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Planned treatment and outcomes in residential youth care: Evidence from Sweden

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ABSTRACT

A recurring theme in evaluations of Swedish residential youth care is that treatment is often unplanned. Using a data set of teenagers placed in youth care in 1991 ($N=357$), we show that planned treatment — in the sense of a known expected duration of treatment — is strongly positively associated with treatment outcomes. In the short term, teenagers with planned treatment are 32% less likely to experience a treatment breakdown and 25% less likely to be reassigned to other forms of residential care after completed treatment. In the long term, teenagers with planned treatment are 21% less likely to engage in criminal behavior and 40% less likely to be hospitalized for mental health problems. The results are robust to controlling for a rich set of potentially confounding factors: Even though observable pre-treatment teenager characteristics explain about one fifth of the variation in criminal behavior 5–10 years after treatment, they have almost no predictive power for whether treatment is planned or unplanned.

1. Introduction

Most western countries use some form of residential care for teenagers with severe behavioral problems. In Sweden, about 3500 adolescents resided in a youth care facility as of November 1st 2008 (National Board of Health and Welfare, (2009)).[1] The majority of these teenagers are placed in care due to drug abuse or juvenile delinquency. Since every young adult who pursues a criminal career imposes a large cost on society, the success or failure of residential care has substantial effects on the welfare of society. Although some literature surveys indicate mixed or moderately positive effects of residential care (e.g., Garrett, 1985; Bates, English, & Kouidou-Giles, 1997), there is arguably scope for improvement. For example, whereas 57% of the boys placed in Swedish residential care in 1991 had shown signs of criminal behavior when first placed in care, 73% were convicted for some crime as young adults.[2] Even though these figures may not reflect a causal effect of treatment, they suggest that Swedish residential care does not succeed in keeping many teenagers from engaging in criminal behavior as adults. Moreover, teenagers placed in residential care fare badly in terms of mortality in early adulthood, earnings and educational attainment (Vinnerljung & Sallnäs, 2008).

What explains the success or failure of residential care? Previous research has focused on how parental involvement (Jenson & Whitaker, 1987), length of stay (Loughran et al., 2009), educational attainment (e.g., Trout et al., 2008), placement stability (e.g., Ward, 2009; Christiansen, Havik, & Anderssen, 2010), teenager engagement (e.g., Englebrecht et al., 2008; Smith et al., 2008), physical restraint (Steckley, 2010), facility ownership (Bayer & Pozen, 2005; Lindqvist, 2008), the punitiveness of the juvenile justice system (e.g. Levitt, 1998; Hjalmarsson, 2009) or peer-group effects among incarcerated teenagers (e.g. Bayer, Hjalmarsson, & Pozen, 2009) affect outcomes. In this paper, we focus on the behavior of the bureaucracy — the social services — responsible for placing teenagers in care and monitoring its progression. A recurring theme in evaluations of Swedish residential care is that the social services do not provide adequate effort in terms of the planning and monitoring of care. As a result, many teenagers are placed in residential care without a plan for treatment.

We test whether the fact that treatment is planned is associated with better outcomes using a data set of teenagers placed in youth care in 1991. The data set is compiled by Vinnerljung, Sallnäs and Kyhle Westermark (2001) and contains detailed information on the teenagers' problems at the time of placement, treatment histories and socioeconomic outcomes in adult age.[3] The data set also contains a variable for whether the expected duration of treatment was stated in advance. We argue that this constitutes a minimum requirement for treatment to be considered "planned". Previous research on

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[1] "Adolescent" is defined here as between 13 and 21 years of age. The figure does not include teenagers in foster homes which is the most common form of out-of-home care in Sweden, nor does it include teenagers in state correctional facilities.

[2] These figures are computed from the data provided by Vinnerljung et al. (2001) and refer to teenagers in HVB-homes (see Section 2). Teenagers in state correctional facilities or foster homes are not included.

[3] Sallnäs et al. (2004), Vinnerljung and Sallnäs (2008) and Lindqvist (2008) also use this data set.

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residential youth care has suggested that teenagers in youth care benefit directly from knowing the expected duration of treatment (Levin, 1998, p. 153; Sallnäs, 2000, p. 186). Moreover, a plan for the length of stay is likely to presuppose an idea of the objective and content of treatment.

We first show that unplanned duration of treatment is associated with other symptoms of bad planning on the social services part. Social services that do not plan the duration of treatment are less likely to seek the consent of the teenager before placement, more likely to initiate treatment breakdowns and more likely to replace the teenager to another facility after the end of treatment. There are also systematic differences in terms of chosen treatment programs: Teenagers with planned treatment are placed in facilities which are more expensive, more likely to have a school within the facility and an explicit treatment program. Finally, planned treatment is associated with better long-run outcomes. As adults, teenagers with planned treatment are less likely to be convicted for a criminal offense or treated for mental health problems. Splitting the sample by sex reveals that the association between planned treatment and outcomes in our data is substantially stronger for boys. Though planned treatment is associated with better outcomes also for girls, the effect is generally not statistically significant.

The possibility that the empirical pattern discussed above is caused by non-random selection of teenagers cannot be ruled out. For example, it is conceivable that it is easier to plan treatment for teenagers with less severe problems. However, the statistical association between planned treatment and outcomes is robust to controlling for a rich set of teenager pre-treatment characteristics. Though the set of observable teenager pre-treatment characteristics explains about one fifth of the variation in adult outcomes, it has no predictive power for whether a placement is planned or not.

2. Residential youth care in Sweden

Residential care is the most comprehensive measure for youth at risk which the Swedish social services can undertake. Most teenagers are placed in residential care due to their own behavior, such as violent crime, drug addiction, or suicidal tendencies. There are two different types of residential youth care facilities in Sweden. First there are state correctional facilities (*Särskilda ungdomshem* or *§12-homes* in Swedish), which treat teenagers with the most serious problems. This study focuses on the other type of facility, *HVB-homes*, which are both run by private and public principals.

The responsibility to act when children have some kind of social problem lies at the municipality level, the lowest tier in Swedish government. It is the municipality social service that acts as buyer in the market for residential youth care. Though each placement must be confirmed by a political committee, the decision to place a teenager in youth care is prepared and implemented by a social welfare secretary (caseworker), employed by the municipality. At the seller side, public facilities are managed by municipalities or county councils, whereas private facilities are run by firms or non-profit organizations.[4]

A recurring theme in evaluations of Swedish residential care is that the social services do not provide adequate effort in terms of the planning and monitoring of care. According to Sallnäs (2005), 60% of 97 interviewed managers at private facilities said that the social services "rarely" or "never" asked for evaluations of treatment quality when placing a teenager at their facility. The Swedish National Audit Office (2002) argued that the municipalities' lack of adequate monitoring is a major problem of Swedish residential youth care. According to Levin (1998, p. 140), only 16% of 61 former residents at Råby (a correctional center) rated the contact with the social welfare secretary responsible for their case as “good”, while 54% rated their contact as “bad” or “no contact”. Many teenagers also experience a high turnover of social welfare secretaries (Levin 1998, p. 142). In an extensive survey of the research on youth care in Sweden and other countries, Andreassen (2003) concluded that a large fraction of residential youth care is not undertaken according to the established principles of effective treatment.

Since 2001, Swedish law states that the municipality social services must make a plan for treatment before placing a child or teenager in care.[5] Among other things, this plan should state the objective and duration of treatment (County Council of Västra Götaland, 2004).[6] Compliance is low, however, as indicated by evaluations undertaken by a number of County Councils.[7] A recurring theme in these evaluations is that treatment plans are often short and expressed in general terms with little reference to the treatment needs of the teenager in question. Even the most basic aspects of treatment, like treatment objectives and expected duration, are often missing. For example, consider the following quote from the County Council of Gotland (2005, p. 2): "It is the opinion of the County Council that several of the examined treatment plans are so short and formulated in such general terms that they cannot be called individual treatment plans" (translation from the original Swedish by the author). After evaluating 89 placements of teenagers from 16 different municipalities, the County Council of Västra Götaland concluded that treatment plans vary a lot in terms of quality and that there was no reference to the expected duration of treatment in 39.3 % of cases. The County Council of Kronoberg (2006) found that 5 out of 21 evaluated placements had no treatment plan at all, and that a large proportion of the treatment plans that did exist were not intelligible. The harsh criticism of the County Councils is remarkable given that the evaluations refer to the period after the law was changed in 2001 to make individual treatment plans a prerequisite for all placements in youth care.

We argue that the lack of effort on the social services part reflects an agency problem. Several factors limit the accountability of the social services. Quality is inherently difficult to measure in residential youth care and information regarding the decisions to place a teenager in care is not publicly available. As employees of the municipality administration, social welfare secretaries have extensive employment protection. Teenagers with social problems (and their families) do not constitute a strong group in society. Although the municipality social services' lack of adequate planning and monitoring has repeatedly been subject to harsh criticism from various other government bodies, there are no sanctions attached to this critique.

3. Data

Our data set was originally compiled by Vinnerljung, Sallnäs and Kyhle Westermark (2001) and is based on the files of all Swedish adolescents (13–16 years of age) who were placed in a HVB-home during 1991, with the exception of teenagers who were only placed in a HVB-home temporarily or for the sole purpose of having their

[4] The counties constitute the second tier in Swedish government, in between the State and the municipalities.

[5] SoL, 11 kap 3 §.

[6] The concept of "planned treatment" which we consider in this paper is not identical to the existence of a "treatment plan" as defined in the evaluations of the County Councils (though, of course, they are strongly related). For example, treatment plans should contain certain aspect of treatment that we do not include into the concept of "planned treatment", such as a description of how teenagers can maintain contacts with their family while in care. Moreover, as will be made clear below, actual treatment plans may not be detailed enough to warrant the label of "planned treatment" (not least because many treatment plans lack information about the expected duration of treatment).

[7] The County Councils have the formal responsibility to monitor the municipality social services. I have considered evaluations from the County Councils of Gotland, Västra Götaland and Kronoberg.