DEFINING GROUP CARE PROGRAMS: AN INDEX OF REPORTING STANDARDS

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Defining Group Care Programs: An Index of Reporting Standards

Group care programs for youth in child welfare, mental health, and juvenile services share common features but are nearly endlessly varied. Some are more than 100 years old, some sit on 100 acre campuses, and some have more than 1000 residents. In contrast, some have opened this year, are community based on a sixteenth of an acre or in an apartment complex, and have fewer than 10 residents. More fundamentally, perhaps these programs have differences that are just as large—although harder to measure—in the way that they implement their programs. Despite this enormous variability, the nomenclature for the entire field varies and the terms "group care", "residential programs", and "treatment facilities" are often used interchangeably to describe settings that provide 24-hour care for youth in peer groups.

Although there are some fundamental commonalities across group care programs, the differences in program characteristics and service settings are often not adequately delineated in considering the role and effectiveness of group care. By aggregating variant programs under the single umbrella of group or residential care, some of these differences in service delivery and program structure are lost. The result can be a loss of differentiation between group care programs that have specific benefits to offer to youth and the tendency to conclude that all group care is useless or worse. However, these differences must be understood to build knowledge about group care effectiveness and to determine how to use and transform the massive national investment in group care for the greatest good. The purpose of this paper is to identify and describe the relevant characteristics that should be reported to understand individual group care programs and improve the likelihood that programs with the most likelihood of providing benefit to youth can be identified.

BACKGROUND

Importance of Differentiating Group Care Programs

To paraphrase James Whittaker (personal communication, 2006), two group care programs may be as different as two European countries (prior to the EU) with different rules, different populations, different cultures, economy and (program) language. Yet much of the research, policy and commentary related to group care services ignore these differences and

broadly presents residential settings as homogenous. For example, the GAO's (2007) report on *Residential treatment programs: Concerns regarding abuse and death in certain programs for troubled youth*, refers to the specific programs reviewed as residential treatment programs; however, the boarding schools, wilderness therapy programs, and boot camps where these abuses occurred were all underregulated private (often for-profit) facilities most commonly used by parents who are hoping to help their wayward children—a slice of group care programs that have little in common with the types of facilities more commonly used and licensed by child welfare services.

Although some good evidence supports the finding that shelter care-based assessment centers for young children have less favorable outcomes than standard foster care used for emergency shelter (DeSena et al., 2005) this should not be overgeneralized to all group care (cf. Barth, 2005). Unfortunately, many of the influential studies that have found that group care underperforms foster care or treatment foster care (e.g., Chamberlain & Reid, 1998; Chamberlain, Leve& DeGarmo, 2007; Ryan, Marshall, Herz & Hernandez, 2008) do not provide much detail on the characteristics of the group care. This practice of generalizing across distinct treatment programs has muddied the science of research endeavoring to determine the relative value of group care and other forms of child and family services.

From a research perspective, drawing conclusions across research findings from diverse program models and types is problematic. Just as "in-home" services like wrap around and multi-systemic therapy have some overlapping elements but are not the same—and may have quite different results (Stambaugh et al., 2007)—the same is likely to be true for group care. Although the research that indicates, in general terms, that "group care" appears to offer no additional overall benefit for the average youth (see, e.g., Barth et al., 2007; Chamberlain & Reid, 1998; Ryan, Marshall, Herz & Hernandez, 2008), this finding has to be tempered by evidence that some group care has better results on some dimensions than does treatment foster care (Lee & Thompson, 2008). Studies of multiple sites that explore cross-site effects have found differences in outcomes (Lyons, Terry, Martinovich, Peterson & Bouska, 2001). By being too quick to generalize across programs with different intervention components and goals, the field loses the opportunity to determine which forms of group care are likely to have benefit in achieving what goals with what youth.

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Earlier Efforts to Differentiate Group Care

Recent attempts to better define group care programs have provided some foundation for this effort. Butler and McPherson (2007) asserted that the minimal evidence for, and declining acceptance of, group care interventions are due in part to a lack of clarity about what is being provided by group care. They argue for the importance of a definition that specifies the essential characteristics of residential treatment as an intervention unique from other family care settings.

From their perspective, these components are: "a therapeutic milieu, a multi-disciplinary care team, deliberate client supervision, intense staff supervision and training, and consistent clinical and administrative oversight" (p. 469). Labeling all programs who meet the above criteria proposed by Butler and McPherson (2007) as residential treatment would, however, still result in a very diverse group of programs and provide little differentiation between group care settings.

In response to Butler and McPherson's effort, Lee (2008) argued for additional dimensions to improve the classification among group care programs. Rather than differentiating residential settings from other out-of-home placements, Lee emphasized the importance of recognizing the heterogeneity within residential group care programs. She demonstrated how various group care settings could meet the criteria of having all the components suggested by Butler and McPherson (2007) and yet still be very different from each other. To elucidate some of these differences, additional dimensions were proposed, including a description of the target population, length of stay, and level of restrictiveness.

On a national level, the Child Welfare League of America has also weighed in on this effort. In their manual on *Standards of Excellence for Residential Services* (2004), CWLA began with a broad definition of residential settings which included not only group homes and residential treatment, but also supervised apartments, emergency shelter, and short-term diagnostic care. In describing the important attributes that differentiate types of residential programs, CWLA (2004) named seven "distinguishing characteristics": admission criteria, service provided, duration, desired outcomes, required staff constellation and staff ratios, staff qualifications and staff responsibilities. The types of residential settings are presented with details about these distinguishing characteristics.

Despite these attempts to define or describe group care programs, a comprehensive set of reporting standards to describe differences in residential programs has not yet been adopted. While empirical articles about group care interventions often include a table and narrative describing the sample of youth (demographic characteristics, placement history, and diagnostic labels), no more than a sentence or two typically describes the group care program that the youth received. The development of intervention manuals— a common characteristic of many mental health treatments in the last decade (Chorpita & Daleiden, 2009))--has not become the norm in group care. Generally, all the program information that is provided is the geographic location, program size, and duration of service. Some overall descriptors of the intervention like "positive peer culture approach" (Eddy & Chamberlain, 2000), "structured behavior modification" (Peterson & Scanlan, 2002) and "delivery of therapeutic services" (Chamberlain, Leve & DeGarmo, 2007) are not very informative. In an effort to understand the differences between residential treatment programs in Colorado, Libby and colleagues (2005) gathered program descriptions from a range of residential treatment and found that the basic daily schedule was often very similar even though the program philosophy, population of children, or approach was often identified as different or unique. Because of the minimal program details provided in group

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care studies, there are many basic group care questions that have not been answered: for example, how many youth are served in what types of group care programs or how similar or different programs are within service systems or geographic areas.

Reporting group care program characteristics in a standardized and comprehensive way would allow a more nuanced understanding of group care practice and effectiveness to emerge. Being able to investigate relationships between program models, structural and process features, and youth populations served with program outcomes would build meaningful knowledge for the field. Improvements in measurement of group care program features would increase the value of studies based on observation and/or existing data. In lieu of randomized trials or sophisticated analysis controlling for relevant group differences (some of which may be unavailable to researchers), quasi-experimental studies of non-equivalent groups using comprehensive measures of program characteristics can begin to identify the most important elements of group care practice.

One approach to estimating the likely effectiveness of a program is to match components of group care interventions to knowledge from other sources about the common elements of *effective* interventions. This "common elements" approach originated within child mental health services (Chorpita , Daleiden, & Weisz, 2005). These common elements were identified through reviewing empirical studies of effective interventions and noting the specific practices that are common across treatments with positive outcomes. Although the exact dose and order of these common elements may vary, there is evidence that this variation does not change the outcomes achieved. By focusing on common elements, the level of analysis of evidence-based practice moved from selecting between treatment manuals to selecting the actual treatment components within evidence-supported interventions (Chorpita & Daleiden, 2009).

Using recent empirical studies of group care, common elements of programs with positive outcomes can be identified. Lee, Bright, Svoboda, Fakunmoju and Barth (in press) identified 19 two-group outcomes studies that compared group care to an alternative intervention or compared one group care model to another group care model. The review included only two-group outcomes studies so the effects of a group care placement could be compared to an alternative service, which is a stronger research design than the more commonly published single group studies. Overall results suggested the most positive effects for family-centered group care models (Landsman et al., 2001), Teaching-Family group care (Lee & Thompson, 2008; Thompson et al., 1996) and multi-dimensional treatment foster care (MTFC; Chamberlain, Leve & DeGarmo, 2007; Chamberlain & Reid, 1998).

Following in the tradition of the common elements approach, the practice components that are emphasized in these more effective group care models can be extracted. In the family-centered group care model (Landsman et al., 2001), visits with family both at the program and in the family home were encouraged as were family therapy sessions. The importance of working with biological family is also included in MTFC. Hence, opportunities for family involvement seem a relevant practice component for effective group care. In the Teaching-Family model, some of the unique practice tenets are family-style living (small groups of youth living in a large family-size dwelling with a live-in married couple), structured motivation system with positive

reinforcement (Chamberlain et al., 2008; Friman et al., 1997), social skills instruction, and individualized levels of restrictiveness based on youth needs. Although MTFC is a foster care model in which youth are placed individually in a home with specially trained foster parents, the performance of MTFC in achieving positive outcomes that exceeded positive peer culture group care programs merits a closer look. The key features of MTFC have been identified as limited exposure to deviant peers, close adult supervision/monitoring, limit setting, positive reinforcement, skills training, and individual and family therapy. By being placed in a treatment foster family setting, family-style living is also implicit in this model. Putting this all together, the common elements across effective out-of-home placement models appear to include the following components: family involvement, family-style living, adult supervision and behavior monitoring, positive reinforcement, limit setting, and social skills training.

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Assuming that these ingredients do contribute to promoting positive outcomes, group care programs that contain them should be expected to outperform those that do not. Yet, descriptions of group care programs rarely contain information about the presence of these elements, and fidelity to them. There may be additional components not yet identified that are also important in promoting positive outcomes. Consistent standards for reporting and describing group care programs are needed so that efforts to determine common elements that are in effective programs can be further refined. This paper introduces a model for reporting group care program characteristics that can provide a basis for understanding which group care program elements are likely to be most gainful.

A REPORTING STANDARDS MODEL

This research effort began with the intention to develop a classification system or typology of group care programs. However, after some initial exploration, significant knowledge gaps became apparent. No available information can identify the universe of current group care programs, the prevalence of program types, and variation across programs. Before it is possible to classify group care program types, more information is needed about current group care practice variation.

Reporting standards may be a method that promotes consistent and comprehensive information to aid interpretation of an intervention's merit. In 2001, the CONSORT (Consolidated Standards of Reporting Trials) Group presented a statement and checklist to improve the adequacy of reporting randomized clinical trials (Moher, Schulz, & Altman, 2001). The goals of

these reporting standards included producing research results that have less bias, less error, and more useful information to support ethical standards of research. The use of reporting standards can also help generate objective information about group care.

The reporting standards checklist contains 22 items to include with any findings from a randomized trial. These items range from specifying the settings and locations where data were collected to declaring any adverse events or side effects for any participants. A key element of the checklist calls for the reporting of "Precise details of the interventions intended for each group and how and when they were actually administered "(Altman et al., 2001, p. 665). Since CONSORT has been launched and adopted by several leading medical journals, the overall quality of reporting clinical trial findings has improved (Han et al., 2008).

The impact of CONSORT in the reporting conventions for clinical trials highlights the potential benefit of reporting standards for group care. In considering what gaps must be filled to better describe the results of group care (whether or not the study is a randomized clinical trial), and to articulate meaningful differences, *group care reporting standards (GCRS)* must be developed. The *GCRS* provided in this paper will follow the format of the CONSORT statement, by providing a description for each item.

To identify the characteristics that may be important to report for describing and differentiating programs, several methods were used. Initially, a review of the literature was conducted to assess what group care program features had been compared in empirical studies or been presented in conceptual models or frameworks. Practice wisdom from the authors informed this initial list. Next, an expert panel of group care scholars was convened to review these distinctions. These eleven national leaders in group care research and practice offered further input and refinement on the characteristics identified.

PROPOSED GROUP CARE REPORTING STANDARDS

The table below presents the elements suggested for inclusion in group care reporting standards. The columns display the group care element, its definition, and some possible category options, where appropriate. Several of the elements in the CONSORT statement correspond directly to elements that should be reported about group care programs. These parallel components will be presented first. Following the CONSORT counterparts, items unique to group care reporting will be described.

Participants (CONSORT item 3). Description: "Eligibility criteria for participants and the settinas and location where the data were collected."

In relation to group care, the participant component from the CONSORT statement includes several elements--the size of the population served, the characteristics of the population, and the setting and location. Although group care programs can be described without reference

to the population of children (i.e., the participants) who receive services, the impact of group care cannot be understood without factoring in the characteristics of the youth served.

Size. The overall number of youth served in a program as well as the number of peers with whom an individual youth resides may influence the group care experience. The program's size is related to the program model but some program models are more scalable than others.

Population. Several characteristics of the youth served in the group care setting may influence quality and performance. While many studies describe the age, gender, and race of youth served in the program, the clinical needs as well as the involvement or status in public systems may also be relevant. Whether the population is relatively homogeneous or heterogeneous is relevant. Concerns have been raised about the practice of co-housing youth from different public systems in the same group care unit; however, little research is available on the frequency or impact of this practice. In addition, some programs serve only local youth, while other programs accept nationwide and even international referrals. Group care programs are often relied on to serve youth who run away from home or other programs—information about the runaway histories of the population served is important. Because a youth's connection to their home community may be a factor for reunification, distance from a youth's local community may also be important to consider.

Setting and Location. The community surrounding a group care program may impact the youth's experiences in the setting. Being in a group home located in a residential neighborhood is likely a different experience than living on a group care campus in a more remote geographic location. Both the geographic density of the surrounding community as well as the location of the program within a community should be identified.

Intervention Description (CONSORT item 4): "Precise details of the intervention intended for each group and how and when they were collected." In the elaboration document, CONSORT authors add that the number, training and experience of interventionists may also be critical to specify (Altman et al., 2001).

For group care programs, the intervention components involve labeling the program model, describing the program activities, and specifying the staff characteristics.

Program Model. There are several prominent program models used in group care settings (e.g., Teaching Family Model, Positive Peer Culture). While some of these program models have empirical support in their development or effectiveness (e.g., Teaching Family [Fixsen & Blasé, 2002]), anecdotal evidence from group care researcher Elizabeth Farmer suggests that some group care programs operate without an identifiable program model (Farmer, 2010), confirming earlier work by Libby et al. (2005).

Program Activities The activities within a program or the availability of specific program offerings should be known in order to better understand the group care intervention. Some of these activities, like family involvement, have empirical support for their relationship with positive youth outcomes from group care (Landsman, Groza, Tyler, & Malone, 2001; Stage, 1999). Research from treatment foster care also shows that the benefit for recipients is mediated by the proportion of interactions with residents that include positive reinforcement vs. negative reinforcement or punishment (Chamberlain et al., 2008, PREVENTION SCIENCE).

Educational Program. Most youth placed in group care are mandated to receive school services. The schooling options for youth in group care vary from attending a local public school to attending an on-grounds school populated only by group care youth. For some group care programs, the adequacy of educational opportunities are concerning (Parrish et al., 2001) while other programs have a central focus on education (Lee & Barth, 2009). The auspices of the school and its accreditation may be indicators of school quality.

Family Involvement. Because most youth in the child welfare system reunify with their family of origin eventually, maintaining connections with family is an important program activity. Opportunities for family involvement may include visits, therapy sessions, and family events within the program.

Mental Health Services. Youth behavior problems is a common reason for placement in group care (Courtney, 1998). Despite the high rate of mental health need in group care settings, access to mental health services is not guaranteed (Burns et al., 2004). The type of services available, the level of individualized treatment, and the credentials of providers may all provide clues to the program's ability to treat youth with mental health needs.

Vocational Services. In addition to traditional academic programs, access to vocational training can represent another opportunity to build youth assets and prepare youth for future success in employment.

Recreational activities. In addition to providing age-appropriate outlets for youth energy and creativity, activities like sports teams, drama, choir, and visual arts provide additional venues for building pro-social values. Belonging to a team or playing a musical instrument allows youth normative experiences that build pride. The variety and availability of recreational activities within the group care setting or surrounding community should be reported.

Staffing. Some research suggests that staffing models-- at least live-in staff compared to rotating shift staff—affects a youth's experience in group care (Jones, Landsverk & Roberts, 2007). Live-in family staff may provide a more family-like environment that more closely approximates foster care than programs that rely on staff changes every eight hours. In addition to staffing models, staff qualifications, selection, training, supervision,

and retention are important components of program quality and appear related to child-level outcomes (Schoenwald, Sheidow, & Chapman, 2009).

Systems Influences. Issues like funding, licensing, and accreditation inform the level of oversight or accountability for a program. The sources, adequacy and flexibility of the financial supports for the program may affect the program's quality. Programs with a robust endowment or high reliance on private donors face different operating challenges than programs solely funded by public dollars. While most group care programs must be licensed, the licensing body may be relevant to understanding program operations. Some group care programs are licensed only as schools, with no additional oversight for the residential components. Accreditation is a further measure of oversight.

Restrictiveness. Some youth in group care settings are in locked units, other programs are gated, and still other programs have rules rather than structures that set the level of restrictiveness. While the ROLES (Restrictiveness of Living Environment Scale; Hawkins, Almeida, Fabry & Reitz, 1992) has long been the reporting standard of choice used to identify a program's level of restrictiveness, the enhanced measure of restrictiveness, the REM-Y (Restrictiveness of Environment Measure- Youth; Rauktis et al., 2009) assesses restrictiveness as a multi-dimensional construct by evaluating limits imposed on movement, activities and other freedoms. Even if the REM-Y is not completed, the description of the intervention should clarify the position of the program on some of these dimensions.

Outcomes (CONSORT item 6): "Clearly defined primary and secondary outcome measurement…"

Outcomes. The goals of a group care program may differ widely across programs in a single county or even agency. Some programs like shelter care are intentionally short-term and focused primarily on providing emergency housing, with safe and short term provision being the outcome of concern. Other programs may have a more definite treatment focus with outcomes evaluated with a measure of behavioral health. Although all child welfare programs are expected to have a salubrious effect on the achievement of safety, permanency, and well-being (for these there are corresponding federal child welfare outcome indicators) the specific objectives of a group care program should be identified so that program performance can be fairly assessed with regard to the specific focus of the service.

CONCLUSIONS

Group care programs are typically treated as if they were indistinguishable, resulting in overgeneralizations that have stymied the development of group care practice. To build a more nuanced and valid understanding of the variation in group care practice and how that variation

might be associated with variation in the achievement of child welfare, mental health, and juvenile service program goals. This paper proposed reporting standards for describing group care programs so that the relationship between these program characteristics and youth outcomes can be used to guide service evaluation and development. The expert panel of group care scholars also vetted the initial model and supported the importance of this contribution.

Implications for stakeholder groups

There are several potential uses for the group care reporting standards. **State systems who contract with group care providers** would benefit from cataloguing these features of each program with whom they work. Including this index of program descriptors in state management information systems along with other vendor information would enrich the state's knowledge of the variability among their portfolio of group care providers. Gaps in service provision could be more easily identified; for example, there may be no short-term treatment programs with family involvement activities or too many shelter settings in a single urban area. Secondary data analysis of these administrative data systems would be greatly enriched by these additional program characteristics. At the current time federal AFCARS reporting requirements do not require states to distinguish group care placement any more narrowly than classifying between two congregate care settings: group home or institutions. Certainly some of the reporting standards suggested above, if incorporated into AFCARS, could provide greater refinement to the understanding of national trends in group care services.

Currently, there is little knowledge about which youth would benefit most from which program types. Solving this problem requires knowing about youth characteristics, program characteristics, and program outcomes. Risk-adjustment techniques are being used (McMillen, Lee, & Jonson-Reid, 2008; Raghavan, 2009) to identify underperforming and above average programs by accounting for child characteristics at intake and examining program outcomes. The utility of the method is limited, however, by the lack of information about program characteristics which hampers the contextual interpretation of risk-adjusted results. For example, risk-adjustment can identify which group care facility has the fewest runaway incidents, but the program with the fewest runaway incidents may also be the only locked or secure program, which would be important to recognize to better understand this finding. Additional characteristics about group care programs can be used to "drill down" and identify the program features that are associated with delivery of positive outcomes.

Without such descriptions, it is not possible to generalize across programs or states based on program characteristics. If more information is provided about the program models through the use of reporting standards (even a reduced set from those proposed here), this could result in a significant advancement in our understanding of which program models were most associated with positive youth outcomes. Additional program descriptors would provide a greater context for risk-adjusted results and allow a more nuanced understanding of performance. For example, it would be possible to identify program models that are most useful for males or females, for youth who enter care as older adolescents, for youth who have a history of running away, and so on. Risk-adjusted outcomes could guide performance-based contracting and contract renewal decisions.

Another stakeholder group that could benefit from a comprehensive index of group care program characteristics is **licensing and accreditation agencies**. Current licensing and accreditation standards follow a "one size fits all" approach, with little opportunity to customize based on the different populations served or treatment models. Even in states that have differentiated licensing and payment levels the criteria may be arbitrary and not based on a link to outcome research. With additional information about group care program characteristics, more individualized practice standards could be developed. Further, program outcomes and quality measures could be compared across programs that are most similar to each other. This would better calibrate performance measurement efforts.

Group care provider organizations would also benefit from a catalogue of program descriptors. In aggregate, the group care reporting standards can be used to demonstrate the breadth of different programs available to serve youth. Knowledge about individual provider programs can improve referrals and appropriate placements for youth who need group care.

Ultimately, **youth services researchers** would benefit from the richer picture of group care practice. If each group care empirical study included the descriptive information about the group care program specified in the group care reporting standards, increased opportunities to systematically build a more precise knowledge of group care's effectiveness based on research evidence would result. Instead of aggregating results across all group care studies, outcomes for subgroups of similar programs could be compared. Group care program characteristics associated with positive outcomes could be easily identified.

Over time, the amassed group care literature with refined program descriptors could lead to an empirically-driven classification system for group care programs that could replace the catch-all labels used currently. Common patterns of program characteristics could be identified through latent class analysis, in which the most frequent constellations of descriptors cluster together in a distinct class. These classes, or groups of similar programs, could then be labeled more specifically. A predictable result is that group care provision would have a more predictable benefit for youth.

As identified in the background section, the nomenclature around group care is anything but clear. Research suggests there are some programs with concerning practices or lacking in positive therapeutic effects. Group care terminology does not adequately differentiate troubled programs from high quality settings. The initiation of group care reporting standards is an important first step towards classifying programs. Just as the CONSORT statement improved the science of randomized clinical trials, group care reporting standards can enhance what is known about group care practice, quality and performance.

TABLE 1. GROUP CARE REPORTING STANDARDS

Characteristic	Definition	Possible options
Size	Population density of living unit or program	*Number of kids per living unit*: size of youth's immediate peer group *Number of kids total in program:* (if more than one living unit): size of residential operations
Population	A description of what types of youth are served and proximity to home communities	*Agency from which referrals drawn*: CW, JJ, MH, DD, Health, mixed *Geographic limits of referrals:* Within county, within state, national
Setting and Location	The physical setting of the group care program;	*Population density of community:* urban, suburban/small town, rural *Campus setting* (many buildings and living units on contiguous property)vs. *free-standing home* (single living unit in residential neighborhood
Program model	The approach or framework that organizes the interventions and activities within the relevant setting(s)	*Teaching-Family model* (Boys Town): social skills training, family-style living, and self-governance *Positive Peer Culture* (Starr Commonwealth): a strengths-based peer-helping model *Project Re-Ed* (Wright School): skills teaching to promote social and academic competence and family resource home visits on weekends *Sanctuary Model* (Andrus Children's Center): focus on recovery from interpersonal trauma *Milieu*: the events of daily living provide opportunities for growth and change;
Practice Elements	Activities within the program	*Family involvement:* Efforts to incorporate bio or foster family participation in program *Educational/Vocational programming:* Opportunities to promote achievement and practical skills, on-grounds vs. off-grounds school *Mental Health Services:* Provision of individual, group, family counseling, medication

		management, etc. *Recreational programming:* Extramural teams or events to promote pride and program identity
Staffing	*Model:* The structure and scheduling of direct care staff *Selection:* how staff are recruited and hired *Training:* Pre-service and ongoing educational opportunities for staff *Retention:* Efforts to prevent turn-over and ability to maintain stable staffing	*Shift staff*: (staff who work for 8 hour shifts in the program) *Single live in houseparent* (staff who remain with youth for at least 24-hr intervals and "live" under the same roof with youth) *Family staffing*: (staff, which may include their children, live with children over a lengthy period of time (e.g, 5 or 7 day shifts).
Systems Influences	Macro-level forces that provide resources or oversight and accountability to a group care program	*Funding:* sources, flexibility and adequacy of resources *Licensing:* Oversight from a public system (child welfare, juvenile justice, education, mental health) *Accreditation:* Oversight from an external reviewing agency (COA, JCAHO)
Restrictiveness	Standards set in the living environment to meet safety, developmental or therapeutic needs	*ROLES* *REM-Y*
Outcomes	The primary goal of the group care program and the purpose for which youth are placed;	*Treatment:* intensive services for mental health/behavioral need; *Emergency care:* Supervision and safety, primarily short-term; *Education/well-being:* Emphasis on academic services and development of strengths through co-curricular activities; *Permanency:* Focus on finding and cultivating permanent connections for youth

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