care. These youth can be highly disruptive; can cause harm to themselves, their peers and staff; and negatively impact the environment and effectiveness of these care settings.

The Children's League of Massachusetts surveyed our members who provide residential care to adolescents and young adults to learn more about these youth, to understand what we mean by "high acuity" and the impact of these behaviors, and to identify solutions to improve our ability to meet the needs of these youth while also maintaining safe and healing environments.

Our survey found a confluence of conditions and challenges that our current system cannot sustain:

- Approximately 15% of contracted beds are currently offline due to staffing shortages, creating more pressure on the existing system of care.
- Youth behaviors that cannot be managed by the standard congregate care setting include running away, threatening or assaulting other youth or staff, self-harm or putting self at risk for sexual assault or trafficking, and drug use.
- The impact on peers is risk of harm, significant trauma, and disruptions to care and healing - the same reasons children are placed out-of-home to begin with.
- Staff feel frustrated, overwhelmed, and powerless. The resulting burnout is exacerbating our current workforce crisis.

We also offer recommendations to improve our system of care for all youth, including:

- Improving the working relationships and communication among adults responsible for youth supervision and caregiving.
- Creating new settings that meet the varying needs of high acuity youth and allow small steps between levels of care and into adulthood.

A “high acuity” youth is one whose behavioral, mental health, and/or medical management needs are mismatched to the care setting in which they are placed. Youth are frequently acting out in response to their trauma, frustration, and difficulty having needs met. Our goal is to help youth heal and thrive. When a youth disrupts the care setting it exacerbates not only their own dysregulation and trauma but that of the youth around them.

2. Introduction

Over the past decade, the child welfare and juvenile justice systems have worked diligently to reduce reliance on residential care, recognizing that a group home setting is not usually the best option for a child's treatment or healthy development. However, **congregate care continues to play a variety of important, specialized roles in the child welfare system**. These can include:

- A place to temporarily stabilize, avoiding the need for emergency department boarding or hospitalization;
- A place to step down from emergency treatment or higher level of care before returning home or to independent living, or shifting to a specialized setting to receive ongoing care;
- Residential schooling for youth with specialized long-term behavioral needs;
- Transitional programming or supportive housing to prepare young adults for independent living;
- Short-term treatment that can be accomplished in a group setting; and
- Specialized, supportive communities for marginalized populations such as LGBTQ+ youth.

Steady emphasis on keeping youth at home and out of the juvenile justice system, combined with beds being offline due to staffing shortages has **reduced the percentage of youth in DCF congregate care overall by 15.4%** in the past 5 years.[1] In FY2022, fewer than 15% of DCF children aged 0-17 and 26% of young adults aged 18+ were placed in a congregate care setting.[2]

As a consequence of this reduced reliance and availability of congregate care overall, **the remaining smaller percentage of youth residing in congregate care naturally present with more serious behavioral needs or "high acuity," and they are more concentrated in numbers at a given site. They act out in ways that contracted programs are not designed to manage.** This report will illustrate:

- The nature of these challenges, including cases of youth who repeatedly run, engage in highly risky behavior, assault other children and staff, or engage in property damage at the program.
- The struggles of programs that want to provide appropriate treatment but have little ability to prevent or address incidents or hold youth accountable.
- The extent of disruption to other youth in the group setting, leading to deteriorating effectiveness of the program overall.

The result of constant crisis and triage mode focused on a small number of highly disruptive youth means that staff are unable to focus on short-term treatment or long-term planning for the youth engaging in these behaviors or other youth who are patiently waiting their turn. Other youth in the program are pulled into negative behavior or triggered and traumatized by their peers. Overall:

1. DCF Annual Report FY2022, Table 10
2. DCF Annual Report FY2022, Table 16

- **The providers' ability to maintain a culture of treatment and healing is disrupted for all youth.**
- **The providers' staff experience high levels of frustration and burnout, creating high turnover and vacancy rates at a time when we need an experienced and stable workforce.**

Snapshot of Acuity: We asked providers to estimate what percentage of youth in their site today fall in each of these categories. The results show that a high percentage of placed youth are mismatched with the type of care the site is designed to serve, exacerbating pressure on already strained staff.

Category	Average Reported Percentage
Highly disruptive – have committed assault, run away multiple times, caused property damage, and/or are **highly mismatched with the program setting.**	**24%**
Occasionally engage in disruptive behavior but not to the level of needing a different setting/not to the level of assault or other criminal-like activity. **May occasionally need extra support to stabilize**.	**39%**
Typical adolescent or exhibit some trauma responses but are not seriously disruptive. **These are youth that the setting is generally designed to serve.**	**37%**

Yet these “high acuity” youth have no place else to go and programs have limited resources to support them effectively. Too often the only available response is an incident review, a police call, or a short-term hospitalization that does not hold the youth accountable for their actions or address underlying causes and returns them to where they started. Except for juvenile justice settings and Intensive Residential Treatment Programs, staff are only allowed to physically intervene if the youth is presenting imminent risk of harm to self or others. **Treatment depends solely on a youth’s desire to remain and engage in treatment.**

How can our system change to address these challenges? We have limited options for placing youth in a care setting that will support meaningful change. **For these youth, we need care settings with a different kind of relationship and staffing pattern to support youth with the highest degree of trauma and resulting “high acuity” behavior**. This report concludes with recommendations for improving the continuum of meaningful care options to effectively meet youth "where they are" and treat the needs at hand.

This case example sums up the cycle of dangerous behavior that escalates, disrupts everyone in the care setting, requires many levels of response, and ultimately results in no change. Put yourself in the shoes of this 15-year-old girl and the children and staff who live and work with her.

> *"The youth made threats to assault and kill another youth at the program. The victim was kept behind a locked door with staff while this youth attempted to break the door down. After several attempts to de-escalate the situation over several hours the staff had to call the police for assistance. When the police arrived the youth fought with the officers that responded which included kicking and biting them. She also attempted to take the officer's gun. An [ambulance] was called to transport her to the hospital for evaluation. She continued to fight with the EMT. It was reported to the program that she was chemically restrained in the ambulance and had to be put in four-point restraint at the hospital. The youth was evaluated by the crisis team. The crisis clinician did not believe the youth met hospital level of care and told the program that this is normal behavior for someone who is taken out of the program against their will. She returned to the program and is currently at the program."*
>
> -Regarding female youth, age 15

Ask yourself: What do we owe to this child and the children around her? What kind of support do the staff who work in her program deserve? How can we ensure that no child has to feel like this is the only way to have her trauma seen and heard?

a. Methodology

To understand these challenges and possibilities for change, CLM conducted a survey of our members who provide congregate care through contracts with the Massachusetts Department of Children and Families (DCF) to ask about the issue of high acuity youth who are disrupting their care setting. The survey asked providers for anonymized profiles of these high acuity youth and incidents, as well as general data about incidents, responses, and the impact on other youth and staff in the program. We also asked for ideas for solutions to move our system past this crisis.

The survey was conducted in January 2023 and asked providers to report information from the period July 1 – December 31, 2022. The aggregated data points cover this six-month time period.

Respondents included 49 program sites operated by 20 provider agencies, with sites located in 33 cities and towns across Massachusetts.[3]

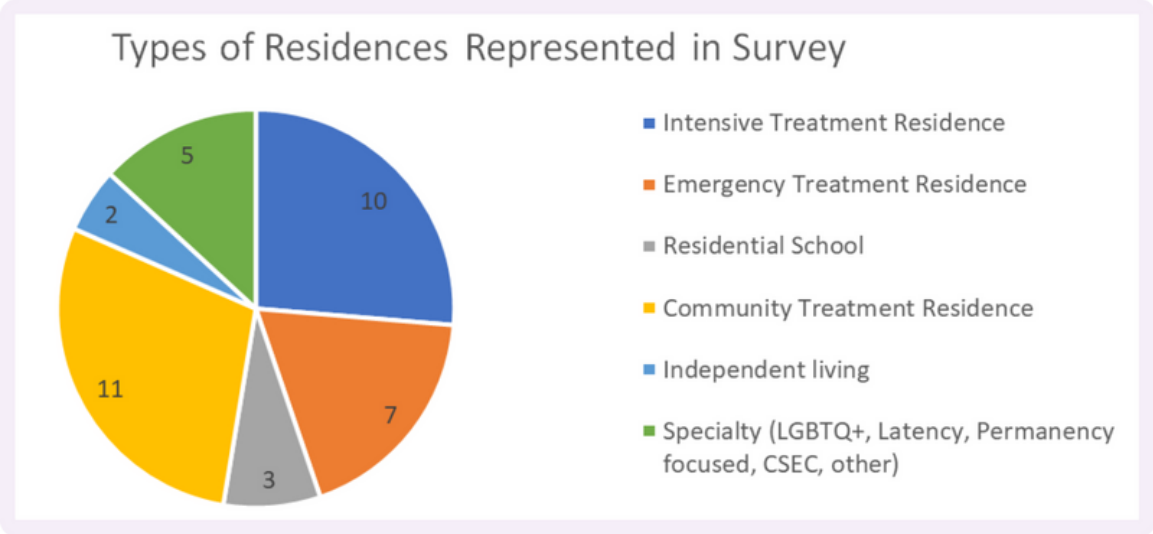
3. Numbers of responses may not total equally across categories and responses, as all sites did not answer all questions, or in some cases sites offered multiple responses across one case.

3. Providers at a Glance

Site Locations:
Provider sites range from Dorchester to Lenox, from Haverhill to Fall River, and everywhere in between. Multiple sites reported from Fall River, Lynn, Springfield, Swansea, Waltham, and Worcester. Overall, the respondents represent 49 program sites operated by 20 provider agencies, with sites located in 33 cities and towns across Massachusetts.

Current Capacity:
Altogether the represented agencies provide nearly 800 beds via contract to DCF, with 119 of those beds currently offline due to staffing shortages or other operational issues.

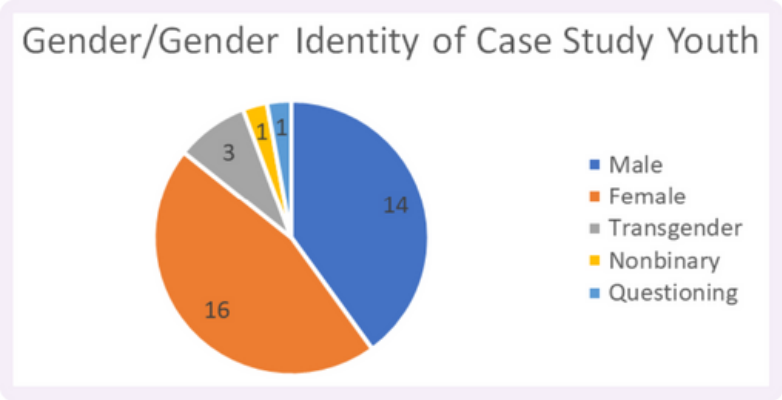
Types of Residences:



Types of Cases:
Program sites vary widely in serving **a mix of Child Requiring Assistance (CRA) and Care & Protection (C&P) cases**, with some serving exclusively one type or another and some serving a mix. Still others have voluntary placements. Across the sites reporting, 39% of their total residents were CRA, 55% of their residents were C&P, and the remaining were voluntary or other types of placement.

4. Youth at a Glance

Demographics:
The ages of youth represented in these "high acuity" case studies ranged from 12 to 20. The average age represented was 15.



Time in Placement:
We asked providers how long the case study youth had been in their care, the total length of time in placement for the case study youth (in any setting) and the total number of placements the case study youth had experienced.

- The range of **length of stay** at the current provider was 1 month to 3+ years. The most common response was 12-18 months.
- The **total length of time in placement** ranged drastically, from under 1 year to 18 years. For several of the youth the total time in placement was unknown to the provider.[4]
- Some sites reported multiple emergency department or hospitalization stays in addition to placement moves. Only standard placement moves were asked for in the survey.

Placement length of stay in out-of-home care has increased by 34.5% over the past five years, reflecting the dearth of available treatment services to support reunification.[5] Think of this in "kid time" – the frustration of long stays in out-of-home care with an unclear resolution contributes to building pressure and trauma that result in youth acting out in dramatic ways.

"Total number [of placements] is unclear; the youth was homeless in Mass. and other states, [and had] several ER placements prior to [arriving at the] group home."

- Regarding male youth, age 16

4. For children who exited DCF care in FY2022, the average total length of stay in placement was 24.8 months. (DCF Annual Report FY2022, Table 19)
5. DCF Annual Report FY2022, Table 19, Average LOS Days for Children Exiting Care by FY End (Average LOS in Months)

Case studies showed that time in care is exacerbating acuity:

"During times of escalation, this youth struggled to self-regulate independently. She became both verbally and physically assaultive to adults, causing staff injury and peers, causing injury and the need for medical treatment…She went missing for several days and sometimes weeks at a time, ending up in other states. During that time, she also engaged in substance use and high-risk sexual behavior. ***This behavior was not present upon intake, but as time in congregate care lengthened, her behaviors regressed, as did her engagement in treatment****. Her substance use was also becoming daily, and she was exposing other youth and encouraging them to leave the program and use substances with her."*

- Regarding female youth, age 15

5. Youth in Crisis - Case Studies

a. Why are youth referred to the congregate care program?

Programs reported some common reasons youth are referred to their sites, with many youth presenting multiple challenges or complex cases. These reasons generally included in order of prevalence:

- General anger management, aggression, defiance, high-risk behavior, or delinquency;
- A victim of domestic violence, commercial sexual exploitation (CSEC), a general trauma history, or lacking a home to which they can safely return;
- A diagnosed mental health or psychiatric disorder, suicide ideation or self-harm, or medication noncompliance;
- Stepping down in preparation to return home, or to independent living.

"[She needs support in] development of independent living skills, maintaining employment, saving money, addressing ongoing mental health needs and [addressing] CSEC concerns."

- Regarding female youth, age 19

"She has a pattern of concerning behaviors that included running from school, and placements, suicide active attempts resulting in hospitalizations, and can be assaultive both verbally and physically."

- Regarding female youth, age 13

"[He] has been abandoned by all of the important family members in his life. He has a history of neglect and physical abuse."

- Regarding male youth, age 13

"[He is stepping down] from inpatient hospitalization and reintegrating back to community with [the] goal of working with mother towards reunification."

- Regarding male youth, age 17

"[Her] complex clinical presentation includes social, emotional, behavioral, and academic disabilities as well as a history of engagement in highly unsafe behavior including self-injurious and assaultive behavior when experiencing heightened levels of dysregulation or agitation."

- Regarding female youth, age 16

b. What does it mean for a youth in care to exhibit “high acuity?”

Youth in care whom we think of as “high acuity” exhibit many different types of behaviors that disrupt their care and that of those around them, threaten the safety of or cause harm to themselves and others, and result in costly damage. As youth dysregulate and act out, incidents escalate to include other youth in the setting and more staff capacity is needed to stabilize. Incidents are rarely isolated; youth whose needs are not being met in the care setting will continue to deteriorate and act out in a downward spiral.

> *"This youth has consistently gone missing from care since the start of intake. She runs to be with different men with whom she has unprotected sex. In the program, she is an alfa [sic] female and bullies other youth to meet her needs or enjoyment... She is very frank about her unwillingness to follow program expectations or participate in provided clinical support."*
>
> - Regarding female youth, age 15

Not only are youth not receiving the treatment they need to stabilize and improve, they put themselves at risk of physical harm and criminal responsibility.

These behaviors that we classify as “high acuity” generally include:

- Threatening, bullying, or assaulting other youth
- Threatening or assaulting staff
- Causing damage to property
- Engaging in sexually risky behavior
- Drug use
- Dismissing medical conditions that require consistent attention from the youth and the staff

> *"Student has engaged in multiple incidents of physically assaulting staff resulting in them being injured ranging from being bit by the student, to concussions from being headbutt [sic] or punched in the face. He has engaged in significant property damage by breaking off the shower spout while using the bathroom, then kicked it through the wall, breaking the pipe."*
>
> - Regarding gender questioning youth, age 13

"The [child's] most common patterns of behaviors were threats to self-harm, suicidal ideation, attempting to bolt from the program, eloping from the program, conflict with other clients, homicidal ideation, aggression, and assaultive behaviors towards staff. The Worcester Police have been contacted on at least five occasions and the child has been hospitalized on a section 12 on two occasions with lengthy stays being boarded in the Emergency Room."

- Regarding nonbinary youth, age 13

"Youth has had numerous seizures while in care that are triggered by stress and require immediate staff response that impacts ratio. Youth does not agree with diagnosis … which has made it challenging to engage her in treatment strategies to mitigate seizures."

- Regarding female youth, age 17

"This youth actively engages in significant property destruction, which he attempts to use as a weapon to assault staff. He has verbalized raping female staff and other clients and has required two psychiatric screenings in the past 30 days. He has run from the program on four occasions and is not engaged in an educational program."

- Regarding male youth, age 13

"Client was found with weapons on multiple occasions; [he] received many criminal charges for threatening and assaulting multiple staff members, [and for] graffiti/vandalism in the community. On one occasion, client waited for the evening shift to leave and broke into supervisor office, grabbed a knife and threatened an overnight staff member."

- Regarding male youth, age not given

c. Incident responses

Providers have limited options for responding to incidents. The most frequently reported next steps taken are:

- Meeting with DCF and updating the service plan for the youth;
- Stepping up oversight and providing 1:1 staffing when possible;
- Removing the youth to the hospital or calling for a crisis referral;
- Calling police, most frequently for helping finding runaway youth;
- Making a referral to another service – many programs reported that referrals were in process or the youth was stuck waiting for the new service to become available.

Programs take all possible measures to address acuity on site within their abilities.

> *"The program developed a personal safety plan at intake, which was immediately made available to all program staff. As child started to exhibit more severe behavioral concerns, further adjustments to the behavioral plan were created in collaboration with the child."*
>
> - Regarding nonbinary youth, age 13

> *"Staff immediately responded to her… This resident was able to work with staff and use the coping skills that she and her case manager had worked on. She has a professional team of DTA, DCF, My Life, My Choice … and case manager. "*
>
> - Regarding female youth, age 20

In the six-month period July 1, 2022- December 31, 2022 providers reported:

- **556 calls to police**, most commonly for either runaway incidents or assault incidents; resulting in only 10 youth taken into police custody. Only 6 of 36 sites (17%) had 0 calls to police.
- **281 incidences** of taking a youth to the emergency department for psych or medical evaluation. Almost all sites had at least one such incident, with a mean average of 8 per site.
- **201+ calls to probation or DYS**, with some sites noting that they report to probation every time a police call is made.

> *"Twice staff had to lock down program to deescalate the situation before it became physical… [in one case] the police department had to be called to program to calm other residents and speak to disruptive resident… staff worked toward referrals for mental health but the waitlist were [sic] lengthy."*
>
> - Regarding female youth, age 20

Many times, responses require referrals and collaboration with other responders and providers, as well as DCF. Unfortunately, these responses tend to focus on short-term stabilization rather than a step toward necessary treatment. These incidents create frustration for all involved when the resolution lands the child right back where they started.

"The program has continually collaborated with DCF, [local] School District, psychiatric prescribers, and community partners to access additional services. The program has consistently stated that this required a higher level of care, such as a residential school to address their treatment needs. The youth would benefit from a program that could provide ALL treatment services on-site. Multiple resolution meetings with DCF were conducted; however, due to funding and acuity issues, the consistent response from DCF was that they had no other placement options for the youth, and he has remained at the group home level of care."

- Regarding transgender youth, age 16

"We have used our local crisis center, and the program has informed us that the presenting behaviors do not meet the crisis screening level."

- Regarding female youth, age 15

"We have communicated needed support to DCF every step of the way regarding our interventions and lack of progress with the youth. However, those meetings produce little success, and the program receives more questions on "what is the program doing to address these behaviors" rather than what DCF can do to support the program with a youth who doesn't want treatment."

- Regarding female youth, age 15

"Police were called to the program, a section was issued, youth remained in [emergency residence] for several days and returned without an intervention. The program advocated for youth to go to a higher level of care (remained in ER but bed was not found). The program advocated for the youth's court date to be moved up, but probation was not able to move the court date. The program was in communication with DCF and Probation throughout the process, and debriefed the incident with the police department regarding how to manage this youth moving forward (arrest vs section)."

- Regarding male youth, age 16

There is no easy fix. Youth with complex needs require high levels of coordinated care. This case example represents a provider's approach to coordinating support for one youth.

> *"[Provider] uses an interdisciplinary approach to meet the youths' complex needs. When this specific youth's behaviors significantly regressed, program staff including the Clinical Director, VP of Residential Services, Education Coordinator, Director of Residential Services, Clinician, Executive Director, and Nurse Manager met to discuss this youths' presenting behaviors and needs. Various interventions were identified, as well as the barriers to this youth's lack of engagement in treatment. Additionally, [Provider] collaborated with outside entities such as DCF, the Child Advocacy Center, [local] Courts, and other collaterals to explore ways to support this youth in maintaining her safety. This also included trying to support the youth in identifying an alternative permanency plan that was more realistic given the youth's family dynamic and her length of time in care. Furthermore, treatment meetings were held frequently, outside of the normal treatment review schedule to maintain ongoing conversations, even outside of time of crisis."*
>
> - Regarding female youth, age 15

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d. The ripple effect of high acuity – impact on other youth in care

The challenge for programs is not in responding to any given youth who is dysregulated on a bad day, or even in the long-term coaching, treatment and support that they are designed to provide. Their challenge is balancing treatment of all youth in a group setting where one "high acuity" youth can significantly and repeatedly disrupt the entire milieu, and cause physical and emotional harm to others.

Programs consistently reported these effects on other youth in the setting:

- Feeling fear;
- Being upset, triggered, or traumatized;
- Being co-opted into the same behavior or following the bad example;
- Feeling concern or worried for the youth in crisis;
- Disruption of the daily routine;
- Disruption of the therapeutic milieu.

Consider that some youth are removed from their homes into DCF care because of violence or trauma they are witnessing or experiencing at home.

Is it fair to place them in a group care setting where they witness and experience similar incidents and have the same fears?

"This resident angers and escalates other residents (parents) and also cause[s] trauma to the babies and toddlers in program who often become nervous and cry as a result of the commotion caused by her yelling and swearing."

- Regarding female youth, age 20

"The youth that get targeted are scared and terrified of continuing placement with him. Other youth emulate him and want to be like him."

- Regarding male youth, age 16

"This child has a tendency to significantly disrupt the routine of the milieu. Other clients have expressed frustration due to the increased staff attention required to maintain the safety of this one child."

- Regarding nonbinary youth, age 13

"Due to the ongoing issues surrounding the client absconding from placement, engaging in self-harm, and self-reported suicidal ideation with a plan, he required a lot of 1:1 support from program staff, and this took away from the attention and care the staff were able to provide for the rest of the youth."

- Regarding transgender youth, age 14

"Other youth in the program often get upset due to the level of aggression and some stated that they have trauma and it is affecting them in a negative way."

- Regarding female youth, age 19

d. Effect on staff

Direct care workers play a vital role in maintaining the healing environment, building positive relationships with youth, and carrying out necessary treatment and care. Bringing staff into care situations they were not trained or prepared to manage causes frustration, fear, and rapid disengagement. While the sector must widen the pipeline of committed care workers coming into the field, we must also take care to respect the staff we have in place and ensure they are supported in their ability to do the job safely and effectively.

Unsafe. Afraid. Stressed. Frustrated. Overwhelmed. Powerless. Hopeless.

These are the words used to express how staff feel about "high acuity" youth in their care during episodes of crisis.

"Staff are frustrated as his behavior doesn't change and give up at times on implementing holds if necessary. Some staff are afraid or "don't want to deal with it/don't get paid enough to deal with it" and call out of work. Staff are afraid of acquiring 51As which might put them out of work and/or out of career."

- Regarding male youth, age 16

"When she has a challenging day, her behavioral outbursts can last throughout much of the day. Staff have at times expressed feeling burnt out due to physical and emotional demands managing her, and frustrated with perceived lack of consistent forward progress towards her goals."

- Regarding female youth, age 13

e. What works to resolve incidents?

Providers were asked to share the factors that contribute to successful resolution when a youth experiences high dysregulation or acts out to a level beyond typical for the care setting.

"Partnership with school, courts, DCF and family that wrapped around the youth to manage incidents and continue to give the youth hope for future."

- Regarding male youth, age not given

Some common themes that emerged were:

- Engaging a strong team for case management that included the program, DCF, and other care providers;
- Building on their relationship and collaborating with the youth themself and the youth's family when appropriate;
- Taking a trauma-informed approach;
- Making a timely transition to the appropriate care setting, and/or correcting the medication plan to meet needs;
- Having clear goals for permanency and a pathway to achievement.

"[The child feels] they have staff they can build a trusting relationship with that does not give up on them even though when they struggle the most."

- Regarding female youth, age 14

"A well-rounded treatment team, supportive DCF offices, collaboration, and willingness to be flexible. [Things work] when the treatment team comes together and advocates for what the youth needs and is responsive within a timely manner."

- Regarding female youth, age 12

6. Recommendations for System Improvement

These case studies highlighted some common themes for policy and practice improvements to the systems of referrals and case management, as well as a call for examining the available care settings to determine where gaps exist for matching the level of care to each youth's needs. Youth we think of as "high acuity" may be fundamentally mismatched to where they are placed, yet we presently offer no better alternative for them.

It is time to re-examine our system of care and ensure it has spaces and staffing for the variety of care needs exhibited by youth, especially those with heighted trauma; mental health, behavioral health, or medically based needs; and developmental support needs.

Equally important is ensuring that children don't regress because of their time spent "in the system." Young people experience time much more slowly than adults; every day spent waiting feels like an eternity in "kid time" and those who are ready to discharge to a lower level of care but have nowhere to go quickly lose hope and begin to decompensate. Clear progress and timely resolution of cases is critical to giving youth a sense of hope and optimism that prevents them from spiraling to more intensive negative behavior.

> *"[We need] more intensive care/youth stabilization options… [with lower] staff to client ratios, more secure setting, and a robust, multidisciplinary team of passionate, qualified professionals. "*
>
> - A provider

CLM and our providers offer these recommendations for more effectively meeting the needs of youth in congregate care.

a. Commit to the relationship-building necessary to make thoughtful placement decisions.

CLM frequently hears that between pandemic isolation and significant staff turnover in recent years, the working relationships between DCF and community providers has deteriorated, making effective collaboration more challenging. DCF must recommit to the work of building local relationships with provider agencies and their staff in order to know intimately the variety of site and care options available in their area, and to have consistently open lines of dialogue for placing each individual child in the setting best equipped to serve them.

"Eliminat[ing] regional placements [would allow] for relationships to be built with providers and DCF offices. The regional model [operates with] minimal relationships and [causes] programs to be over-filled with more acute placements which the department has identified as being the most secure. The increase in relationships with offices will decrease the number of acute placements and departments knowing who they are placing and the impact that has on providers programming. "

- A provider

"Frequently [DCF] need[s] a bed … and when the provider tries to explain that the referred youth may be a bad match, it is often met with frustration and they are told they have to take that youth or they will get someone even more difficult."

- A provider

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b. Improve transparency, completeness, and collaboration between DCF and providers when making referrals in order to set programs and youth up for success.

Referrals must include comprehensive and thorough information about the child's needs and treatment plan. Transparency is critical to ensuring that providers know what to expect when a child is placed with them, and how to best meet their needs. Relationships between DCF and providers must foster honest conversation about behavioral challenges. Providers need complete information and the necessary time to evaluate the placement in order to be set up for success.

"[We need] honest and accurate referrals. The need is so high for kids to be placed in care, but it feels like sometimes there is not always accurate reporting, or a full history is not gathered. We as residential [providers] understand that the kids are going to have behaviors (some that seem scarier than others), but if we are not receiving full transparency in the referral process, it can have a major impact on the referred youth, as well as the other youth in treatment. When we are aware of their needs, we can more accurately prepare for intake and treatment right from the start, or make a decision that our current milieu might just not be the best fit for that client or the others to safely access treatment."

- A provider

"For any youth that has demonstrated disruptive behaviors in a prior placement a referral meeting would be beneficial, and when possible, involving the prior placement in that meeting. This would allow for an exchange of information, including what interventions work well for the youth."

- A provider

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c. Foster opportunities for local system-building that bring together all agencies and providers who contribute to youth care in a community.

Provider residential and treatment centers don't operate in a vacuum. Stabilizing and treating youth often require response and intervention from multiple actors in a community. DCF should take the lead in ensuring that these local system players have opportunities to plan, collaborate, share resources, and build trusted relationships outside of times of crisis, so they are ready to work together when the need arises.

"[We need] a system to regularly interface, problem solve and collaborate with the local police and emergency services. More than ever congregate care facilities are forced to use these services to support our youth and staff. These relationships can take many shapes and sizes. Some positive, and unfortunately, some that are not. We need a conduit to bring these groups together to share resources, information and interventions collaboratively."

-- A provider

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d. Stand up more robust and secure care settings that meet the needs of higher intensity youth who don't fit the standard congregate care model.

A top recommendation from providers was to have programs deliberately designed for youth with greater needs that would allow for more intensive individualized treatment to occur.

"I would like to see smaller programs … to provide more specialized care that have full time clinicians available assist with mental health and clinical work. These youth need regular therapeutic sessions to excel and thrive."

- A provider

These settings would have smaller ratios of staff to clients or 1:1 staffing, a smaller overall census, specialized staff, better training for dealing with aggressive youth, spaces that allow respite for youth and reduce distractions or triggers from the environment, and more secure facilities or strategies to prevent youth from running and engaging in high-risk or criminal behavior and self-harm.

"An increase in substance abuse settings which are currently scarce and require youth to be willing and on board to be placed and require them to work on their substance misuse."

- A provider

"While being mindful of the juvenile justice system and the long-term impact youth incarceration can have on recidivism, I believe that the reinstatement of the DYS's least-restrictive setting should be considered. Diversion from the legal system is always preferred, however, an emergency residence is not always the most appropriate setting for those clients who are aggressive and have the patterns of delinquent behaviors."

- A provider

Having more levels and smaller steps down between care settings would help match to a youth's needs rather than risk placement into a setting they are not ready for, and where they would be highly disruptive to the treatment of other youth.

These settings would have smaller ratios or 1:1 staffing, smaller overall census, better training for dealing with aggressive youth, spaces that allow respite for youth and reduce distractions or triggers from the environment, and possibly more secure facilities to prevent running and self-harm.

"While being mindful of the juvenile justice system and the long-term impact youth incarceration can have on recidivism, I believe that the reinstatement of the DYS's least-restrictive setting should be considered. Diversion from the legal system is always preferred, however, an emergency residence is not always the most appropriate setting for those clients who are aggressive and have the patterns of delinquent behaviors."

- A provider

"An increase in substance abuse settings which are currently scarce and require youth to be willing and on board to be placed and require them to work on their substance misuse."

- A provider

e. Stand up more options for older youth who are getting ready to age out of DCF but need significant and deliberate support to either independent living or adult treatment services.

Across Massachusetts, over 2,700 youth age 18-22 annually receive voluntary services from DCF as they exit state care without permanency and prepare for life as independent adults.[6] Though they are exiting state care, they leave with ongoing needs for a successful transition to independent living, including adult behavioral and developmental services, parenting support, access to education and employment, and the infinite array of assistance that parents give to a young person who is reaching adulthood. Our survey found that the residential programs for these youth provide a vital service but that youth with higher needs require much more support and structure to make this transition successfully.

"Many of the inappropriate referrals that we get are from youth that are out of school or about to graduate and need a congregate care setting but are way too high risk to be in a community-based group home."

- A provider

"CBAT programs are great for latency age and minors, however I think there needs to be something similar for 18-22 year old's who are being 'forced' out of intensive group homes or res-ed programs due to their age. While they may be 18, there should be an intermediate step to get the resident accustomed to more freedom and responsibility."

- A provider

f. Continue investing in solutions that reduce child removal and reliance on congregate care for children and families with lower-level needs.

Massachusetts, like many states, is working to bolster options for care and treatment that reduce the overall need for out-of-home placement and congregate care. These efforts not only keep families intact and reduce the trauma of DCF involvement, they preserve congregate care spaces for youth who are best served in those settings.

6. DCF Annual Report FY2022, Table 37

For youth who must be removed from home, the most supportive placement setting is a **foster home,** preferably of kin or fictive kin. In these settings youth get individualized attention, love, and support. In FY2022, 39% of all placed children were in kinship care, a percentage that is steadily growing.[7] We must double down on efforts to recruit, support, and retain foster homes in the community, especially those willing to take youth with complex needs, and kinship homes of many types.

Prevention services, in-home counseling, and outpatient therapies for both youth and adults keep children from being removed from their home or allow those who are temporarily removed to return home quickly. These solutions require investments in the resources that help struggling families and prevent child abuse and neglect such as: public benefits that reduce poverty, Family Resource Centers that help parents get help for their children without court intervention, substance use disorder treatment for youth and adults, and targeted mental and behavioral health services for youth.

7. DCF Annual Report FY2022, Table 16

7. Conclusion

The work of serving youth in crisis is not easy. The reasons for placement and needs of children are as individualized as the children themselves. With an overall reduction in available beds, our child welfare system has too often been forced to place youth in settings that are not designed to meet their needs, especially those with high needs. A dysregulated child doesn't just affect him or herself and the staff who respond, but also the other youth in the home who are themselves are trying to maintain a path to healing.

We cannot accept that "high acuity youth" are just a fact of the system. How do we create settings that ensure individual youth needs are met and staff are set up for success?

We must commit to maintaining strong relationships and robust communication among the adults who make these decisions and are responsible for serving the needs of the youth for whom the state has assumed responsibility.

We must become more nimble in standing up and staffing the kinds of spaces that are responsive to the needs and challenges of high acuity youth and create small increments for stepping up and down through care.

We must acknowledge the staffing needed to provide higher levels of care, continue efforts to grow this workforce, and support the people who have committed to doing this hard work every day.

We must flood youth with the resources they need to "graduate" from our care to a stable and successful adulthood.

And we must be relentless in helping families get the support and resources they need to keep youth at home or with kin, to reduce our overall reliance on congregate care for all but the most vulnerable children.

We must ensure that every youth in our care has a place where they are safe, supported, and on a path to healing.

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CHILDREN'S LEAGUE OF MASSACHUSETTS

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