Residential Care in Illinois: Trends and Alternatives

Executive Summary

Stephen Budde
Susan Mayer
Andrew Zinn
Melissa Lippold
Adam Avrushin
Ava Bromberg
Robert Goerge
Mark Courtney

Chapin Hall Center for Children
at the University of Chicago

June 30, 2004

©2004 Chapin Hall Center for Children at the University of Chicago

Chapin Hall Center for Children
at the University of Chicago
1313 East 60th Street
Chicago, IL 60637
773-753-5900 (phone) 773-753-5940 (fax)
www.chapinhall.org

CS-104

Contents

Page

Introduction and Methods 1

Key Findings and Implications 2
Residential Care Utilization 2
Characteristics of the Residential Care Caseload 2
Residential Care Decision Making 3
Discharge Outcomes 4
Post-Discharge Outcomes 5
Factors that Were Predictive of Key Placement Experiences/Outcomes for Youth 6

Conclusions 7

INTRODUCTION AND METHODS

As part of its efforts to improve the utilization and quality of residential care, the Illinois Department of Children and Family Services (DCFS) asked Chapin Hall Center for Children at the University of Chicago to study residential care and alternatives to residential care for youth in foster care. The purpose of the study is to provide DCFS and service providers with information that can inform management and practice decisions about how to better serve the most troubled children and youth in substitute care in Illinois.

Two reports were completed, based on several types of research methods. In the Interim Report,[1] we analyzed administrative data to describe trends in residential care utilization from 1993 to 2003. For our final report, we presented multivariate analyses to predict entry to residential care and discharge/post-discharge placement outcomes; examined case records and conducted interviews with a variety of key informants to understand the decision-making processes surrounding referral to and placement in residential care; and conducted a review of selected literature.[2]

By *residential care*, we refer to institutional (i.e., IPA[3]) and group home settings in which some DCFS wards live. Other types of residential settings (e.g., shelter care, detention, hospitalization) are examined in relation to institutional and group home care experiences, and we do not refer to them as residential care. Residential care is also distinct from different types of foster care, in which a child lives in a family setting with a foster parent.

Our analyses are grounded in a *continuum-of-care* perspective in which residential care is viewed within the context of an array of service options, and youth's experiences in residential care are put in the historical context of their pre-residential and post-residential care experiences. In addition to describing trends in the utilization of residential care, we provide descriptive information about the following sequence of a youth's potential experiences in placement with DCFS:

- Prior to entering residential treatment (e.g., foster care, hospitalization)
- During placement with a specific residential care provider
- Discharge outcomes (i.e., where youth go at the point of discharge)
- Post-discharge outcomes (i.e., what happens to youth after discharge)

This is one of the most extensive studies ever conducted of residential care. The analyses of residential care utilization and the placement experiences of youth provide findings that can inform critical policy and practice dialogues, as well as decisions about the utilization of residential treatment. The findings fall into six areas:

---

[1] The full name for the Interim Report is: *Residential Care in Illinois: Trends and Alternatives; Interim Report: Descriptive Findings from Analysis of DCFS Administrative Data*.

[2] Most of our analyses in the interim report focus on youth in placement in Illinois who were 12 years and older, since they make up the bulk of children in residential care. In the final report, we extended our analyses to include children and youth 10 and older.

[3] *IPA* is a code for institutional placements in the administrative data that stands for *Institution Private Agency*.

- Residential care utilization
- Characteristics of residential care caseloads
- Residential care decision making
- Discharge outcomes
- Post-discharge outcomes
- Factors that were predictive of key placement outcomes for youth

Below, we discuss the key findings in each of these areas and suggest some basic implications of these findings.

KEY FINDINGS AND IMPLICATIONS

Residential Care Utilization[4]

There were significant declines in the use of residential care over time in Illinois.[5] Key findings include:

- Between fiscal years 1995 and 2003, there has been a statewide reduction in the residential care caseload in Illinois, resulting from policies designed to serve more children and youth in less restrictive settings and limit the utilization of residential care. Specifically, the number of children in residential care declined from 4,015 in 1995 to 1,683 in 2003.

- The percentage of youth (age 12 and older) in substitute care who were placed in residential care declined from 26 percent to 15 percent between 1995 and 2003.

The reduction in the size of the residential care caseload has implications for residential programs and for the foster care system more broadly. Over 60 residential programs have closed since 1994. DCFS and foster care providers are serving proportionately more youth in foster care rather than in residential care. Furthermore, some of the youth served in foster care in recent years may have been served in residential care in previous years.

Characteristics of the Residential Care Caseload[6]

The residential care caseload has changed over time to include an increasing concentration of highly troubled and traumatized youth. As the caseload declined after fiscal year 1995, the character of the population entering residential care programs for the first time shifted. In

---

[4] Findings in this section are based on analysis of administrative data from 1993-2003, see Interim Report for details.

[5] While we are confident in the overall trends presented here, some proportion of the declines reported may be due to declines in the use of shelter care. We were able to identify most shelter care placements that were coded as residential placements in the database, but some shelter care placements could not be accurately distinguished from residential care placements.

[6] Findings in this section are based on analysis of administrative data from 1993-2003, see Interim Report for details.

comparison to 1995 first-time entrants, youth entering in 2003 had been in foster care longer, had experienced multiple failed placements, or were being "stepped down" from more restrictive locked settings—juvenile detention, Department of Corrections facilities, or psychiatric hospital programs. Specifically:

- The average number of prior placements for youth first entering institutional placements was 4.8 in 1995 and 9.3 in 2003.
- More than one-third (over 500 youth) of first time entrants into residential care in 2003 had 11 or more prior placements.
- Almost 40 percent of youth entering residential care in 2003 (over 650 youth) entered directly from locked settings.
- The median time from entry into out-of-home care to first entry among youth (12 and older) into an institutional residential care placement almost doubled from about 1.25 years in 1995 to over 2 years in 2003.

A large number of youth now being placed in residential care have experienced the trauma of multiple placement disruptions and failures, long stays in foster care, and the lack of a permanent home before entering residential care. These findings also suggest that the smaller number of residential programs in Illinois now are, on average, serving more troubled youth than residential programs in the mid-1990s.

Residential Care Decision Making[7]

We examined case records and conducted interviews with a variety of key informants to understand the decision-making processes surrounding referral to and placement in residential care.

- Residential care is used as a last resort. Regional DCFS staff and consultants review referrals for residential care as a last resort after all other placement and therapeutic options have failed.

- Some youth referred to and approved for residential care do not appear to have received intensive services that could potentially prevent residential care. Despite the emphasis on using residential treatment as a last resort, our analysis of case records in which youth were approved for residential care suggests that some of these youth had not previously received three key types of intensive support services available through DCFS (intensive case management, crisis intervention, or system of care) or intensive foster care placements (e.g., specialized foster care). However, these youth may have received other therapeutic or supportive services.

[7] Findings in this section are based on analysis of interviews with decision makers, caseworkers, and foster parents; and case record reviews, see Final Report for details. Initial decisions about whether a youth needs residential care are made by regional Placement Review Teams. For youth who are approved for residential care, decisions about where to place youth are made by a statewide committee. The key findings are drawn primarily from analyses of regional decision-making.

- Regional decision making on referrals for residential care is structured to focus narrowly on whether or not to approve residential care. Although alternative services are often recommended, decision makers have no direct access to intensive alternatives (e.g., system of care services, specialized foster care), which require separate authorization.

- Decisions are often made in isolation from the youth's experience; decision makers often do not meet the youth or foster parents, and there is no mechanism to provide decision makers with systematic feedback on how youth fare after decisions are made.

Using residential care as a last resort is consistent with efforts to serve youth in the least restrictive setting possible, and it promotes reduction of residential care utilization and associated costs. However, the emphasis on failed placements as a fundamental criterion for approving residential care may leave no planful way for a child to be placed into residential care and inhibit the success of subsequent treatment efforts. Some youth did not receive any of the primary intensive placement or supportive service options prior to being approved for residential care. Although residential care may be the appropriate placement choice for some or most of these youth, it is possible that others could be served effectively through alternative strategies that can be initiated quickly and that are of sufficient intensity, quality, and duration to meet the needs of youth who have been in highly restrictive settings.

The narrow focus on residential care decisions may serve a function of adding clarity to the decision making process, but it appears to have some negative consequences as well. First, the lack of an integrated regional decision-making process in which both residential and alternative care and service options are considered forces caseworkers to spend more time navigating through the system when youth are not approved for residential care. This may result in delays in providing alternative services in crisis situations when a quick response is needed. Second, key people, including youth, may not be sufficiently involved in decision making and case planning. Third, decision makers who get no systematic feedback on the outcomes of their decisions will have a hard time improving decision making. Finally, the narrow focus on whether to approve residential care at a single point in time does not support, and may detract from, efforts by DCFS and services providers to focus more on the child or youth's experience and outcomes over time.

Discharge Outcomes[8]

One useful way of using the administrative data is to examine where youth go when they leave residential care. We call their next destination a *discharge* outcome. Youth may be *stepped down* from residential care to less restrictive settings such as foster care or a potentially permanent living arrangement (e.g., home, adoption, guardianship). These are generally considered *positive* discharges. Alternatively, youth may go to what we call *negative* discharge destinations, which include going to a psychiatric hospital,[9] detention, running away, or another residential

[8] Findings in this section are based on analysis of administrative data in both the Interim and Final Reports.

[9] It is important to note that hospitalizations may be needed and can potentially be therapeutic short-term placements for some youth. We include these events as *negative* discharges because they were clearly not the original or optimal discharge goal for youth.

placement. These discharge outcomes provide one limited but useful way of understanding how youth fared in residential care.

- A high percentage of youth leaving residential care experienced negative discharge outcomes. Over 40 percent of youth experienced negative discharge outcomes between 1995 and 2002.
- Among youth entering residential care institutions for the first time in 2002, 59 percent experienced one of these negative discharge outcomes, compared with 45 percent of 1995 entrants.
- Multivariate analyses showed that the higher levels of negative discharge outcomes and the lower levels of stepdowns among youth entering residential care in 2002 and 2003, relative to 1995 entrants, were due to changes over time in the characteristics of youth entering residential care.

The fact that a majority of youth in institutional residential placements in 2002 experienced negative discharge outcomes suggests the need to explore how to better address the considerable mental health and placement needs of youth who enter residential care.

Post-Discharge Outcomes[10]

One of the most important issues in assessing residential care outcomes relates to how youth fare after leaving residential care. In the findings described below, we focus on youth who experienced two types of *positive* discharge outcomes—moving into foster home care or returning home. While it is important to try to serve youth in these less restrictive familial settings, we want to see whether these arrangements remain stable over time.

Youth with positive discharges from residential care were often unable to stay in these less-restrictive settings. Among youth who were discharged from their first residential care setting to less-restrictive settings during 1995 – 2003:

- About half (51%) of 1,677 youth discharged to foster care eventually returned to higher levels of care during this time frame.
- About one-third (31 %) of 625 youth discharged to a living arrangement with the goal of permanency (home, adoption, subsidized guardianship) eventually returned to higher levels of care during this time frame.

These findings highlight the importance of exploring how to best support youth and caregivers following discharge from residential care.

[10] Findings in this section are based on analysis of administrative data discussed in the Final Report.

Factors that Were Predictive of Key Placement Experiences/Outcomes for Youth[11]

We examined factors that were predictive of the likelihood that a youth would experience three types of placement outcomes:

- *Entering residential care* (among youth entering substitute care from outside the child welfare system or from non-residential placements such as foster care)
- *Experiencing one of four types of discharge events at the end of their first residential placement over time*: foster care, a setting in which the goal is to have a permanent living arrangement (e.g., return home, subsidized guardianship, adoption), negative events (running away or going to locked psychiatric or correctional settings), or lateral moves (i.e., going to other residential programs)
- *Going back into residential care* (among youth who were placed in foster care or who went home at discharge)

The predictors we examined included demographic characteristics, youth placement and maltreatment experiences, and region of residence. These analyses show the unique association of each factor with placement outcomes while simultaneously taking into account (i.e., controlling for) the effects of the other factors in each model. Identifying risk factors for negative placement outcomes can help DCFS and service providers better target services to youth at various points along the continuum of substitute care.

Below we highlight some of the key predictors of one or more of the three placement outcomes for youth.

- *Number of prior placements*. Repeated placement failures before entering residential care increased the likelihood of subsequent negative discharges from residential care (to detention, DOC, hospitalization, or running away) and, for youth stepped down to foster care at discharge, increasing the likelihood of stepping back up into residential care.

- *Gender*. Boys were more likely than girls to experience residential care as a first or subsequent placement, less likely to step down to foster care (a less-restrictive and usually less-intensive form of substitute care), and if stepped down to foster care, more likely than girls to be stepped back up to residential care.

- *Race*. Hispanic youth in foster care were less likely than other youth to enter residential care. Among youth in residential care, African American youth were significantly more likely than other youth to be discharged to foster care, but significantly less likely to be discharged to a permanency setting (reunification with parents, adoption, subsidized guardianship).

- *Maltreatment*: Youth who experienced inadequate supervision (a type of child neglect) prior to entering substitute care were at greater risk of entering residential care from

[11] Findings in this section are based on statistical analyses of factors that were predictive of placement outcomes that a youth. See Final Report for details.

foster care, experiencing a lateral discharge from one residential care placement to another, and being stepped back up to residential care following discharge to foster care or permanency.

- *Running away*: Running away from foster care more than doubled the likelihood of entering residential treatment, and, for youth in residential care, running away 2 or more times prior to entering residential care doubled the likelihood of negative discharges.

- *Length of stay in residential care*: Among youth stepped down to foster care, having been in residential care for less than 90 days significantly increased the likelihood of stepping back up to residential placement.

In summary, the trauma of repeated placement failures appears to influence subsequent placement outcomes for youth throughout their experience in substitute care. These findings highlight the critical importance of preventing placement instability at an earlier point in time, during a child's initial experiences in foster care. One reasonable interpretation of the strong gender differences is that acting out problems, which may be more common among boys, have a greater impact on placement outcomes and decisions than other types of emotional or behavioral problems (e.g., youth who internalize their problems and feel anxious or depressed). The racial differences are modest, but they suggest the need for further research in this area to better understand racial differences. The finding that inadequate supervision and child neglect may have long-term effects on the subsequent functioning and placement experiences of youth suggests that although our society tends to focus on the consequences of physical and sexual abuse, the consequences of child neglect warrant greater attention. Although shortening the length of stay in residential care is sometimes a focus of child welfare policy, shorter stays can potentially have negative consequences for some youth.

CONCLUSIONS

In the mid-1990s, DCFS began to implement extensive gatekeeping procedures in order to reduce the utilization of residential treatment programs in Illinois. Our data suggest that these efforts likely have produced their desired effect—residential treatment utilization has declined consistently and dramatically since 1995, at a much faster rate than utilization of all other types of placements. Declines in residential treatment utilization have resulted in cost savings for DCFS that have undoubtedly enabled the department to focus its fiscal resources on other important needs for children and families, especially in an era of fiscal austerity and budget cuts.

The continuing relative declines in residential caseloads suggest that the criteria for admission to residential treatment, whether formal or informal, may have gotten progressively more restrictive after 1995, especially between 1995 and 2001. Accordingly, the tight admissions criteria for residential care were reflected in our qualitative study of decision making—youth referred for residential care were often only approved when other options had failed them or when they were coming from highly restrictive settings.

Although this study cannot draw conclusions about whether these changes were good or bad for youth, our findings do show that there is considerable room for improvement in serving youth before, during, and after their residential care experiences.

Despite the emphasis on using residential care as a last resort, programmatic efforts to divert youth from residential care are structurally disconnected from the extensive process of deciding whether to approve referrals for residential care. This may result in critical delays in providing these alternative services and considerable extra work for caseworkers.

In recent years, residential care providers have been serving a smaller population of youth that appears to be, on average, more difficult to care for than previous populations. Nonetheless, the fact that over half of youth experience negative discharge outcomes from their first institutional residential care placement highlights the need for both DCFS and providers to explore ways to improve services to these youth.

Furthermore, many youth who experience what we have called *positive* discharges (i.e., to less-restrictive settings) from residential care eventually end up back in more-restrictive settings. Thus, discharge from residential care is a challenging transition for many youth and their subsequent caregivers, and the system of care can explore ways of supporting both groups more effectively.

Finally, many youth entering residential care for the first time had already experienced the trauma of multiple placement disruptions and failures in foster care. Significantly, having more prior placements was predictive negative discharge and post-discharge outcomes, illustrating some of the consequences of earlier placement instability for youth and for the system. Efforts to help youth in any setting are likely to be inhibited by a history of prior placement instability and failure. Youth who run away or are placed in detention in foster care are also at increased risk of entering residential care and of experiencing negative placement outcomes at discharge. Thus, whenever children and youth experience placement disruptions, run away, or are put in detention, these events can serve as very concrete triggers to activate DCFS's new efforts to assess placement and mental health needs and services.