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Therapeutic Residential Care for Children and Youth: A Consensus Statement of the International Work Group on Therapeutic Residential Care*

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As of July 2016, the Consensus Statement of the International Work Group on Therapeutic Residential Care has been endorsed by the following associations: the European Scientific Association on Residential and Family Care for Children and Adolescents (EUSARF); the International Association for Outcome-Based Evaluation and Research on Family and Children's Services (IAOBER); the Association of Children's Residential Centers (ACRC) (USA); and the Centre of Excellence for Looked After Children in Scotland (CELCIS).

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Introduction

In many developed countries around the world, "group care" interventions for children and adolescents have come under increasing scrutiny from central government, private philanthropic, and child advocacy agencies desirous of:

(1) achieving better outcomes for vulnerable children and youth;
(2) doing so in closer collaboration with their families and in closer proximity to their home communities and cultures in ways that reduce the potential for abuse while maximizing the use of informal helping resources; and,
(3) with the hope of reducing the high costs often associated with group residential provision.

In some jurisdictions, efforts to reduce residential care resources in the absence of sufficient alternatives to serve high-resource needing youth has had unintended and negative consequences (Ainsworth & Hansen, 2005).[1] Underpinning these many reform efforts has been a widely shared desire to design interventions that are effective and consistent with what is known about avoiding iatrogenic effects such as "deviancy training" and providing multiple opportunities for children to progress to the full limit of their developmental potential wherever they are served. Robbie Gilligan from Trinity College, Dublin has succinctly illuminated the challenges confronting those who seek to identify a place and purpose for high quality therapeutic residential care services in an overall child and family services system (Gilligan, 2014).

Within the U.S., leadership for these efforts has come from the residential field itself, for example, from the Association of Children's Residential Centers (ACRC, 2016), from federal and state government entities such as the Center for Mental Health Services, as well as from a few uniquely positioned, well-endowed private philanthropies. These include singular leadership philanthropies such as the Annie E. Casey Foundation (AECF), which is committed to the task of child welfare reform and more narrowly to the task of "right-sizing congregate care" through a well-designed portfolio of inter-connected strategic initiatives. A distinct and separate national foundation—Casey Family Programs (CFP)—is dedicated to child welfare reform and, in particular, foster care reform. As an example of current work, CFP's recently issued review paper—*Elements of Effective Practice for Children and Youth Served by Therapeutic Residential Care*—prepared by Peter Pecora and Diana English (2016) contains a detailed and nuanced account of both challenges faced by therapeutic residential care and promising solutions.[2]

[1]While the focus of this present effort and the review volume that preceded it (Whittaker, Del Valle, & Holmes, 2014) is on therapeutic residential care (TRC), a specialized form of group care, we view our work as supportive of a much wider effort internationally concerned with the quality of care children receive when, for a variety of reasons, they need to live away from their families. See, for example, The Better Care Network as one example of an attempt to improve the quality of care for children globally: http://www.bettercarenetwork.org/. Also the work of CELCIS on the UN Guidelines on Alternative Care and the publication of Moving Forward in a number of languages - http://www.alternativecareguidelines. org/Home/tabid/2372/language/en-GB/Default.aspx

[2]Both Casey Foundations bring considerable assets to the child welfare policy discussion in the U.S.: each have sizable endowments measured in the billions of dollars as well as large staffs of highly trained professional advocates and analysts. For further information on major AECF and CFP initiatives, please see: Annie E. Casey Foundation, Casey Family Program. See also Association of Children's Residential Centers.

In the UK, Prime Minister David Cameron's recently commissioned[3] review of children's residential homes being conducted by former Barnardo's head, Sir Martin Narey, is due for publication in Summer 2016 and follows similar parliamentary reviews of the role and purpose of residential placements within the wider child welfare system. The current review also follows an update to the inspection regulations and a new framework for the inspection of children's homes across England introduced in 2015 (Ofsted, 2015), and a comprehensive review of the existing evidence base to explore the place of residential care within the child welfare system in England (Hart, La Valle and Holmes, 2015). New programs of children's residential care also feature as part of a Department for Education funded initiative focused on innovation across child welfare in England.[4] These include the introduction of whole home training in children's residential care, RESuLT, developed by the National Implementation Service (Berridge et al., 2016) and a program of interagency support (No Wrong Door) for adolescents using residential homes as hubs to support both youth in out-of-home care and those living with their families (Holmes et al., forthcoming).

In the recent past, Scotland has created an innovative support and analysis structure in the service of enhancing alternative care across a range of care settings, including high quality residential care, fostering and kinship care services—the Centre of Excellence for Looked After Children (CELCIS)—hosted by Strathclyde University (www.celcis.org). Similar efforts to ascertain the needs of a changing children's residential sector are also underway in Spain (Del Valle, Sainero and Bravo, 2014) and Italy (personal communication: Cinzia Canali, 29 May, 2016; Fondazione Zancan, 2008) as well as other European countries. In Spain, the Ministry of Health, Social Services, and Equity ordered the elaboration of Quality Standards of Residential Child Care that were recently published (Del Valle et al., 2013) to improve these programs, particularly those devoted to adolescents with severe behavioral and emotional disorders. Furthermore, the recent modification of the Spanish National Law of Child Protection in 2015 introduced a large chapter regulating the use of "special residential child care" (similar to the international term of "therapeutic residential care"), recognizing the relevance of these programs and the need for a formal regulation.

It is within this context that a group of international experts representing research, policy, service delivery, and families convened recently at the Centre for Child and Family Research, Loughborough University in the UK for a Summit meeting on therapeutic residential care for children and youth

[3]The review of children's residential homes was announced in October 2015; please see Review of Residential Homes.

[4]The Department for Education Children's Social Care Innovation Programme was launched in 2014; see Social Care Innovation Programme. Interim learning from the program has recently been published; see Innovation Programme Interim Learning Report. Individual independent evaluation reports will be published by the Department for Education throughout 2016 and in early 2017.

funded by the Sir Halley Stewart Trust (UK). The focus of our working group (International Work Group for Therapeutic Residential Care) centered on what is known about therapeutic residential care, for example, the current state of model program development and what key questions should inform a priority list for future research. We proceeded from the assumption that within an overall child and family service system, a properly designed, carefully monitored, and well-implemented therapeutic residential component should reside within a suite of intensive family-based and foster family-based interventions to offer choice to service planners as well as to family and youth consumers with high resource needs.[5] Finally, we proceeded with a sense of urgency given that in some countries—the U.S. offering a prime, but not a singular example—a variety of factors including media reports of current and historic abuse within residential settings, lack of consensus on critical ingredients, concerns about attachment, a comparably slim evidence base (James, 2014), concerns about "deviancy training" (the unintentional exposure of youth to negative influences through peer associations), limited family involvement and rising costs had stimulated both legislative and administrative reform efforts that sought to significantly limit the use of residential provision.[6]

No attempt will be made here to summarize the policy initiatives or research behind this declining confidence. The interested reader is directed to our website (https://lboro-trc.org.uk/) set up as an integral part of the Summit to access links to key reports, including many previously cited reports of the Annie E. Casey Foundation, for example, the policy brief on "Rightsizing Congregate Care" (2010) and the recent AECF-commissioned research on congregate care in the U.S. executed by Wulczyn et al. (2015) at the Chapin Hall Center for Children at the University of Chicago. See also the previously cited review by the Casey Family Program on "therapeutic residential care" by Pecora and English (2016). Finally, the recent international review edited by Whittaker, Del Valle, and Holmes (2014) represents a collective effort that included many individual members of the recent Summit and which helps to illuminate the present international context for therapeutic residential care. As but one example, the cross-national research summarized in our review volume, highlights the considerable variations in residential placements of all kinds in developed and transitional economies (Thoburn & Ainsworth, 2014); a finding that presages both the interstate, as

[5]A full listing of participants may be found on the title page of this consensus statement. These included members from 13 countries consisting of England, Netherlands, Norway, Denmark, Germany, Spain, Israel, Scotland, Ireland, Italy, Australia, Canada, and the U.S.

[6]Nonetheless, Thompson and Daly (2014) report on promising results from the Boys Town Family Home Program in the U.S., one of several programs identified by James (2011, 2014) as meeting the test for "promising evidence" when rated against standards utilized by the California Evidence-Based Clearinghouse for Child Welfare. Andreassen (2014) also reports on a model therapeutic residential care program MultifunC developed in Norway and presently being implemented in several Scandinavian countries.

well as intrastate variation in "congregate" placements found by Wulczyn et al. (2015) in their recent study of U.S. placement data. We are thus in agreement that a critical requisite for cross-national comparisons, as well as within country analyses, will be a clearer delineation of the multiple forms that group residential placement takes in different contexts, as well as a more precise understanding of the taxonomy of terms used to identify them: "residential care," "congregate care," "group care," and "therapeutic residential care," "children's homes" and "socio-pedagogical homes" for example.[7]

Defining Therapeutic Residential Care

We believe a necessary first step in identifying the critical elements in therapeutic residential care is arriving at a commonly accepted working definition that both leads us to key principles and exemplary programs, while allowing for diversity of expression to accommodate cultural, philosophical, and historical differences that inform and influence service provision viewed in cross-national context.

We began our Summit discussion with a working definition of "therapeutic residential care" derived from the previously cited recent international review volume (Whittaker, Del Valle, & Holmes, 2014). Building on an earlier attempt at definition (Whittaker, 2005), the volume editors offered the following nominal definition for therapeutic residential care which our Summit group believes offers a useful starting point towards a cross-national definition:

'Therapeutic residential care' involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection to children and youth with identified mental health or behavioral needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources. (Whittaker, Del Valle, & Holmes, 2014, p. 24)

Therapeutic residential care is typically delivered through community-based centers (e.g., children's homes) utilizing community schools, or through campus-based programs which provide on-site school programs. We view therapeutic residential care in either form as a specialized segment of residential or group care services for children, although we consider our principles underpinning TRC as being relevant for all forms of residential child care. While sharing certain common setting characteristics, these

[7]We view therapeutic residential care as nested within the group or residential care portion of what are typically called out-of-home care services for children and adolescents. This sector of care typically includes relative and non-relative foster family care, some of which may be designed to provide treatment as well as basic care. As research by Thoburn and Ainsworth (2014) indicates, countries vary considerably both in the relative proportions of fostering and residential services, as well as the terms used to describe them and the philosophies and practices that inform them.

services vary greatly in treatment philosophies and practices including their purposes and the intensity and duration of interventions provided. We are well aware that discussions of "residential care," or as in the U.S., "congregate care," often lump together many of these services in ways that blur and confuse key distinctions. Hence, while there are a wide variety of group care arrangements in the international service arena, our specific focus in both the review volume and in the Summit discussion that followed, was on those exemplars of therapeutic residential care purposefully designed as complex interventions to meet the needs of high-resource using children and youth.

While participants found the working definition offered a useful framework for organizing discussion, we in no sense viewed it as being confined to a single model of "therapeutic residential care" (TRC), any more than the term non-residential "family-based intervention" is aligned with a single approach: for example, Multi-Systemic Therapy (MST) or Multi-Dimensional Treatment Foster Care (MTFC). We anticipate that commonly shared principles of therapeutic residential care, and even innovative and promising program models and practices, may result in different expressions of service in differing cultural and political contexts. We view these differences as an opportunity to learn how culture and experience shape service responses and thus as an added reason to pursue cross-national research in the delivery and implementation of TRC and related child and family services (Berridge et al., 2011; Berridge, Biehal, & Henry., 2012; Grupper, 2013).

Simply put, we view the definition as a step in the direction of establishing a common language for therapeutic residential care, as it provides a place at the table for policy discussion and ensures that it will be utterly consistent with what are thought to be principles of progressive child welfare and mental health practice as well as exemplary child development. In the U.S., for example, these would include but not be limited to what are known as "Systems of Care Principles"[8] from the federal Center for Mental Health Services. Moreover, a more precise definition of therapeutic residential care begins to move us away from the unintended connotation of terms like "congregate care" which both tend to mask important program differences by lumping together programs that might be quite different when attempting

[8]The core values of the "systems of care" philosophy specify that systems of care are:

- Family-driven and youth-guided with the strengths and needs of the child and family determining the types and mix of services and supports provided.
- Community-based with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.

Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care. (http://www.tapartnership.org/ SOC/SOCvalues.php). A related initiative from the Center for Mental Health Services and many community partners is BUILDING BRIDGES: a national initiative working to identify and promote practice and policy that will create strong and closely coordinated partnerships and collaborations between families, youth, community—and residentially—based treatment and service providers, advocates, and policymakers to ensure that comprehensive mental health services and supports are available to improve the lives of young people and their families http://www.buildingbridges4youth.org/index.html. See also Blau, G.M, Caldwell, B., and Lieberman, R.E. (Eds.) (2014).

survey research. "Congregate" also harks back to the 19th century shift from large, barracks-like congregate institutions to a cottage model of care and, thus generally, reinforces a narrative of negativity for residential intervention of any type. In practice and in description, we think "congregate" offers a poor and misleading descriptor for what quality therapeutic residential care has to offer.

Principles of Therapeutic Residential Care

The Summit work group was strong in its recommendation that therapeutic residential care in any of its particular expressions is defined not simply by a completed check-list of certain attributes or strategies, but instead builds on a solid foundation of shared values of which the following principles are illustrative:

(1) **We are acutely mindful that the first principle undergirding therapeutic residential care must be "primum non nocere": to first, do no harm. Thus, our strong consensus is that "Safety First" be the guiding principle in the design and implementation of all TRC programs**.
Given the prevalence of historical and present abuse in group care settings in many countries, our work group was unanimous in designating child safety as "primus inter pares" among the building blocks of high-quality therapeutic residential care. While many components including staff screening, monitoring, detailed procedures for detection and reporting, listening to and hearing children and youth, along with community involvement are essential in realizing this first principle, we believe that a well-designed, growth-oriented, carefully implemented, and continuously evaluated program design is central to both prevention of abuse and "deviancy training" in therapeutic residential care.

(2) **Our vision of therapeutic residential care is integrally linked with the spirit of partnership between the families we seek to serve and our total staff complement—whether as social pedagogues, child or youth care workers, family teachers, or mental health professionals. Thus a hallmark of TRC programs—in whatever particular cultural expression they assume—is to strive constantly to forge and maintain strong and vital family linkages**.
Small, Bellonci, and Ramsey (2014: 157) identify three central foci for family-centered practice in therapeutic residential care:

- Preserve and, whenever possible, strengthen connections between the young person in care and his or her extended family, most broadly defined;

- facilitate and actively support full participation of family members in the daily life of the program; and,
- promote shared responsibility for outcomes, shared decision-making, and active partnership between family members and all helpers.

While there are many innovative particulars of family engagement, the work group was clear on intent: effective and humane therapeutic residential care is best seen as a support to families who are struggling, rather than as a substitute for families who have failed (Geurts, Boddy, Noom, & Knorth, 2012). We believe the multiple and creative ways in which partnerships with families are being given expression in TRC make visible and salient the oft-quoted mantra of the family support movement—"nothing about us without us." As the essence of our first principle conveys, safety first remains the highest priority for all concerned.

(3) **Our view of therapeutic residential care is one in which services are fully anchored in the communities, cultures, and web of social relationships that define and inform the children and families we serve. We view TRC programs not as isolated and self-contained islands, but in every sense as contextually grounded**.
This suggests to us the critical importance of continually striving for what Urie Bronfenbrenner (1979) termed "ecological validity," as well as building data systems, selecting outcomes, custom designing interventions to meet individual child needs, and honoring personal strengths and cultural assets in ways that reduce social exclusion and isolation (Palareti & Berti, 2009). In another sense, we view TRC as a critical element in a rich and varied service array that includes community, family, and foster-family based service alternatives which work together in combination to offer choice and individualized programming to families.

(4) **We view therapeutic residential care as something more than simply a platform for collecting evidence-based interventions or promising techniques or strategies. TRC is at its core informed by a culture that stresses learning through living and where the heart of teaching occurs in a series of deeply personal, human relationships**.
Many strands of practice research and scholarship contribute to this notion of a "unifying something" in TRC—a rich literature from early contributions on the therapeutic milieu (Redl & Wineman, 1957; Hobbs, 1966); on the importance of "the other 23 hours" as both means and context for teaching competence (Trieschman, Whittaker, & Brendtro 1969), to seminal contributions on applying the principles of applied behavior analysis in a family style group living context (Phillips, Phillips, Fixsen, & Wolf, 1974), to more recent contributions

including Anglin (2002), Thompson and Daly (2014), and Holden et al. (2014) on engaging the total TRC setting in a process of quality improvement. We note here with special significance the opportunities for research at the intersection of what is a rich and deep European tradition and literature of social pedagogy—as thoughtfully summarized by Hans Grietens (2014)—with what Lyons and Schmidt (2014) have described in a North American context as the "transformational role" of therapeutic residential care in the lives of young persons.

(5) **We view an ultimate epistemological goal for therapeutic residential care as the identification of a group of evidence-based models or strategies for practice that are effective in achieving desired outcomes for youth and families, replicable from one site to another, and scalable, i.e., sufficiently clear in procedures, structures, and protocols to provide for full access to service in a given locality, region, or jurisdiction**.

Our work group is informed by the assessments of researchers such as Sigrid James (2011, 2014), Annemiek Harder and Erik Knorth (2014) and others to ascertain the relative efficacy of existing models of therapeutic residential care and/or probe deeply at "what is inside the black box" of effective TRC practice. Here we are in agreement with Sigrid James (2011: 320):

It is in the best interest of group care settings that genuinely try to deliver quality care to collaborate with child welfare service systems and researchers to identify the essential elements of their program, to critically review their program in light of the needs of the youth they serve, and to consider adopting or learning from the treatment models that already have an evidence-base.

That said, we are also mindful of the challenges involved in mounting rigorous research in a service context where contracts are increasingly focused, time-limited, and specific with respect to desired outcomes. It is unlikely that identification of evidence-based models of therapeutic residential care will emerge from service contracts alone. Adding to this challenge is the relative dearth of funding specific to model development, testing, refinement, and dissemination for therapeutic residential care. In the U.S. for example, it has been more than 40 years since TRC has received any significant government or private foundation monies for the development of model TRC programs. The last, in fact, appears to be the Teaching Family Model (previously Achievement Place) which received funding in the early 1970s from the Center for Crime and Delinquency Studies at the National Institute for Mental Health. This lacunae in developmental funding since the early 1970s stands in sharp contrast to extensive private philanthropic and government research and development grants that have gone to what now

are evidence-based or evidence-informed, non-residential, community-based interventions. As but one example, Wraparound Services—a promising, family- and community-based initiative from the late 1970s and 80s in several locations in the U.S.—developed as an alternative to more medically oriented models of service that were judged as failures:

The wraparound theory of change that has evolved from this grassroots development is that children with severe emotional and behavioral problems will develop a more normal lifestyle if their services and supports are family centered and child focused, strengths based, individualized, community based, interagency coordinated and culturally competent. (Burns & Hoagwood, 2002:70)

From the early 2000s to the present, the wraparound approach has matured greatly and under the able leadership of Drs. Janet Walker and Eric Bruns, the National Wraparound Initiative (NWI) has garnered substantial research, model development, and dissemination support from a variety of federal agencies, including recent funding for a National Wraparound Implementation Center (http://nwi.pdx.edu):

During the late 1970s and early 80s, Wraparound emerged gradually from the efforts of individuals and organizations committed to providing individualized, comprehensive, community-based care for children and their families. While the term Wraparound came to be more and more widely used throughout the 1990s, there was still no formal agreement about exactly what Wraparound was. Many Wraparound programs shared features with one another, but there existed no consensus about what was essential for Wraparound. Some programs were able to document extraordinary successes, but it also became apparent that many teams and programs were not operating in a manner that reflected the Wraparound principles. Toward the early 2000s, it became increasingly clear that without a clear definition of what Wraparound was (and wasn't), any practice could be called "Wraparound," regardless of quality. Furthermore, it would be impossible to establish evidence for Wraparound's effectiveness without a clear definition of the practice. (See: NWI "Mission and History" at http://nwi.pdx.edu)

At least in the U.S., therapeutic residential care has not yet had the benefit of anything like a similar resource allocation for research and development, particularly in the area of model specification and implementation. As noted, it is unlikely that existing service contracts for therapeutic residential services will, in themselves, yield anything like the results of the National Wraparound Initiative. Without new resources specifically designated for research and development, particularly with respect to the identification of essential elements, it is likely that the critical questions raised by Sigrid James about TRC will remain largely unanswered.

Dimensions of Therapeutic Residential Care: Pathways for Future Research

In their concluding chapter of the previously cited review volume on TRC, Whittaker, Del Valle, and Holmes (2014: 329) observe:

To say, 'residential care' or 'residential services' communicates little beyond minimal setting information. The sheer range and variability of service components, change theories, frequency, intensity and duration of specific intervention strategies, organizational arrangements (size of living units, lengths of stay, staffing arrangements, for example)—to say nothing of protocols for staff training and development and the integration of on-going, systematic evaluation—all argue for increasing precision and specificity in both description and analysis. If residential services have fallen from favor as many of our contributors have noted, at least a partial reason must surely be that the term can mean so many different things in different contexts. This masking of differences in the use of umbrella terms like 'residential care' contrasts ever more sharply with the conceptual and empirical precision which characterize many newer evidence-informed and evidence-based approaches to work with troubled youth.

We have tried in this present effort to bring some clarity at least to the definition and scope of what we mean by "therapeutic residential care."[9] Much work remains to be done. For example, concerns continue to arise with respect to "deviancy training," though research from the Boys Town Family home program seems to demonstrate that a well-specified, properly designed, and monitored program serves as a countermeasure to potential negative effects of specific peer interactions (Lee & Thompson, 2009; Huefner, Smith, & Stevens, 2014). The field needs to rigorously examine the perception that negative contagion effects are a necessary consequence of any group placement (Weiss et al., 2005).

The editors continue:

The case for residential placement increasingly goes beyond the need for basic care and involves a decision that high intensity treatment services are needed for a small but challenging number of children and youth who present with multiple needs that cannot be effectively met in their family homes or communities, or even in specialized treatment foster care. Our continuing hope is that there are other pathways to effective therapeutic residential care besides that of a 'last resort'. Children with multiple and complex needs should not have to 'fail their way' into needed services, but should receive them as a treatment of choice when indicated. (Whittaker, Del Valle, & Holmes, 2014: 330)

[9]For example, we are not talking here about large, sterile, regimented congregate care settings where children are consigned largely for reasons of dependency, and often for the duration of their childhoods, though such settings appear to be a primary focus of some recent critiques of group care (Dozier et al., 2014).

With respect to therapeutic fostering, we would make two brief points. Firstly, incredible gains have been made since Nancy Hazel's first experiments with the modality in Kent (UK) in the 1970s. Patti Chamberlain of the Oregon Social Learning Center and her team continue to improve the design and outcomes of Oregon Treatment Foster Care (formerly Multi-Dimensional Treatment Foster Care), now widely used and disseminated internationally as an evidence-based intervention.[10] It occupies an important space in the suite of intensive services designed to meet the needs of high-resource using youth. As such, we are struck with its close resemblance to current versions of the Teaching Family Model—in particular, the Boys Town Family Teaching Model (Thompson & Daly, 2014), in its theory of change, its use of applied behavior analysis principles, and its reliance on married couples as the prime service deliverers. More comparative research is needed to tease out similarities and differences, as well as the possibility of new constellations of interventions. Secondly, we are reminded that using foster family care as a vehicle for delivering services is not without its potential hazards. As a comprehensive study of its own foster care alumni, plus comparison groups receiving foster family care through public provision, Casey Family Programs in the U.S. found serious continuing problems among alumni with respect to mental and physical health issues, employment and educational attainment, and reported sexual abuse while in care.[11] We believe there are strengths and limits and attendant risks to all setting-based interventions—family, foster family, and residential—and that it is paramount for future research to identify what these are and design interventions accordingly.[12]

What are Some Promising Pathways for Future Research in Therapeutic Residential Care?

Our previously cited review volume was organized around seven major themes which offered a useful set of lenses for examining therapeutic residential care in its many facets. These included:

[10]See Treatment Foster Care Oregon-Adolescents' (TFCO-A). *In: Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved in Child Welfare*. Policy Brief (January 2016). Chadwick Center and Chapin Hall Center for Children.

[11]Pecora, P.J., Kessler, R.C., Williams, J., O'Brien, K., Downs, A.C., English, D., White, J., Hiripi, E., White, C.R., Wiggins, T., & Holmes, K.E. (2005). *Improving family foster care: Findings from the Northwest Foster Care Alumni Study*. Seattle, WA: Casey Family Programs. Available at www.casey.org.

[12]More recent research by Euser et.al. (2013) on a smaller sample in the Netherlands found higher prevalence of child sexual abuse in residential over foster family settings: *Results based on both sentinel report and self-report revealed higher prevalence rates in out-of-home care than in the general population, with the highest prevalence in residential care. Prevalence rates in foster care did not differ from the general population. According to our findings, children and adolescents in* residential care are *at increased risk of CSA compared to children in foster care. Unfortunately, foster care does not fully protect children against sexual abuse either, and thus its quality needs to be further improved* (Euser et al., 2013: 221).

1. **Promising Program Models and Innovative Practices**
   See: Jakobsen (2014); Andreassen (2014); Thompson and Daly (2014); McNamara (2014); and James (2014).
2. **Pathways to Therapeutic Residential Care**
   See: Thoburn and Ainsworth (2014); Del Valle, Sainero, and Bravo (2014); Lyons, Obeid, and Cummings (2014); and Lausten (2014).
3. **Engaging Families as Active Partners**
   See: Small, Bellonci, and Ramsey (2014).
4. **Preparing Youth for Successful Transitions from Therapeutic Residential Care**
   See: Okpych and Courtney (2014); Stein (2014); and Zeira (2014).
5. **Improving the Research Base for Therapeutic Residential Care: Logistic and Analytic Challenges and Methodological Innovations**
   See: Harder and Knorth (2014) and Lee and Barth (2014).
6. **Calculating Costs for Therapeutic Residential Care**
   See: Holmes (2014).
7. **Linking Focused Training and Critical Evaluation as a Foundation for Staff Support in Therapeutic Residential Care (Whittaker, Del Valle, & Holmes, 2014)**
   See: Bravo, Del Valle, and Santos (2014); Grietens (2014); Holden, Anglin, Nunno, and Izzo (2014) and Lyons and Schmidt (2014).

While beyond the scope of this brief introductory paper, our work group has committed itself to building on the contributions to the review volume and, drawing on other sources, developing a prioritized set of research questions using these dimensions as a framework for the development of a research agenda for therapeutic residential care with clear potential for cross-national collaboration. We continue to believe that while intra-country and regional differences will shape the particular expression TRC assumes, there is much to be gained from broadening our perspective to one that is cross-national. We are committed to strengthening that potential for cross-national collaboration in research, policy development and sharing of exemplary practices.

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