REPORT TO THE GENERAL ASSEMBLY

December 31, 2019

(20 ILCS 505/2.2 new)

**Youth in care waiting for placement**

Pursuant to PA 100-0087 (SB 973), the Children and Family Services Act was amended adding Section 2.2, requiring annual reports on youth in care waiting for placement. The annual report is to be submitted to the General Assembly by 12/31/18 and each year thereafter through December 31, 2023 for previous fiscal year information on the number of youth in emergency placements (shelters, foster homes) for longer than 30 days, in psychiatric hospitals Beyond Medical Necessity (BMN), or in a Detention Center or Department of Juvenile Justice (DJJ) facility beyond the release date. For each of these areas the Department is to report the gender, ages, recommended placement type, total length of time in in emergency care, barriers to timely placement, and was the youth placed into the recommended placement type and if not what type of placement was made.

In preparation for the submission of the first annual report, the Department needed to create a database including the above data requirements. There was no single database that captured the relevant information required for this report. The first few months of FY18 were spent determining and agreeing on the information needed for the database and how that information would be collected. Much of the information collected is done manually and is then crosschecked with other data sources. Throughout FY18 we found that we needed to make refinements to the database to improve the quality of the data collection; this continued in FY19. Also, beginning with the third quarter of this fiscal year, there will be modifications in the barriers to timely placement category. The definitions need to be objectively defined and standardized across the three data bases.

Statistics

The total youth in care on 6/30/19 was 17,791. The chart below represents the number of unique youth in emergency placements (shelters/foster homes) for longer than 30 days, in psychiatric hospitals BMN, and in a detention center or DJJ facility 15 days beyond the release date for FY19.

|  |  |
| --- | --- |
| **Location** | **7/1/18 to 6/30/19****Number of Youth** |
| Psychiatric Hospital | 309 |
| Emergency (Shelter) Placements | 233 |
| Detention / DJJ | 49 |

Figure 1: Number of Males and Females by Level of Care

Figure 2: Age of Youth by Level of Care

Most of the youth range in age from 12 to 18, with the overall average age being 14.

* Psychiatric Hospital – ages ranged from: 3 – 18, with the average age being 13\*
* Emergency Placements – ages ranged from: 1 – 21, with the average age being 15\*\*
* Detention/DJJ – ages ranged from: 14 – 20, with the average age being 16

*\*It is not common for a youth under age 5 to be psychiatrically hospitalized. This 3-year old has multiple diagnoses including Autism Spectrum Disorder, likely Global Developmental Delay, Hydrocephaly, and is non-verbal.*

*\*\*The Department explores all options to place children in homes with relatives when they come into care. In the unfortunate event that a young child, infant to 10-years-old, needs emergency placement due to the lack of a relative resource, the Department makes it a practice to first explore an emergency foster home rather than a traditional shelter.*

Youth Who Remained in **Psychiatric Hospitals** Beyond Medical Necessity

Figure 3: Number of Youth in Psychiatric Hospitals BMN by Barriers to Placement

Most youth being discharged from a psychiatric hospital are recommended to be placed in a residential treatment program. The top three barriers to placement are severe mental health, limited foster home availability, and aggressive behavior. The recommended Level of Care:

* Residential Treatment: 193 youth (167 went to Residential, others to an array of placements)
* Specialized Foster Care: 90 youth (52 went to Specialized/Therapeutic Foster Care, others to an array of placements)
* Traditional Foster Care, Home of Relative, or Home of Fictive Kin: 16 youth (5 went to a Traditional Foster home, 5 went to a Home of Relative, 3 went to a Home of Fictive Kin, 2 went to a Specialized Foster Home, 1 went to a Residential Facility)
* Transitional Living Program: 3 youth (2 went to Transitional Living Program, 1 went to a Residential Facility)

Tracking information on hospitalized youth and developing placement recommendations is a multi-faceted process. Psychiatric hospital information is gathered from several DCFS Clinical Division data sources and on the Department legacy system. The Clinical Division tracks information related to the work that is done with youth, both in and out of the hospital, who have mental health needs. Depending on the purpose of the Clinical Division’s involvement, information and documentation is collected and stored in different databases. All information that is entered into these various databases and/or logs by Clinical staff is checked by a supervisor to assure clean, correct information.

To reduce the length of time youth in care wait in psychiatric hospitals, Clinical Division Administrators, Managers, Psychiatric Hospital Program (PHP) Liaisons, and Intake staff receive a daily list of admissions to psychiatric hospitals, along with the consents from the DCFS Guardian’s office. Clinical Division Intake staff schedule a staffing for any youth 12 years old or younger within three to five business days of admission to review the youth’s service needs and any specialized placement needs the youth may have. For youth who are 13 or older, the Regional Clinical Manager consults with the youth’s caseworker, hospital clinical staff, and any other involved parties who can assist in understanding the services and placement needs of the youth. If it is determined that a staffing is needed during that consult, Clinical Intake is notified, and a full staffing is scheduled. All clinical staffings focus on the youth’s strengths, needs, service intensity and any placement changes that may be necessary. These staffings are to be inclusive of the youth’s caseworker, supervisor, subject matter experts who can support the assessment and recommendations, hospital staff, GAL, youth (if over the age of 12 and clinically appropriate), caregiver, and biological parent(s), if appropriate.

Following a full clinical staffing, the Central Matching Team receives a Clinical Summary/Child and Adolescent Service Intensity Instrument (CASII) or an Early Childhood Service Intensity Instrument (ECSII) with an Action Plan within seven business days of hospital admission for each youth who does not have an identified placement to return to upon discharge from the hospital. The Action Plan outlines the youth’s immediate and future service and placement needs and is provided to all who participate in the staffing.

For any youth who is admitted from a Residential, Group Home, Transitional Living Program or Independent Living program, it is the responsibility of the Monitoring Unit to follow up with the facility or program to ensure that the youth is being staffed by the treatment team consistent with the Residential protocol. If the treatment team or monitor for the agency program identify that additional clinical support is necessary, they reach out to the Clinical Manager for integration of DCFS clinical staff into the youth’s existing treatment team.

PHP Liaisons intercede when youth are psychiatrically locked out in the hospital and there is no referral from the Division of Child Protection. The liaisons ensure the Clinical Managers are aware of the potential lockout and assists in obtaining necessary releases so that a clinical staffing can occur. This is done to be proactive in planning for these youth who may enter DCFS care and need a placement. PHP liaisons are also in communication with the psychiatric hospital treatment team, including hospital therapists, case managers and/or clinical managers about any significant treatment issues for a youth psychiatrically hospitalized. The PHP Liaisons receive information about the youth’s behaviors, treatment plan, discharge plan recommendations and ensures that the youth’s clinical needs are being met while they remain hospitalized. The PHP Liaisons also monitor the youth’s medical necessity for hospitalization and communicate information around clinical readiness for discharge and discharge plans to the youth’s assigned clinical team and treatment team. The Liaisons also ensure that the hospital receives support and information from DCFS related to the youth’s needs while hospitalized.

Youth in **Emergency Placements** (Shelters/Foster Homes) for More Than 30 Days

Figure 4: Number of Youth in in Shelters/Foster Homes >30 Days by Barriers to Placement

Youth in shelters and emergency foster homes most commonly move to residential or specialized foster care placements. The top barriers to their placements are severe mental health, aggressive behavior, and limited foster home availability. The recommended Level of Care:

* Residential Treatment: 80 youth (30 went to Residential Treatment Facilities, others to an array of placements)
* Specialized Foster Care: 88 youth (26 went to Specialized Foster Care, others to an array of placements)
* Traditional Foster Care, Home of Relative, or Home of Fictive Kin: 31 youth (16 went to Foster Care, 2 went to Home of Fictive Kin, others were in emergency placements at end of fiscal year)
* Transitional Living Program: 18 youth (6 went to Transitional Living, 1 went to Home of Parent, others were in emergency placements at end of fiscal year)

DCFS has created a database to capture the information requested by the General Assembly on each youth in care who remained in an emergency placement longer than 30 days. The process for identification of all youth in emergency placement begins with individual daily census reports from the shelters and emergency foster care providers. Youth who remain in emergency placements longer than 30 days are entered in the data base.

To reduce the length of time youth in care wait in emergency placements, the Department utilizes a centralized system that has a gatekeeper who oversees emergency placement referrals submitted by DCFS and private agency caseworkers. The Department’s Shelter Administrator, Operations Division, is responsible for approving youth for emergency foster homes and shelters. The Department contracts with private agencies for emergency shelter facilities. The Shelter Administrator hosts and facilitates a conference call with each shelter supervisor and DCFS Area Administrator every weekday morning. The purpose of the call is to confirm the shelter census, current bed availability, significant events, status on any safety/supervision plans, the climate of the milieu, status on placements and discharges. Specific focus is given to youth that are in the shelter beyond 30 days.

Children and youth that remain in emergency placements beyond 30 days and present significant barriers to securing the appropriate level of care are brought to the attention of a higher-level team. The team meets weekly and is facilitated by Clinical Division managers and other senior staff. The purpose of the weekly roundtable is to provide urgent case consultation and support to the case managers responsible for clients that present the highest degree of psychiatric and behavioral issues.

Youth in **Detention Center/DJJ** More than 15 DaysAfter Release Date

Figure 5: Number of Youth in Detention/DJJ > 15 Days by Barriers to Placement

Legal involvement, extensive criminal involvement, and substance abuse are the primary barriers to timely placement for the detention/DJJ population. Most youth are waiting to be placed in a residential treatment center. The recommended Level of Care:

* Residential Treatment: 30 youth (8 went to Residential, 2 to Home of Parent, others were in Detention/DJJ at end of fiscal year)
* Specialized Foster Care: 2 youth (1 went to Specialized Foster Care, 1 was in Detention/DJJ at end of fiscal year)
* Home of Relative: 2 youth (1 went to Specialized Foster Care, 1 went to Residential Treatment Facility)
* Transitional Living Program/Group Home: 8 youth (3 went to Transitional Living Program, 1 went to Group Home, 1 went to Residential Treatment Facility, others were in Detention/DJJ at end of fiscal year)

DCFS created a database to capture all the information requested on each youth in care who remained in detention or a DJJ facility for more than 15 days beyond their Targeted Release Date (TRD). Identifying and tracking all youth in Juvenile Detention Centers (JDC) and DJJ facilities involve separate processes. The Cook County Juvenile Temporary Detention Center (JDTC) is the only detention center that electronically transmits a list of youth with release dates to the Department, this list is received daily by the Dually Involved Program Administrators. Youth detained by the Cook County JTDC and ordered to be released are referred to as Release Upon Request (RUR), which is the point where the Department begins to track the number of days the RUR youth remain in detention beyond the release date. DCFS legal staff is notified immediately once a youth is ordered and classified as RUR. The youth is then assigned to a case management agency within 24 hours and scheduled for a clinical placement meeting within 48 hours. During this meeting, the desired level of care for the next placement is identified and the referral process begins. The caseworker is responsible for identifying a placement and provides a weekly report to the Juvenile Court on the status of the placement. The RUR process does not occur with the other 15 JDCs within Illinois, which are county-operated.

DCFS established a re-entry program for youth who are detained and are ready to be released from detention but are awaiting a placement in a residential treatment center. DJJ provides a monthly list of DCFS youth that are incarcerated in a DJJ facility or on aftercare (synonymous with juvenile parole), which provides the anticipated release date. Dually Involved Program Administrators meet monthly with DJJ Aftercare Administration to discuss the youth who are scheduled to be discharged within the next 90 days. Frequently the anticipated release date moves to an earlier date, which can impact the Department’s ability to effectively secure placement in a timely manner. Dually Involved Program Administrators provide monthly status reports to the Cook County Juvenile Court Dually Involved Committee and to the DJJ administrators. Over the course of this fiscal year the Department will continue to refine the data tracking ability of these youth as well as continue to work to improve the timeliness to placement.

Department Placement, Data Collection, Reorganization, and Process Change

Over the past year, there has been an increasing number of youth coming into care, and more of these youth are coming in from psychiatric hospital lock outs and remanded from court. Many of them have experienced complex trauma, display emotional, psychological, developmental and/or behavioral problems, and have an above average need of multiple services. There are several areas the Clinical & Child Services and Residential Divisions are fine-tuning during the third quarter of FY20 to respond to the needs of these youth and families.

For youth in psychiatric hospitals, the needs of the caregiver support system will be considered as it relates to services or access to resources that will preserve the wellbeing of the hospitalized youth after discharge. This involves many adjustments to the Priority Clinical Staffing (PCS) including having a more rapid response starting with the notification of admission, triaging the case within 24 hour, identifying specialty service partners and staffing needs based on whether there is a return to placement or possible need for a new level of care, and having the Psychiatric Hospital Program (PHP) Liaison deliver a preliminary case summary. The PCS team will collect relevant information and meet with Clinical Specialty Services staff. After the staffing there will be a 15-, 30-, and 60-day follow up by the Facilitator/ Implementation Specialist to ensure access to recommended resources and assist with any barriers.

In the Central Matching department, the process of matching youth to placements is being revamped to improve communication between the Department and the providers. The current email stream with multiple providers will be changed to one provider being contacted per email. This will reduce the number of people on an email and number of emails making it much easier to track the progress of the referral and responses, along with ensuring independent decisions are being made for each youth. Also, the process is being streamlined to ensure that all the information needed for matching is available initially, and is clear, up to date, and accurate. This is being done by working within the Clinical Practice department to ensure the necessary documentation is provided at the staffing to eliminate having to wait for the information once a youth has been matched to a placement.

Another area we are looking closely at is the number of readmissions to Psychiatric Hospitals. Over a two-year period, from November 2017 to November 2019, the average number of readmissions varied by the prior level of care. For youth in Residential Treatment Centers, there was an average of 2.89 readmissions, Specialized Foster Homes was 1.51, and Family Based Homes was 1.27. Starting in the third quarter of FY20, we are going to revisit the practice of only providing clinical support when contacted by residential treatment team or agency monitor. We would like to develop a protocol for more active involvement in the follow up process with the facilities.

The Central Matching and Resource Development teams are improving data collection to ensure that timely placements are available at each level of care. We are improving the data collection process and working to integrate the data sources in order to track the movement of youth through the various levels of care. Central Matching is reviewing each youth listed to determine the status of their referral to match with providers that have available resources. There are many youth that have been matched and waiting for an open placement. While the focus is on three groups: Beyond Medical Necessity (BMN), Shelters/Emergency Placements, Residential discharge – Phase II (youth waiting to be placed), and DJJ/Detention – Release Upon Request (RUR), all youth will benefit from this resource plan.

The Department has identified there is a need for each level of care to ensure that resources are available for youth that have been matched for a higher level of care and for youth stepping down to lower levels of care. We understand that it is important to not overdevelop as we look forward to the implementation of Family First and the subsequent time-limited treatment for youth in residential facilities. The long-term greatest need will be for youth to be moved from high end care to community-based services. Keeping this in the forefront, the objective is to continue to build Specialized and Therapeutic Foster Care Homes, Group Homes, and Independent/ Transitional Living Placements. In addition, Integrated Care Centers/Units serve as short-term transitional placements, which offer quality care and compassion to youth who have been recently removed from their homes and/or who may have disrupted from their current living arrangement. Attention is given to minimizing trauma by providing a safe environment, which is predictable and structured. These programs provide increased clinical services to serve youth with greater needs who may have recently met acute inpatient psychiatric criteria but do not meet continued care criteria or youth no longer in need of remaining incarcerated and have symptoms and functional impairments where continued assessment, treatment, and longer-term planning is needed. The goal is to identify areas where resources need to be developed for youth to be placed in a timely manner and ensure that services are identified and brought on line in a systemic manner that will address the needs of the youth in care.

The Department has approved the hiring of four Residential Recruitment Specialists; one for each region. These Specialists will conceptualize, coordinate, monitor, and develop the residential recruitment program for their assigned geographic area. They will work in their local area to develop and implement a plan to identify residential resource needs, provide outreach to local community stakeholders, as well as appropriate DCFS staff, to develop recruitment strategies that will facilitate the expansion of resources needed to better serve children and families. Also, they will provide professional assistance and resource development support to casework staff with specialized, problematic service need cases and conduct annual needs assessments in the region to determine unmet service needs.

Summary

The Clinical and Child Services Division is working diligently to improve our process at each level of care to ensure that children needing a higher level of care are matched and moved to an appropriate placement. The goal is when youth are matched, to have available beds so they can be moved expediently. And once their treatment has been completed, they are able to move to a home in the community with the proper supports and not need to return to that high level of care. In addition, we are working on ways to provide services and support to maintain youth in their current placements and to work with foster parents and caseworkers on an individual basis to address their needs. We want to improve clinical consultation prior to the extreme instabilities in the youth’s mental and behavioral health that result in the need for psychiatric hospitalization and higher levels of care, or involvement in the Detention/Department of Juvenile Justice.